13

Health

As usual, the General Assembly was quite active in the area of health law in 2006. There was some major new public health legislation, including new laws affecting private drinking water wells, food safety, and the on-site wastewater permitting program. A controversial 2005 law that would have required kindergarteners to receive comprehensive eye examinations was amended. An overhaul of North Carolina's impaired driving laws contains several sections that significantly affect health care providers who interact with law enforcement officers investigating impaired driving cases. Several new laws affect the management of confidential information maintained by health care providers, including the impaired driving law changes, amendments to the Identity Theft Protection Act of 2005, new protection for records maintained by the public health lead program, and changes to North Carolina's juvenile code (G.S. Chapter 7B).

This chapter summarizes all of the above, as well as the 2006 appropriations act provisions affecting public health, new laws affecting health insurance, the regulation of various health care professions, and health care facilities. Other laws that may be of interest to public health agencies or health care providers are briefly noted.

Public Health

Budget

The 2006 appropriations act, S.L. 2006-66 (S 1741), provides funding to the North Carolina Division of Public Health to expand several significant public health programs. Recurring funds were appropriated as follows:

- $7.1 million to the early intervention program for children from birth to age three, to support the increased number of children who have been referred to the program for services.
- $5.5 million to the universal vaccine program, to expand coverage of influenza and pertussis vaccines.
- $3.25 million to support sixty-five school nurse positions that previously had time-limited support from federal grants

- $2 million to the Community-Based Eliminating Health Disparities Initiative. (The 2005 appropriations act, S.L. 2005-276, provided $2 million in nonrecurring funds.) The money is to be used to provide grants-in-aid to local health departments, American Indian tribes, and faith-based or community-based organizations, to improve minority health status. The funds will also support one position to manage the program.
- $390,000 in funding for dental preventive services. The funds are to be used to support the fluoride mouth rinse program in schools, community water fluoridation, and dental sealants and other dental services for children at high risk of tooth decay.
- $90,000 to fund one position and support the costs of implementing the North Carolina Institute of Medicine's recommendations for initiatives to prevent child abuse and neglect.

The General Assembly also appropriated nonrecurring funds to support several public health programs and initiatives. Nonrecurring funds were appropriated as follows

- $400,000 to the Division of Public Health to match federal funds for the purchase of antiviral influenza medication. The North Carolina pandemic influenza response plan calls for the state to stockpile antiviral medication to be used for first responders and healthcare workers in the event of a flu pandemic. $300,000 as a grant-in-aid to the Healthy Start Foundation.
- $200,000 to the Women's Health Services Branch to provide family planning services for uninsured women who are not eligible for Medicaid.
- $150,000 to provide education on pre-term birth and, in some cases, to purchase medication for women at risk of giving birth prematurely.

Both the Division of Public Health, which is within the Department of Health and Human Services (DHHS), and the Division of Environmental Health, within the Department of Environment and Natural Resources (DENR), received funds to support a new statewide private well program (described below). The Division of Environmental Health received a recurring appropriation of $271,079 and a nonrecurring appropriation of $827,550. These funds will pay for five new positions—four environmental health regional specialists and one administrative assistant. In addition, funds will support technical and enforcement assistance to counties. A nonrecurring appropriation of $226,000 will pay for equipment and supplies for the state public health laboratory to expand its capacity to test private well water samples, as it is anticipated that the number of samples the lab must test will increase when the new program is implemented. Section 10.20 of S.L. 2006-66 amends G.S. 130A-5 to authorize the Secretary of DHHS to charge a fee of up to $55 to pay for the state laboratory's analyses of water samples from newly constructed private wells and use fee receipts to support personnel working in the new public well program.

Additional appropriations to the Division of Environmental Health will support the following programs and activities:

- Nonrecurring funds in the amount of $300,000 are allocated to pay for notification of residents and business operators who obtain drinking water from a private well that is located within 1,500 feet of known groundwater contamination. The funds may also be used for testing private drinking water wells for contamination and providing alternative drinking water supplies to persons whose drinking water is contaminated.
- Recurring funds in the amount of $140,079 will pay for two positions (one soil scientist and one environmental engineer) to provide technical on-site assistance to customers requesting septic tank permits.
- A recurring appropriation of $167,980 and a nonrecurring appropriation of $11,020 will create three new positions to work with shellfish sanitation and provide funds to monitor and classify North Carolina's shellfish growing waters.

Several special provisions in the appropriations act expand or modify public health programs and activities.

Section 11.7 amends G.S. 130A-328 to increase community water system operating permit fees effective January 1, 2007. The appropriations act provides that the new revenue from the fee

increases will fund eighteen environmental engineer positions and one environmental technician position within DENR. The new staff members will be responsible for field response, inspections, technical assistance, compliance oversight, laboratory support, and review and approval of plans to protect public drinking water supplies. The positions will be funded as revenue is generated. It is expected that seven positions will be funded in fiscal year 2006–07 and the remainder in 2007–08.

Section 10.13 appropriates nearly $10 million to the Division of Public Health to fund the development and implementation of the Health Information System (HIS), which is intended to replace the outdated Health Services Information System (HSIS). The purpose of the Health Information System is to provide an automated means of capturing, monitoring, reporting, and billing services provided by local health departments, children's developmental services agencies, and the state public health laboratory. Allocation of the funds is contingent upon full compliance with Section 10.59A.(b) of the 2005 appropriations act, which required the Division of Public Health to report on the use of funds appropriated in 2005–06 by March 1, 2006.

A special provision in the 2005 appropriations act provided that $2 million of the funds appropriated for community health grants for the 2005–06 and 2006–07 fiscal years would be allocated to federally qualified health centers, local health departments, and specified other health care facilities to increase medically indigent and uninsured persons' access to preventive and primary care services. Section 10.16 of the 2006 appropriations act amends this special provision to provide that $5 million of the funds appropriated for community health grants must be used in this manner in fiscal year 2006–07. It also amends the 2005 provision (1) to allow additional types of agencies that provide health care to receive funding and (2) to add items to the list of issues DHHS is required to consider in distributing funds to the various facilities.

Finally, a special provision in the 2006 appropriations act allows expanded eligibility for the state's AIDS Drug Assistance Program. In fiscal year 2005–06, eligibility for the program was limited to HIV-positive individuals with incomes at or below 125 percent of the federal poverty level. Section 10.21 of S.L. 2006-66 provides that, for the 2006–07 fiscal year, DHHS may adjust the financial eligibility criterion for the program up to at or below 250 percent of the federal poverty level. If such an adjustment is made and a waiting list for the program develops as a result, DHHS must give priority on the waiting list to individuals at or below 125 percent of the federal poverty level.

Private Wells

Arguably the most significant public health legislation enacted this past session was a new mandate for local governments to develop programs to regulate private drinking water wells [S.L. 2006-202 (H 2873), S.L. 2006-259, sec. 51 (S 1523)]. Under the law, a "private drinking water well" (or private well) is one that (1) serves or is proposed to serve fourteen or fewer service connections or (2) serves or is proposed to serve twenty-four or fewer individuals.[1] Prior to the adoption of this new law, private drinking water wells were not subject to regulation by the state. Since 1967, state law has included construction standards for private wells, but there was little oversight of the construction or enforcement of the standards in most counties.[2]

All local health departments are involved with private wells to some extent. State law requires each local health department to have a program for collecting water samples from private wells and submitting the samples for laboratory testing.[3] This sampling and testing is typically done in response to a property owner's or resident's request or in response to a disease or outbreak

[1] The full definition of "private drinking water well" is "any excavation that is cored, bored, drilled, jetted, dug, or otherwise constructed to obtain groundwater for human consumption and that serves or is proposed to serve 14 or fewer service connections or that serves or is proposed to serve 24 or fewer individuals. The term 'private drinking water well' includes a well that supplies drinking water to a transient noncommunity water system as defined in 40 Code of Federal Regulations § 141.2 (1 July 2003 Edition)." S.L. 2006-202 (amending G.S. 87-85).

