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2005 LEGISLATION AFFECTING PUBLIC HEALTH

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During the 2005 legislative session, the North Carolina General Assembly enacted more than sixty bills and budget special provisions affecting public health, government health insurance, health care facilities, and the health care professions. Some of the key developments affecting public health included:

- Mandatory accreditation for local health departments.
- Expanded local authority to regulate smoking in public places.
- Several school health initiatives, including a requirement that local boards of education adopt policies permitting students with asthma or life-threatening allergies to carry and self-administer medications.
- The transfer of children under age six from North Carolina Health Choice, the state children's health insurance program, to the Medicaid program.
- Funding for a number of public health initiatives, including grants for community-based programs to eliminate disparities in health status between majority and minority populations, and a pilot program to pay for interpreter services for local health department patients who do not speak English proficiently.

Several other new laws that are not specifically directed to public health nevertheless will be of interest to public health professionals, including the Identity Theft Protection Act and the Methamphetamine Lab Prevention Act.

This Bulletin summarizes significant 2005 legislation affecting North Carolina's public health system. It concludes with a summary of funding provided for public health initiatives in the state's 2005-2007 biennial budget.

Local Health Department Accreditation

In late 2003 Secretary of Health and Human Services Carmen Hooker Odom convened the Public Health Task Force 2004 and charged it with developing recommendations for improving North Carolina's public health infrastructure, improving the health status of North Carolinians, and eliminating disparities in health status between the majority population and minority groups. From the outset, one of the task force's goals was to implement a statewide system for accrediting local health departments in North Carolina, building on a pilot accreditation program that had been underway for several years. When the task force released its final report

in January 2005, one of its key recommendations was to establish a mandatory accreditation system for all local health departments in North Carolina.[1]

That recommendation was carried out in S.L. 2005-369 (S 804). This law enacts new G.S. 130A-34.1, which requires all local health departments in North Carolina to obtain and maintain accreditation. The initial accreditation of local health departments will be implemented over a period of eight years, beginning January 1, 2006.

The new law creates the Local Health Department Accreditation Board within the North Carolina Institute for Public Health (a unit of the University of North Carolina School of Public Health). The Accreditation Board will have seventeen members appointed by the Secretary of Health and Human Services, including county commissioners, local board of health members, local health directors, and staff members of the state Divisions of Public Health and Environmental Health. It will be responsible for developing a schedule by which local health departments must apply for initial accreditation, reviewing each department's application for accreditation, and assigning each department a status as follows:

- "Accredited" means the department has satisfied the standards for accreditation. Accreditation expires after four years and the department must apply for re-accreditation.
- "Conditionally accredited" means the department has failed to meet one or more of the standards for accreditation and has been granted short-term accreditation status that is subject to conditions set by the board. This status is good for two years. By the end of that time, the department must have satisfied the board's conditions and met the criteria for accredited status, or it will become unaccredited.
- "Unaccredited" means the department has continued to fail to meet one or more of the standards after a period of conditional accreditation.

Finally, the new law authorizes the Commission for Health Services to adopt accreditation standards and rules for the accreditation process, which must include a health department self-assessment and a site visit. The commission also must adopt rules for informal procedures for review of Accreditation Board decisions.[2]

Smoking Regulation and Cigarette Tax

Article 64 of G.S. Chapter 143 regulates smoking in public places in North Carolina. When it enacted this law in 1993, the General Assembly expressed the intent to "address the needs of both smokers and nonsmokers" by providing that public places contain both smoking and nonsmoking areas.[3] 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. Local governments were permitted to enact more stringent local regulations until October 15, 1993, but local rules or ordinances enacted after that date must provide for a smoking area in most local government buildings, indoor arenas, and other public places. However, G.S. 143-599 provides a list of facilities that are exempt from the provisions of Article 64 and in which smoking may be prohibited entirely.

The list of exemptions in G.S. 143-599 has always included local health departments, but while it was clear that smoking could be prohibited in all of the health department's interior spaces, it was unclear whether the prohibition could extend to the health department's grounds. It also was unclear whether smoking could be prohibited throughout a building containing a health department when the building also contained another government agency that was not on the exemption list. S.L. 2005-19 (H 239) clarifies these two issues. It amends G.S. 143-599 to specify that the exemptions include the local health department and the building and grounds where it is located. S.L. 2005-168 (H 1482), enacted later in the session, further amends the same subsection to add the local department of social services and the building and grounds where it is located to the exemption list. "Grounds" is defined to mean the area located within fifty linear feet of a local health department or a local department of social services.

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[1] North Carolina Department of Health and Human Services, *North Carolina Public Health Improvement Plan: Final Report* (January 15, 2005) (available on the Internet at http://www.ncpublichealth.com/taskforce/docs/FinalReport1.15.05.pdf).

[2] Temporary rules were approved by the Commission for Health Services in December 2005 and became effective on January 1, 2006. The rules will be codified as Chapter 48 of Title 10A of the North Carolina Administrative Code.

[3] S.L. 1993-367, sec. 1 (codified at G.S. 143-595).

S.L. 2005-239 (S 482) amends the list of exemptions in G.S. 143-599 to include indoor arenas with a seating capacity of greater than 23,000.