[2] *See* G.S. Chapter 87, Article 7 (North Carolina Well Construction Act).

[3] *See* 10A NCAC 46 .0210(a); *see also* G.S. 130A-1.1(b)(2)b (providing that water safety and sanitation is a mandated public health service under state law).

investigation. Some local governments had gone even further, however, by establishing local permitting programs for private wells and actively enforcing the state construction standards. Under G.S. 87-96, local boards of health are authorized to implement such programs by adopting the Environmental Management Commission's well regulations by reference and incorporating more stringent provisions when necessary to protect the public health.

Under the new law, all local health departments are now required to implement programs for permitting, inspecting, and testing wells. Local programs must be operational by July 1, 2008. The statute outlines some of the basic requirements applicable to these local programs, but many of the details will be outlined in the coming months in regulations to be adopted by the Environmental Management Commission.[4] Once the state regulations are in place and the local environmental health specialists are enforcing the state regulations, the specialists will be considered agents of DENR for liability and insurance purposes.

Finally, the new law permits local health departments to charge fees associated with their private well programs.[5] The fees must be cost-related and must be deposited in the local health department's account and used for public health purposes.[6]

The General Assembly appropriated $827,550 in nonrecurring funds to DENR to distribute to counties that need assistance setting up local programs to enforce the statewide well construction standards.[7]

Food Safety

Two new laws relate to food safety. One expands the authority of public health officials to embargo unsafe food and drink, and the other requires certain stakeholders to develop a plan to protect the food supply from intentional contamination.

For many years, environmental health professionals have lacked the direct authority to embargo—or hold—unsafe food or drink they discovered in restaurants and other regulated establishments. The law granted the North Carolina Department of Agriculture and Consumer Services (DACS) broad embargo authority and provided that DENR and local public health officials could embargo food or drink (with the exception of milk and shellfish) only if DACS delegated the authority to them. Typically, if an environmental health specialist encountered unsafe food or drink in a regulated establishment, he or she would ask the owner or manager not to serve it to the public. If the owner or manager insisted upon serving it, the specialist could

- contact DACS and request the agency's assistance in embargoing the item,
- immediately suspend or revoke the establishment's permit on the ground that the item presented an imminent hazard to the health of the public, or
- ask the state or local health director to declare the food or drink an imminent hazard and proceed with an abatement of the hazard under G.S. 130A-20.[8]

---

[4] S.L. 2006-202, sec. 2 [amending G.S. 87-87; subdivision (7)] requires the Environmental Management Commission to adopt regulations governing private wells. The commission is expected to adopt state regulations governing the private well programs by July 1, 2008.

[5] The fees must be based upon a plan recommended by the local health director, approved by the local board of health, and approved by the board(s) of county commissioners. G.S. 130A-39(g).

[6] For detailed information about the new well law, see Aimee N. Wall, *North Carolina Environmental Health: 2006 Legislative Update*, HEALTH LAW BULLETIN No. 85 (UNC School of Government, October 2006).

[7] North Carolina General Assembly, Joint Conference Committee Report on the Continuation, Capital and Expansion Budgets (S 1741) at H-5 (June 20, 2006) (providing "funds for technical support and enforcement assistance to counties as they enforce statewide private water supply well construction standards"). In addition to this technical assistance funding for counties, the General Assembly provided DENR with funding for five new staff positions to support the new well program.

[8] The term "imminent hazard" is defined as "a situation that is likely to cause an immediate threat to human life, an immediate threat of serious physical injury, an immediate threat of serious adverse health effects, or a serious risk of irreparable damage to the environment if no immediate action is taken." G.S. 130A-2(3). Environmental health specialists are authorized to suspend or revoke permits immediately only when an imminent hazard exists. G.S. 130A-23(d).

S.L. 2006-80 (H 2200) revises the existing embargo statute (G.S. 130A-21) to supplement the embargo authority of DACS by providing both DENR and local health directors with the authority to embargo food and drink in regulated establishments. There are several important limitations on this authority with respect to its scope and delegation.

The new embargo authority may be used only with respect to food or drink that is either adulterated or misbranded (as defined by state law)[9] and found in establishments that are either

- regulated by DENR pursuant to G.S. Chapter 130A; or
- the subject of a food-borne illness outbreak pursuant to G.S. 130A-144.

Regulated establishments include, for example, restaurants, food carts, and hotels. Establishments that are exempt from regulation, such as private clubs and certain nonprofit corporations, are not subject to this new embargo authority.

The law grants this embargo authority to the Secretary of DENR and to local health directors. Many of North Carolina's public health laws provide legal authority or responsibility to the Secretary of DENR or DHHS or to a local health director. In practice, however, local environmental health staff members typically perform functions such as inspecting restaurants. State law specifically authorizes delegation of these responsibilities and authority to local environmental health specialists.[10]

The embargo law is different. It states that the new embargo authority "shall not be delegated to individual environmental health specialists in local health departments."[11] The new law grants this authority to two groups of individuals:

- local health directors, and
- DENR regional environmental health specialists and their superiors.

Local health directors may not act alone when seeking to exercise embargo authority. The director must consult with a regional environmental health specialist before issuing an embargo order.

When faced with a potential embargo, a person in charge of a regulated establishment may voluntarily agree to destroy the food or drink that the local health department or DENR identifies as problematic. If the person does not voluntarily dispose of the food or drink, then the health director or DENR staff has the authority to move forward with the embargo. This means that the health director (in consultation with DENR) or a DENR representative can take immediate steps to detain the item and subsequently go to court seeking an order requiring the person to destroy it.[12]

The same legislative subcommittee that recommended enhancing public health's embargo authority also called for development of a broader food defense plan. S.L. 2006-80 directs DACS, DENR, and DHHS to "jointly develop a plan to protect the food supply from intentional contamination." According to DENR, a joint task force with representatives from all three agencies is currently in the process of developing a three-part plan that will address protection of food, plants and crops, and livestock.

Smoking Regulation

Article 64 of G.S. Chapter 143 regulates smoking in public places in North Carolina. In most cases, Article 64 requires at least 20 percent of the interior space of public buildings to be designated as a smoking area, unless to do so is physically impracticable. However, G.S. 143-599 provides a list of facilities that are exempt from the provisions of Article 64 and in which smoking

---

[9] *See* G.S. 106-129 (foods deemed to be adulterated); G.S. 106-130 (foods deemed to be misbranded).

[10] G.S. 130A-4 ("When requested by the Secretary, a local health department shall enforce the rules of the Commission under the supervision of the Department. The local health department shall utilize local staff authorized by the Department to enforce the specific rules."); G.S. 130A-6 ("Whenever authority is granted by this Chapter upon a public official, the authority may be delegated to another person authorized by the public official.").

[11] G.S. 130A-21(a). Note that this restriction on delegation does *not* apply to the pre-existing embargo authority for milk and shellfish.

[12] For more detailed information about the embargo law, see Aimee N. Wall, *North Carolina Environmental Health: 2006 Legislative Update*, HEALTH LAW BULLETIN No. 85 (UNC School of Government, October 2006).

may be prohibited entirely. In recent years, the General Assembly has added several facilities to the list of exemptions. For example, in 2005 it added local health department grounds and large indoor arenas, among other facilities.[13] S.L. 2006-133 (H 448) adds community colleges to the list of facilities that are not required to provide smoking areas in their buildings.

The 2006 General Assembly also restricted smoking in its own buildings. S.L. 2006-76 (H 1133) amends G.S. 143-597 to designate all areas of any building occupied by the General Assembly as nonsmoking areas.

On-Site Wastewater

State law provides a comprehensive certification program for persons who install and repair drinking water wells[14] and for registered sanitarians,[15] but until recently, it did not have a similar certification system for people who install or inspect on-site wastewater systems. S.L. 2006-82 (H 688) enacts Article 5 of G.S. Chapter 90A, a comprehensive new law that sets out a certification system for on-site wastewater contractors and inspectors. In summary, the law

- establishes a new certification board;
- authorizes the board to adopt regulations and oversee the certification process;
- requires persons to be certified at different grade levels that will vary based on design capacity, complexity, projected costs, and other factors; and
- outlines the basic requirements for certification.

The provisions establishing the new certification board went into effect on July 10, 2006, but the provisions requiring certification by the new board do not go into effect until January 1, 2008.

Over the last few years, the public health community has discussed the possibility of integrating private-sector soil scientists into the on-site wastewater permitting process in order to possibly expedite the permitting process. During recent legislative sessions, several bills have been introduced that would have made these and other changes to the current permitting system.[16] In 2006, the General Assembly did not pass a comprehensive change to the current system, but it did enact S.L. 2006-136 (H 1094), authorizing DENR to establish a pilot program to test out such a system in certain counties.

The pilot program is an option only in a county that meets the following three conditions:

- The county's population must be 25,000 or less (according to the most recent census).
- The county must have had more than 900 on-site wastewater applications (improvement permits or construction authorizations) pending before the health department on July 19, 2006.
- The county's board of commissioners and board of health must approve a resolution authorizing the county's participation in the pilot program.

In August, both the board of health and the board of county commissioners in Cherokee County approved resolutions requesting participation in the pilot program, and the county health department and DENR are currently moving forward with implementation. The pilot program is scheduled to expire on July 1, 2011. Beginning in October 2007, DENR is required to submit annual evaluations of the pilot program to the General Assembly. The evaluations must examine whether the pilot program

(1) reduced the amount of time for processing applications,

(2) resulted in an increased number of on-site system failures, and

(3) resulted in new or increased environmental impacts.[17]

---

[13] See *North Carolina Legislation 2005*, Chapter 12, "Health."

[14] G.S. Chapter 87, Article 7A (Well Contractors Certification).

[15] G.S. Chapter 90A, Article 4 (Registrations of Sanitarians).

[16] During the 2005-06 session, the primary vehicles for this discussion were House Bill 900 and Senate Bill 902.

[17] For more information about the new on-site wastewater legislation, see Aimee N. Wall, *North Carolina Environmental Health: 2006 Legislative Update*, HEALTH LAW BULLETIN No. 85 (UNC School of Government, October 2006).

Injury Prevention

North Carolina has had a mandatory seat belt use law since 1985. Initially, G.S. 20-135.2A applied only to the driver and front-seat passengers. A later-enacted law, G.S. 20-137.1, required persons under the age of sixteen who occupied the rear seats to be restrained either by a seat belt or a child safety seat (depending on the child's age or weight). S.L. 2006-140 (S 774) makes seat belt use mandatory for all occupants of motor vehicles, including adults occupying the rear seats. It also adds to the existing list of exceptions to the seat belt requirement an exception for occupants of motor homes who are not either driving or riding as a passenger in the front seat. A driver or front-seat passenger's failure to wear a seat belt is a primary offense, meaning a law enforcement officer needs no other justification to stop the vehicle and issue a citation. In contrast, S.L. 2006-140 provides that the failure of a rear-seat passenger to wear a seat belt is not in itself justification for stopping the vehicle. Rather, it is a secondary offense that may be charged only if the vehicle has been stopped for another reason. Finally, the new law sets the fine for the offense at $10 and no court costs (the fine for a front-seat passenger's failure to wear a seatbelt is $25 plus court costs). The new law became effective December 1, 2006, and only warnings for violations may be issued for the first six months. Law enforcement officers may begin issuing citations for violation of the new law on July 1, 2007.

S.L. 2006-177 (S 1289) enacts new G.S. 20-137.3, which prohibits teens under the age of eighteen from using mobile phones while driving. The driver may use a mobile phone if the vehicle is stationary. In addition, the driver may use a mobile phone while driving to communicate with his or her parent, legal guardian, or spouse. The driver may also use a mobile phone while driving if there is an emergency and the driver is using the phone to communicate with an emergency response operator, a hospital, a physician's office, a health clinic, an ambulance company, a fire department, or a law enforcement agency. Violation of the new law is an infraction punishable by a fine of $25. In addition, a teenager who would otherwise be eligible to move up a level in the graduated driver licensing system—for example, from a limited learner's permit to a limited provisional license, or from a limited provisional license to a full provisional license—will not be permitted to do so if he or she has committed this infraction within the preceding six months. However, no driver's license points, insurance surcharge, or court costs may be assessed as a result of the violation. The new law became effective December 1, 2006.

Other Public Health Issues

The General Assembly established the Justus-Warren Heart Disease and Stroke Prevention Task Force in 1995.[18] The Task Force's duties include adopting and promoting a state Heart Disease and Stroke Prevention Plan and facilitating the efforts of state and local agencies in implementing it. S.L. 2006-197 (H 1860) amends G.S. 143B-216.60(j) to require the task force to establish and maintain a Stroke Advisory Council. The council must advise the Task Force on the development of a statewide system of stroke care, including a system for identifying and disseminating information about the location of primary stroke centers. Uncodified portions of the law specify the membership of the advisory council and require the task force to make recommendations to the General Assembly by February 15, 2007.

[18] S.L. 1995-507, sec.26.9. The task force was initially called the North Carolina Heart Disease and Stroke Prevention Task Force. It was renamed the Justus-Warren Heart Disease and Stroke Prevention Task Force in 2003 (S.L. 2003-284, sec. 10.33B).

School Health

Kindergarten Vision Screening

In 2005, the General Assembly enacted G.S. 130A-440.1, which required a child entering kindergarten in a public school to have a comprehensive eye examination performed by an ophthalmologist or optometrist. The law proved quite controversial and was quickly challenged in court. In the summer of 2006, a court delayed enforcement of the law in order to allow the General Assembly an opportunity to reconsider the provisions under challenge.

The General Assembly responded by enacting G.S. 2006-240 (H 2699), which amends G.S. 130A-440.1. The law replaces the requirement for a comprehensive eye examination with a requirement for vision screening. Beginning with the 2007–08 school year, children enrolling in public kindergarten[19] must have *either* a comprehensive eye examination *or* a vision screening within the twelve months preceding their enrollment. The vision screening may be conducted by a physician, optometrist, physician assistant, nurse practitioner, registered nurse, or orthoptist or by a vision screener certified by Prevent Blindness North Carolina. Parents of children subject to this requirement must present certification of the screening to the school within 180 days of the start of the school year. If a child receives a vision screening as part of the kindergarten health assessment required by G.S. 130A-440, the health assessment transmittal form required by that statute satisfies this certification requirement.

The new law still requires comprehensive eye examinations for a subset of children—those who receive and fail to pass the required vision screening. The optometrist or ophthalmologist who conducts such an examination must present a signed transmittal form to the child's parent, and the parent must submit the form to the child's school. However, a child may not be excluded from school because the child's parent fails to obtain a required examination. Instead, the school must send a written reminder to the parent that includes information about funds to pay for the examination that may be available from the Governor's Commission on Early Childhood Vision Care.

The law also provides that school personnel may recommend a comprehensive eye examination for a child enrolled in grades K–3 if there is reason to believe the child has a vision problem. When such a recommendation is made, the school personnel must notify the parent that funds to pay for the examination may be available.[20]

Section 2 of the new law amends G.S. 143B-216.75 to expand the membership of the Governor's Commission on Early Childhood Vision Care to include a pediatrician and a school nurse. An uncodified provision of Section 2 requires the commission to work with the Department of Public Instruction to establish procedures for identifying and referring children who need vision screenings or comprehensive eye examinations.

Environmental Hazards in Schools

The Schoolchildren's Health Act of 2006, S.L. 2006-143 (H 1502), adds several provisions to G.S. Chapter 115C that are intended to protect school children from environmental hazards in schools. The act requires the State Board of Education to

- Develop guidelines for sealing arsenic-treated wood in playground equipment or establish a timeline for removing the wood from playgrounds.
- Develop guidelines for testing soil for contamination from arsenic-treated wood.

[19] In some cases, children entering first grade will be subject to this requirement as well. If a child entering first grade has not previously been enrolled in a kindergarten program that required a vision screening, the child must receive a vision screening and the child's parents must provide certification of the screening within 180 days of the start of the school year.

[20] Funds for this program were reduced by $1.5 million in the 2006–07 budget. Joint Conference Committee Report on the Continuation, Capital and Expansion Budgets (June 30, 2006), page G-2 (available on the Internet at http://www.ncleg.net/sessions/2005/budget/2006/budgetreport6-30.pdf).

Formatted: Default Paragraph Font

- Establish guidelines to reduce students' exposure to diesel emissions from school buses.
- Study methods for mold and mildew prevention and mitigation and incorporate recommendations into the public school facilities guidelines.
- Establish guidelines for integrated pest management in accordance with a 2004 policy of the North Carolina School Boards Association.
- Establish guidelines for notifying students' parents and school staff about pesticide use on school grounds.

The act also requires local boards of education to

- Adopt policies addressing the use of pesticides in schools. Among other things, the policies must require annual notification of parents and school staff of the schedule of pesticide use.
- By October 1, 2011, require the use of integrated pest management,[21] with an emphasis on pest prevention.
- Prohibit the purchase or acceptance of arsenic-treated wood for future use on school grounds and either seal existing arsenic-treated wood or establish a timeline for removing it. The boards are encouraged but not required to test soil on school grounds for arsenic contamination.
- Prohibit the use of elemental mercury and mercury compounds as teaching aids. There is an exception for barometers containing mercury. The boards are encouraged but not required to remove and properly dispose of existing mercury.
- Adopt policies and procedures to reduce students' exposure to diesel emissions.

Section 3 of the act, which is not codified, provides that the act does not create a private cause of action against the State Board of Education, a local board of education, or the agents or employees of those boards.

Transportation Safety

S.L. 2006-208 (H 1155) addresses the safety of public school students involved in school-sponsored travel. Section 1 amends G.S. 115C-247 to require local boards of education that operate activity buses to adopt a policy for proper use of those vehicles. Section 2 is uncodified and directs the Department of Public Instruction, in cooperation with the Department of Transportation, to develop a program for issuing a statewide permit to commercial motor coach companies that seek to contract with local school systems to transport students and others on school-sponsored trips. Among other things, the program must require the companies to demonstrate compliance with federal safety regulations.

Pregnant or Parenting Students

Public school students who are pregnant or have children are entitled to receive the same educational instruction as other students under new G.S. 115C-375.5, enacted by Section 4 of S.L. 2006-69 (H 1908). This law, which was effective at the beginning of the 2006–07 school year, requires local boards of education to adopt policies to ensure that pregnant or parenting students are not subjected to discrimination or excluded from school or school programs, classes, or extracurricular activities. Among other things, the local policies must provide for homebound instruction when necessary, allow excused absences for pregnancy-related care, and provide for the student to attend to his or her child's illness or medical appointments.

[21] The law defines "Integrated Pest Management" as "the comprehensive approach to pest management that combines biological, physical, chemical, and cultural tactics as well as effective, economic, environmentally sound, and socially acceptable methods to prevent and solve pest problems that emphasizes pest prevention and provides a decision-making process for determining if, when, and where pest suppression is needed and what control tactics and methods are appropriate."

Other sections of S.L. 2006-69 may be of interest to school nurses and other health care providers. The bulk of this act rewrites the laws governing the education of children with special needs. Those provisions are summarized in Chapter 10, "Elementary and Secondary Education."

Health Insurance

Teachers' and State Employees' Medical Plan

S.L. 2006-174 (S 837) requires individuals who are first hired as teachers or state employees on or after October 1, 2006, to complete at least twenty years of service under the Teachers' and State Employees' Retirement System before becoming eligible for the Comprehensive Major Medical Plan on a noncontributory basis. If an individual first hired on or after October 1, 2006, has at least ten but less than twenty years of service, the state will pay 50 percent of the contributory portion. However, any individual who is first hired on or after October 1, 2006, and who has less than ten years of service may participate in the medical plan only if he or she pays the full premium for participation—the state will not pay any part of the premium. The same provisions apply to members of the General Assembly first taking office on or after February 1, 2007.

S.L. 2006-249 (H 1059) makes several substantive and technical changes to the Teachers' and State Employees' Comprehensive Major Medical Plan. It empowers the plan's Executive Administrator and Board of Trustees to authorize coverage for over-the-counter medications and to require co-payments for these medications. It authorizes the Executive Administrator and Board of Trustees to adopt incentive programs to encourage plan members to achieve and maintain healthy lifestyles and improve their health. Participation in these programs is voluntary for members. An incentive plan may provide for waiver of deductibles, co-payments, and coinsurance in order to determine the effectiveness of the incentive program. The law also amends G.S. 135-40.6A(b) to add surgically implanted bone anchored hearing aids to the list of services that may be subject to prior approval procedures. Finally, it amends G.S. 135-39.5B(b) to provide that benefits under the Comprehensive Major Medical Plan may not be paid to persons enrolled in an optional prepaid hospital and medical benefits program, except when approved by the Executive Administrator in cases of continuous hospital confinement.

A special provision to the 2004 appropriations act authorized five North Carolina local governments to provide health care coverage to their employees through the Teachers' and State Employees' Comprehensive Major Medical Plan (S.L. 2004-124, sec. 31.26). The provision applied only to Bladen, Cherokee, Rutherford, Washington, and Wilkes counties and had a sunset date of June 30, 2006. In S.L. 2006-7 (S 1208), the 2006 General Assembly repealed the sunset date.

Teachers' and State Employees' Disability Income Plan

Article 6 of G.S. Chapter 135 establishes a disability income plan for members of the Teachers' and State Employees' Retirement System or the Optional Retirement Program for certain employees of North Carolina's public universities. The plan permits a member who has been receiving short-term disability benefits to participate in a trial rehabilitation, in which the member is given an opportunity to attempt to return to work and will not be required to undergo a waiting period before disability benefits resume if the attempt is unsuccessful. S.L. 2006-74 (S 1738) provides for a similar trial rehabilitation period for a member who has been receiving long-term disability benefits. It adds a new subsection (c1) to G.S. 135-106 (long-term disability benefits) permitting the member to return to service for up to thirty-six months. If the member is unable to continue in service—whether due to the initial cause of incapacity or a different cause—the member may be eligible to have his or her long-term disability benefits restored without a

waiting period or a period of short-term disability benefits if the member's disability is certified by a medical board.

Small Employer Health Plans

S.L. 2006-154 (H 1987) implements several recommendations of the House Select Committee on Health Care for small employer health plans. It amends G.S. 58-50-125 to permit the statutory basic and standard health plans for small employers to have optional deductible and co-payment levels, including high deductible options. Changes in deductibles or co-payments must be approved by the Commissioner of Insurance, who is also authorized to periodically review and update the benefits provided by small employer plans.

G.S. 58-50-125(d) requires small employer health insurance carriers that wish to operate in North Carolina to offer at least one basic and one standard health care plan. S.L. 2006-154 enacts a new section, G.S. 58-50-126, which permits the carriers to limit the coverage offered under G.S. 58-50-125(d) if the carrier offers at least two different health insurance policies that meet certain conditions. One of the options permits the carrier to offer a choice of a lower-level coverage and a higher-level coverage.

The new law makes several other changes to the laws governing small employer health insurance carriers, including permitting the carrier to charge premium rates that vary by up to 25 percent from the adjusted community rates. Under prior law, carriers were not permitted to charge rates that varied by more than 20 percent. Amendments also permit carriers to take an employer's industry into account in determining rating factors.

Finally, the act amends G.S. 58-50-149 to provide for the termination of the North Carolina Small Employer Health Reinsurance Pool. The pool will cease to reinsure any individual or group on January 1, 2007.

Health Care Access for Uninsured Persons

Section 10.12(a) of the 2006 appropriations act (S.L. 2006-66) directs the Secretary of Health and Human Services to develop a plan to expand health care access for uninsured North Carolinians. The plan must make use of public/private partnerships and federal resources and must promote the provision of charity care. The Secretary must use $100,000 of the funds appropriated to the Division of Medical Assistance for fiscal year 2006–07 to support the development of the plan.

Medicaid

The 2006 General Assembly made a number of changes to North Carolina's Medicaid program. These are described in detail in Chapter 24, "Social Services."

Health Information

Disclosure of Information to Law Enforcement Officers in Impaired Driving Cases

S.L. 2006-253 (H 1048) made extensive changes to the laws governing driving while impaired. Two of the changes significantly alter health care providers' duties with respect to medical information that may be relevant to an impaired driving case.

Section 17 enacts new G.S. 90-21.20B, which requires any health care provider[22] who provides medical treatment to a person involved in a motor vehicle crash to

- Disclose to a law enforcement officer investigating the crash, upon the officer's request, the person's name, current location, and whether the person appears to be impaired by alcohol, drugs, or another substance.
- Provide law enforcement officers with access to the person for visiting (presumably so that the person may be observed) or interviewing, except when the health care provider requests temporary privacy for medical reasons.
- Disclose a certified copy of all identifiable health information related to the person as specified in a search warrant or an order issued by a judicial official.

A prosecutor or law enforcement officer who receives identifiable health information under this section may not re-disclose the information, except as necessary to the investigation or as otherwise required by law.[23]

Section 19 of S.L. 2006-253 also amends G.S. 8-53.1 to provide that no privilege established in G.S. Chapter 8, Article 7 precludes a health care provider from disclosing information to a law enforcement agency pursuant to new G.S. 90-21.20B.

Confidentiality of Public Health Lead Program Records

Local health departments and the Department of Environment and Natural Resources (DENR) keep extensive records related to childhood blood lead level testing, results, investigation, and remediation.[24] Over the last several years, health departments and DENR have received numerous public record requests for copies of results from childhood blood lead testing. Public health officials were usually uncomfortable releasing the information in a manner that identified the child or the family because the information was health-related. Given that medical records held by local health departments are confidential under state law and are therefore exempt from the public records law,[25] many assumed that lead screening and investigation records were also confidential.

Prior to the 2006 legislative session, the law in this area was not entirely clear. First, no specific confidentiality laws appeared to protect the blood test results that are collected and maintained by DENR. In the absence of a law making the information confidential, the information should be a public record under state law.

When the information was maintained by local health departments, some argued that G.S. 130A-12, the statute that protects the confidentiality of much of the medical information maintained by health departments, applied to the lead screening and investigation information, at

---

[22] The new section incorporates the definition of "health care provider" found in G.S. 90-21.11, "any person who pursuant to the provisions of Chapter 90 of the General Statutes is licensed, or is otherwise registered or certified to engage in the practice of or otherwise performs duties associated with any of the following: medicine, surgery, dentistry, pharmacy, optometry, midwifery, osteopathy, podiatry, chiropractic, radiology, nursing, physiotherapy, pathology, anesthesiology, anesthesia, laboratory analysis, rendering assistance to a physician, dental hygiene, psychiatry, psychology; or a hospital or a nursing home; or any other person who is legally responsible for the negligence of such person, hospital or nursing home; or any other person acting at the direction or under the supervision of any of the foregoing persons, hospital, or nursing home."

[23] Some health care providers may be concerned that the federal HIPAA privacy rule prohibits them from making these disclosures of information. It does not. The privacy rule explicitly permits health care providers who are covered by the rule to make disclosures of identifiable health information when the disclosures are required by law. 45 C.F.R. 164.512(a). So long as providers limit their disclosures of information to the information specified in the law, they will not run afoul of the privacy rule.

[24] All laboratories in the state are required to report the results of all childhood blood lead tests to DENR. G.S. 130A-131.8. As a result, DENR maintains a large database containing individually identifiable test results. Local health departments maintain this type of information in at least two capacities. First, they have information in medical records for children who are receiving testing and care through the clinical arm of the department. Second, the environmental health arm of the department holds information related to investigations of children within its jurisdiction.

[25] G.S. 130A-12.

least with respect to the name of the child. But a close reading of the statute and other laws suggested otherwise. Specifically, the law protected two types of records:

- Records containing privileged patient medical information
- Records containing information protected under the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule (often called "protected health information" or PHI)

The child lead investigation records created by local health departments and shared with DENR are typically neither privileged information[26] nor protected health information.[27]

Section 13.2 of S.L. 2006-255 (S 1587) settled this issue by amending G.S. 130A-12 to make confidential all records collected under the authority of the state's child lead screening and investigation program. Therefore, all lead screening and investigation records in the custody of local health departments, DHHS, or DENR are now clearly not public records. It is worth noting that the confidentiality protection in G.S. 130A-12 extends to the entire record that contains information collected through the state's lead program. It is not limited to the medical information.

Identity Theft Protection Act Changes

In 2005, the General Assembly enacted a law requiring private businesses and government agencies to protect personally identifying information that could be used for identity theft. S.L. 2005-414 added a new Article 2A to G.S. Chapter 75, called the "Identity Theft Protection Act." This article applied only to businesses, which were defined to exclude government agencies. Another part of the law amended G.S. Chapter 132 and applied only to government agencies. It enacted G.S. 132-1.10, which restricted government agencies' collection of Social Security numbers and required agencies that collect Social Security numbers to take specific steps to guard against their unauthorized disclosure and to take other actions to guard against the public disclosure of specified identifying information. Although the law applied the name "Identity Theft Protection Act" only to the new article in Chapter 75, the entirety of S.L. 2005-414 has come to be known as the Identity Theft Protection Act.[28]

S.L. 2006-173 (H 1248) amends the portions of the Identity Theft Protection Act that apply to government agencies in several significant ways. First, it adds a new subsection (c1) to G.S. 132-1.10 to extend to government agencies the portions of G.S. Chapter 75, Article 2A that deal with security breaches. The new subsection requires government agencies that experience a "security breach" as defined in G.S. 75-61(14)[29] to comply with G.S. 75-65, which specifies the

[26] In general, the term "privilege" applies to information that was generated as part of a physician–patient relationship or a nurse–/patient relationship and is used in the course of caring for the patient. *See, e.g.*, G.S. 8-53 (physician privilege); G.S. 8-53.13 (nurse privilege). The lead-related information collected by DENR or the environmental health arm of a local health department is not generated through such clinical relationships.

[27] Information is protected health information only if it is held by an entity or person that is regulated by HIPAA (a "covered entity"). DENR is not a covered entity under HIPAA and therefore lead-related medical information in DENR's custody is not considered protected health information.

While all North Carolina local health departments are covered entities, the environmental health arms of many health departments are not subject to HIPAA. Health departments have the option of carving out non–health care components (i.e., those components of the entity not providing patient care), such as environmental health, from the covered entity so as to minimize the department's compliance responsibilities. *See* 45 C.F.R. 164.105(a). Many departments have chosen to carve out their environmental health arms and, as a result, the environmental health records—including lead reports and investigations—would not be considered protected health information.

[28] The effects of S.L. 2005-414 on public health agencies and private health care providers were summarized in *North Carolina Legislation 2005*, Chapter 12, "Health."

[29] G.S. 75-61(14) defines "security breach" as "[a]n incident of unauthorized access to and acquisition of unencrypted and unredacted records or data containing personal information where illegal use of the personal information has occurred or is reasonably likely to occur or that creates a material risk of harm to a consumer. Any incident of unauthorized access to and acquisition of encrypted records or data containing personal information along with the confidential process or key shall constitute a security breach. Good faith

actions to be taken in the event of a security breach. Among other things, government agencies that experience a security breach are required to notify affected persons of the breach, determine the scope of the breach, and restore the security and confidentiality of the data system from which the breach occurred. The content of the notice that must be provided to persons affected by a security breach is specified in G.S. 75-65, as are the methods by which notice may be given.

The law also amends G.S. 132-1.10(b)(5) to clarify that information protected by the Identity Theft Protection Act is confidential and not a public record. However, if a record would be a public record but for the identifying information, the portions of the record that do not include identifying information remain public. Agencies that maintain such records must produce them in response to a public records request as promptly as possible by providing the record with the identifying information removed or redacted.

Additional amendments to G.S. 132-1.10 provide that documents filed with the Secretary of State must not include Social Security numbers or specified other financial and identifying information unless expressly required by law and permit any person to request that the Department of the Secretary of State redact such information from records that are made available to the general public.

Confidential Information about Juveniles

S.L. 2006-205 (S 1216) amends portions of North Carolina's juvenile code that affect the ability of local agencies to disclose confidential information about children in specified circumstances. Section 1 amends G.S. 7B-302 to permit departments of social services to disclose confidential information to any federal, state, or local government entity that needs the information in order to protect a child from abuse or neglect. The new law could result in disclosures of confidential information to local health departments if a department of social services were to determine that the disclosure was necessary to protect a child. When confidential information is disclosed by a department of social services, the agency that receives the information must keep it confidential and re-disclose it only for purposes directly connected with carrying out the agency's mandated responsibilities.

Section 2 of the law amends G.S. 7B-3100, the law that authorized the Department of Juvenile Justice and Delinquency Prevention to adopt rules designating local agencies that are required to share information about juveniles with the department or other local agencies upon request. Local health departments are on the list of agencies that must share information.[30] Under prior law, an agency's duty to share information began when a juvenile petition was filed and lasted only as long as a court was exercising jurisdiction over the juvenile. The law still requires agencies to share information under those circumstances, but it has been expanded to create a duty to share information in child protective services cases in which a petition has not been filed. Thus, agencies on the list must now share information with other listed agencies upon request when a department of social services begins an assessment of a report of child abuse, neglect, or dependency or begins the provision of protective services. The duty to share information in these cases continues until the child protective services case is closed by the department of social services.

Provision of Private Health Insurance Information to the Division of Medical Assistance

A special provision in the 2006 appropriations act requires health insurers to provide specified information to the North Carolina Department of Health and Human Services, Division of Medical

---

acquisition of personal information by an employee or agent of the business for a legitimate purpose that is not used for a purpose other than a lawful purpose of the business is not a security breach, provided that the personal information is not used for a purpose other than a lawful purpose of the business and is not subject to further unauthorized disclosure."

[30] 28 NCAC 01A .0301 (2003).

Assistance. Section 10.8 enacts G.S. 58-50-46, which requires health insurers and pharmacy benefit managers to provide information about individuals who are eligible for state medical assistance benefits to the Division of Medical Assistance upon request. The purpose of the disclosure of information is to permit the division to determine what period the individual or the individual's spouse or dependents may be (or may have been) covered by a health insurance policy and the nature of the coverage provided.

Release of Medical Review Information to Patient Safety Organizations

Some health care facilities use medical review committees to review cases or incidents for quality assurance purposes. G.S. 131E-95 protects the information considered and created by these committees from discovery or introduction into evidence in civil actions against the facilities or providers whose actions were the subject of review. However, the information may be released to professional standards review organizations that accredit or certify the facilities. Section 3.2 of S.L. 2006-144 (H 1301) amends G.S. 131E-95 to provide that the information may also be released to a patient safety organization or its contractors. "Patient safety organization" is defined as "an entity that collects and analyzes patient safety or health care quality data . . . for the purpose of improving patient safety and the quality of health care delivery." A patient safety organization that receives the information must keep it confidential, except as necessary to carry out its patient safety activities.

Health Care Professions

Physicians and Others Licensed by the North Carolina Medical Board

S.L. 2006-144 (H 1301) amends North Carolina's medical practice act in several ways. Section 4 of the new law amends G.S. 90-14, the statute that permits the North Carolina Medical Board to deny licenses to practice and to discipline physicians, physician assistants, and nurse practitioners. In the past, the board's disciplinary powers have permitted it to suspend or revoke licenses and take other actions such as limiting the licensee's practice. The amendments to G.S. 90-14 authorize the board to take additional disciplinary actions. Among other things, the board may now place a licensee on probation, reprimand a licensee or issue a public letter of concern, require the licensee to provide free medical services, or require the licensee to complete treatment or educational programs. The amendments also add a new ground for the board to take disciplinary action: failure to practice or maintain continued competency for the two-year period immediately preceding an application for an initial license or a request to reactivate an inactive, suspended, or revoked license.

G.S. 90-14(b) requires the board to refer physicians and physicians assistants who are significantly impaired by substance abuse or mental illness to the North Carolina Physicians Health Program (formerly the State Medical Society Physician Health and Effectiveness Committee). The new law amends this subsection to specify that sexual misconduct does not constitute mental illness for purposes of the referrals.

Section 5 of S.L. 2006-144 rewrites G.S. 90-14.5, one of several statutes that address how the board conducts hearings before revoking or suspending licenses. The changes clarify that the board may appoint a hearing committee to take evidence and submit a recommended decision to the full board. As previously written, the statute appeared to provide for the use of one or more "trial examiners" appointed by the board only when the licensee requested that the hearing be held in a county other than the county designated for the full board to meet to consider the matter.

G.S. 90-14.13 requires the administrators of health care facilities and provider organizations (including HMOs and PPOs) to report disciplinary actions they take against physicians to the North Carolina Medical Board. Under prior law, administrators were required to report only revocation, suspension, or limitations of a physician's privileges to practice in the facility or

organization. Section 6 of S.L. 2006-144 amends this statute to require the administrators of health care facilities and provider organizations to report all of the following actions within thirty days of their occurrence:

- Summary revocation, suspension, or limitation of privileges, regardless of whether a final determination on the action has been made.
- Revocation, suspension, or limitation of privileges that has been finally determined. However, hospitals are not required to report suspensions or limitations of privileges that are due to failure to timely complete medical records, unless it is the third such suspension or limitation within a single calendar year.
- A resignation from practice or a voluntary reduction of privileges, unless the resignation is due solely to the physician's completion of a medical residency, internship, or fellowship.
- Any action reportable under the federal Health Care Quality Improvement Act of 1986.

G.S. 90-14.13 requires the board to report violations of the reporting requirement to an institution's licensing agency. The new law further amends this statute to authorize the licensing agency for the health care institution to order institutions that fail to report to pay civil penalties.

G.S. 90-14.13 also requires administrators of insurance companies that provide professional liability insurance for physicians to report awards of damages or settlements of lawsuits to the North Carolina Medical Board. Cancellations or nonrenewals of professional liability coverage must also be reported if the cancellation or nonrenewal was for cause. Section 6 of S.L. 2006-144 adds to this statute a requirement that professional liability insurers report to the board any malpractice payments reportable under the federal Health Care Quality Improvement Act of 1986. The new law also authorizes the Commissioner of Insurance to assess civil penalties against insurers who fail to make the required reports.

A final amendment to G.S. 90-14.13 establishes that reports required under that statute are confidential and not subject to discovery, subpoena, or other means of legal compulsion for release to anyone other than the board or its employees or agents, except in limited circumstances.

Section 7 of S.L. 2006-144 amends G.S. 90-14.16 similarly, to provide the same confidentiality and protection from production for all records, papers, and investigative information the board receives or possesses in connection with complaints or disciplinary matters. However, that information must be divulged to a licensee or applicant if the board intends to use the information as evidence in a contested case and the licensee or applicant or his or her attorney, submits a written request for it.[31] Further, if the investigative information indicates that a crime may have been committed, the board must make a report to an appropriate law enforcement agency and must cooperate with and assist law enforcement agencies in criminal investigations by providing information that is relevant to the investigation. However, information disclosed to law enforcement under these circumstances remains confidential and may not be disclosed by the investigating agency except as necessary to further the investigation. Finally, the board may release to any health care licensure board in any state confidential information about licensure actions and the reasons for them, voluntary surrenders of licenses, and investigative reports made by the board. The board must notify a licensee within sixty days after the information is transmitted. A licensee may make a written request for a copy of the information, and the board must provide it unless the information relates to an ongoing criminal investigation or the enforcement or investigative responsibilities of the Department of Health and Human Services.

Another amendment to G.S. 90-14.16 requires a person licensed by the North Carolina Medical Board to self-report to the board within thirty days if the person is arrested or indicted for any felony, driving while impaired, or possession, use, or sale of a controlled substance.

[31] Even if such a request is made, the board still may refuse to divulge a board investigative report, the identity of a complainant who is not providing testimony, attorney work product, attorney-client communications, or any material protected by a privilege recognized by the rules of civil procedure or evidence. If information is provided to a licensee or applicant or his or her attorney, the information will be subject to discovery or subpoena in a civil case in which the licensee or applicant is a party.

Dentists and Dental Hygienists

G.S. 90-29.4 authorizes the State Board of Dental Examiners to grant an intern permit to a person who has graduated from an approved dental school but is not licensed to practice in North Carolina. An intern permit authorizes the person to practice dentistry under the supervision or direction of a licensed dentist. Intern permits are valid for one year and generally may not be renewed for more than five additional one-year periods or for more than a total of seventy-two months for a person who has attempted and failed a board-approved examination. S.L. 2006-41 (H 1343 amends the statute to authorize the board, in its discretion, to renew intern permits for additional one-year periods beyond the seventy-two-month limitation if the intern permit holder has held an unrestricted dental license in another state for at least five years immediately preceding the issuance of the intern permit and the permit holder's employing institution supports the continuance of the permit.

S.L. 2006-235 (S 1487) amends G.S. 90-233(a) to permit the Board of Dental Examiners to contract with a regional or national testing agency to conduct clinical examinations of applicants for a North Carolina dental hygienist license. The results of the examinations may then be used by the board in determining whether to grant a license to an applicant. The law also amends G.S. 90-232 to provide that the board may require an applicant who takes a clinical examination administered by a regional or national testing agency to pay the actual cost of the examination, instead of the usual examination fee of $350.

Physical Therapists

The North Carolina Board of Physical Therapy Examiners is responsible for licensing physical therapists and physical therapy assistants. G.S. 90-270.26 sets forth the board's powers and duties. Among other things, the statute empowers the board to examine applicants for licensure and to suspend or revoke licenses or otherwise discipline its licensees. Section 1 of S.L. 2006-144 amends this statute by adding a provision authorizing the board to require licensees to demonstrate their continuing competence in the practice of physical therapy. The board may adopt rules requiring licensees to submit evidence of continuing education activities, accomplishments, or compliance with board-approved measures, audits, or evaluations. The board may require remedial action if necessary for license renewal or reinstatement. Section 2 of S.L. 2006-144 amends G.S. 90-270.32 to provide that the board may also decline to renew the license of a physical therapist or physical therapy assistant who fails to comply with continuing competence requirements.

Orthopedic Physicians and Podiatrists

Section 3.1 of S.L. 2006-144 (H 1301) amends the Professional Corporation Act (G.S. Chapter 33B) to permit physicians practicing orthopedics and licensed podiatrists to jointly form professional corporations to render both orthopedic and podiatric services.

Other Health Care Professionals

S.L. 2006-175 (H 1327) amends the Psychology Practice Act (G.S. Chapter 90, Article 18A) to permit the North Carolina Psychology Board to request criminal history record checks on applicants for licensure or licensees who are under investigation for alleged violations of the act. The board may deny licensure to an applicant who refuses to consent to a criminal history record check. If a licensee refuses to consent to a check, the board may revoke or refuse to reinstate the person's license or take other disciplinary actions.

Occupational Licensing Boards

Occupational licensing boards, including boards that license and regulate the conduct of the various categories of health care professionals, are required by G.S. 93B-2 to prepare annual reports summarizing their licensure activities, financial status, and other matters. In the past, boards were required to file the reports with the Secretary of State and the Attorney General. S.L. 2006-70 (S 1485) amends G.S. 93B-2 in three ways. First, it requires the reports to be filed with the Joint Legislative Administrative Procedure Oversight Committee as well. Second, it requires an occupational licensing board to include in its annual report the substance of any anticipated changes in the board's rules and any anticipated request by the board for legislation. Finally, it specifies the nature of the information that must be included in the board's financial report. The law became effective July 1, 2006, and requires each board to submit a report complying with the amended statute no later than July 1, 2007.

Health Care Facilities

Public Hospitals

On three separate occasions in the past twenty years, the General Assembly made amendments to G.S. 131E-18 that applied only to Craven County (S.L. 1997-922, S.L. 1999-190, and S.L. 1999-15). The amendments affected the appointment of commissioners for the Craven Hospital Authority. S.L. 2006-24 (H 2110) repealed the amendments that were specific to Craven County.

Long-Term Care Facilities

New laws affecting long-term care facilities are summarized in Chapter 23, "Senior Citizens."

Other Laws of Interest

Impaired Driving Law Changes

Two of the provisions of S.L. 2006-253 (H 1048) that are likely to be of most significance to health care providers are described above, in the section on Health Information. Another significant change is found in Section 16, which amends G.S. 20-139.1. As previously written, subsection (c) of that statute provided that when the charging officer specified that the chemical analysis of a potentially impaired person should be a blood sample, only a physician, registered nurse, or other qualified person was permitted to draw the sample. The law did not require any such person to draw a sample. As rewritten, the law requires a physician, registered nurse, emergency medical technician, or other qualified person to obtain a blood sample or a urine sample when a law enforcement officer determines a blood or urine test is required for chemical analysis. The rewritten law specifies that no further authorization or approval for the test is required. It also provides immunity from liability for persons who comply with a law enforcement officer's request and for their employers, except that there is no immunity for negligence in obtaining the samples. Upon the request of the physician or other person directed to obtain the sample, the law enforcement officer must provide written confirmation of his or her request for the sample.

Section 16 also adds three new subsections to G.S. 20-139.1 that pertain to the procurement of urine or blood samples. If a person refuses to submit to a blood or urine test, subsection (d1) permits a law enforcement officer to compel the person to submit without obtaining a court order if the officer reasonably believes that the delay caused by obtaining the court order would result in the dissipation of alcohol in the person's blood or urine. Subsection (d2) requires physicians,

registered nurses, emergency medical technicians, and other qualified persons to obtain a blood or urine sample that is requested by a law enforcement officer under the authority of subsection (d1). Upon the request of the physician or other person directed to obtain the sample, the law enforcement officer must provide written confirmation of his or her request for the sample. Subsection (d3) provides immunity from liability for persons who comply with a law enforcement officer's request and their employers, except that there is no immunity for negligence in obtaining the samples.

Other portions of this extensive rewrite of the impaired driving laws may be of interest to health care providers as well, including

- New G.S. 20-38.3, which authorizes a law enforcement officer to take an arrestee for evaluation by a medical professional to determine the extent or cause of the person's impairment.
- New G.S. 20-38.5, which directs the Department of Health and Human Services to work with chief district court judges, district attorneys, and sheriffs to approve a procedure for allowing access to a person in custody so that blood or urine samples may be obtained.
- An amendment to G.S. 20-16.3 transferring from the Commission for Health Services to the Department of Health and Human Services the duty to examine and approve devices suitable for on-the-scene tests of a driver's impairment by alcohol.
- An amendment to G.S. 20-139.1(b2) to require the Department of Health and Human Services to perform preventive maintenance on breath-testing instruments.
- A new subsection, G.S. 20-139.1(b6), which requires the Department of Health and Human Services to post on a website and file with each clerk of superior court a list of all persons who have a permit to perform chemical analyses, along with information about the types of analyses the person can perform, the instruments the person is authorized to operate, the effective dates of the person's permit, and the records of preventive maintenance of instruments.
- An amendment to G.S. 20-17.8 creating an exception to the requirement that certain drivers whose licenses have been restored after a conviction of impaired driving may drive only motor vehicles that have been equipped with ignition interlock devices. The new exception applies to persons who have a medical condition that makes them incapable of activating an ignition interlock system. Two or more physicians must examine the person and complete a certificate devised by the Commissioner of Motor Vehicles and designed to elicit the maximum medical information necessary to assist in the determination of whether the person is incapable of activating the system. The certificate must contain a waiver of physician–patient privilege.[32] The commissioner is not bound by the recommendations of the examining physicians.

The new law is described in detail in Chapter 19, "Motor Vehicles."

Methamphetamine Lab Prevention Act Changes

In 2005 the General Assembly enacted the Methamphetamine Lab Prevention Act (G.S. Chapter 90, Article 5D), which placed restrictions on over-the-counter sales of certain products containing pseudoephedrine (a decongestant that is often used in the manufacture of methamphetamine). S.L. 2006-186 (S 686) amends the restrictions placed on the purchase and sale of those products. The new law specifies that pseudoephedrine products sold in tablet, caplet, or gel cap form may not be sold loose in bottles but must be in blister packages. Previously, the blister packaging requirement applied only to tablets containing at least thirty milligrams of pseudoephedrine per tablet. The act also reduces the amount of certain pseudoephedrine products that may be purchased, from 6 grams per single transaction to 3.6 grams per calendar day. Retailers who sell regulated pseudoephedrine products must provide information about the

[32] The limits of the waiver of the privilege are unclear. It seems most likely that the waiver would be limited to the information provided in the certificate and perhaps to the records of the examination that produced the information for the certificate.

restrictions to purchasers and obtain purchasers' signatures on a form that states the purchaser is aware of the restrictions and the possibility of criminal penalties. The new law amends G.S. 90-113.52(c) to clarify that signatures may be obtained in electronic form and to specify how retailers who use electronic signatures may provide the required information to purchasers.

Finally, the law enacts new subsection G.S. 90-113.61 to provide that pediatric pseudoephedrine products and other pseudoephedrine products in the form of liquids, liquid capsules, or gel capsules are not subject to the requirements of the state Methamphetamine Lab Prevention Act unless the Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services exercises its authority under G.S. 90-113.58 to make the products subject to the Act. These products are subject to the federal Combat Methamphetamine Act of 2005.[33]

Immunity for Members of State Medical Assistance Teams

G.S. 166A-14 provides qualified immunity from liability for emergency management workers in a disaster or other state of emergency. S.L. 2006-81 (H 2195) amends this statute to extend qualified immunity to health care workers performing health care services when the health care workers are members of a hospital- or county-based State Medical Assistance Team.

Mental Health Reform

S.L. 2006-142 (H 2077) amends Chapter 122C of the General Statutes to make changes in how mental health reform is being implemented in North Carolina. Among other things, the changes

- Require area authorities, when contracting with private providers, to use a standard contract adopted by the Secretary of Health and Human Services.
- Require the state plan for mental health, developmental disabilities, and substance abuse services to include mechanisms for measuring performance on several indicators, including access to services.
- Clarify that the term "local management entity" includes area authorities, county programs, and consolidated human services agencies.
- Specify the functions and responsibilities of local management entities.
- Establish community and family advisory committees within area authorities and at the state level.

This law is summarized in Chapter 17, "Mental Health."

Miscellaneous

Several other new laws affecting health services are summarized in Chapter 23, "Senior Citizens." S.L. 2006-108 (S 1278) addresses the provision of adult day health services to persons served by the Community Alternatives Program. S.L. 2006-110 (S 1279) requires the Department of Health and Human Services to make recommendations to address biases identified in the North Carolina Institutional Bias Study Report. S.L. 2006-194 (S 1280) requires the North Carolina Division of Medical Assistance to establish a pilot program to evaluate the use of telemonitoring equipment for home- and community-based services. Also, in order to allow time for the implementation of new home care rules, the law places a one-year moratorium on the issuance of new licenses for home care agencies that intend to offer in-home aide services (however, the Department of Health and Human Services may issue licenses to certified home health agencies to offer these services or to agencies that need a new license for an existing home care agency being acquired).

[33] Pub. L. No. 109-177, Title VII.

Other new laws are summarized in Chapter 24, "Social Services." S.L. 2006-109 (S 1276) requires the Department of Health and Human Services to review the Community Alternatives Program for Disabled Adults.

Jill Moore

Aimee N. Wall