S.L. 2005-372 (S 1130) regulates smoking and other tobacco use in buildings that are part of a state correctional institution. New G.S. 148-23.1 prohibits the use of tobacco products in state correctional institution buildings by inmates, employees, and visitors, effective January 1, 2006. The prohibition extends to chewing tobacco and snuff, as well as cigarettes and cigars. The new law applies only to facilities operated by the Department of Correction (DOC) and therefore does not extend to local jails. Furthermore, it addresses only the use of tobacco products inside buildings—it does not extend to facility grounds. However, an uncodified provision of the law authorizes DOC to conduct one or more pilot programs banning smoking on facility grounds as well. If DOC conducts such a pilot, it must offer inmates and staff of the facility an opportunity to participate in a smoking cessation program, but no person may be required or coerced to participate. Finally, S.L. 2005-372 adds state correctional facilities operated by DOC to the list of facilities exempt from the provisions of G.S. Chapter 143, Article 64.

A significant increase in the tax on cigarettes was included in the 2005 appropriations act. Section 34.1 of S.L. 2005-276 increased the tax to 1.5 cents per cigarette, or 30 cents per pack, effective September 1, 2005. On July 1, 2006, the tax will increase to 1.75 cents per cigarette, or 35 cents per pack. Section 34.1 also increased the tax on other tobacco products from 2 percent to 3 percent of the wholesale price.

School Health

There was significant legislative activity in the area of school health this year. Among other things, new laws authorize students who have asthma or life-threatening allergic reactions to possess and self-administer medication, regulate food products sold in school vending machines, and establish a comprehensive eye examination requirement for students enrolling in public kindergarten.

Asthma and Anaphylaxis Medications

S.L. 2005-22 (H 496) requires local boards of education to adopt policies authorizing students who have asthma or who are subject to anaphylactic allergic reactions to possess and self-administer medication during the school day, at school-sponsored activities, or while in transit to or from school or school-sponsored events. The policies must include a requirement that parents provide the school with several documents:

- Written permission for the student to possess and self-administer the medication.
- A written statement from the student's health care provider verifying the student's diagnosis and prescription for medication that may be needed during school or school-related activities. The health care provider's statement must affirm that the student has been instructed in self-administration of medication and has the skills necessary to use the medication and any device required to administer it.
- A written treatment plan and emergency protocol formulated by the health care provider who prescribed the medication.
- A signed statement acknowledging that the school is not liable for an injury arising from a student's possession and self-administration of medication.

Local policies also must require the student to demonstrate his or her ability to self-administer the medication to the school nurse or the nurse's designee. The student's parent or guardian must provide back-up medication to the school to be kept in a location where the student will have immediate access in the event of an emergency. If a student uses the medication for a purpose other than that for which it was prescribed, he or she may be subject to discipline in accordance with a school's disciplinary policy, but the disciplinary measures may not limit or restrict the student's immediate access to the medication. Finally, the new law provides qualified immunity from liability for local boards of education and their members, employees, designees, and agents for any act authorized by the new law or any omission related to it. S.L. 2005-22 was enacted in April 2005 and is in effect for the 2005-06 school year.

Nutritional Value of Foods Sold in Schools

Two new laws are directed at improving the nutritional value of foods and beverages sold in schools. S.L. 2005-253 (S 961) regulates the sale of products sold in school vending machines. Since 1992, G.S. 115C-264 has permitted schools, with

local board of education approval, to use vending machines to sell soft drinks to students, as long as the drinks were not sold (1) during breakfast or lunch times, (2) to elementary students, or (3) contrary to the requirements of the National School Lunch Program. S.L. 2005-253 deletes the provisions addressing soft drink vending from G.S. 115C-264 and reenacts them in a new section, G.S. 115C-264.2, which governs all snack and beverage vending machines in schools. Under the new law, any vending contracts executed or renewed after August 1, 2005, must provide that sugared carbonated soft drinks will not comprise more than 50 percent of the offerings for sale to students in high schools, and they may no longer be sold in middle schools at all. Furthermore, bottled water products must be available in every school that offers beverage vending. Finally, by the 2006-07 school year, snack vending in all schools must meet the "proficient" level of the North Carolina Eat Smart nutrition standards. The proficient level requires that there be no snack vending in elementary schools, and that 75 percent of the snack vending products in middle and high schools contain 200 calories or less.

Another law, S.L. 2005-457 (H 855), directs the State Board of Education to develop statewide standards for school meals, à la carte foods and beverages, and items served in after-school programs and local education agencies' child nutrition programs. The standards must promote gradual changes to increase the availability of fruits, vegetables, and whole-grain products and decrease foods that are high in fat or sugar.

Comprehensive Eye Examinations and Governor's Vision Care Program

A special provision in the 2005 appropriations act enacts new G.S. 130A-440.1, which will require each child entering kindergarten in the state's public schools to have an eye examination, beginning with the 2006-07 school year. This requirement has been extremely controversial and is being challenged in court by the N.C. School Boards Association and several local boards of education. It is likely the legislature will revisit this issue during the 2006 legislative session.[4] However, as presently written, the law will require each child enrolling in kindergarten in a public school to present proof of a comprehensive eye examination by an ophthalmologist or optometrist. If a child has moved to North Carolina within the sixty days immediately preceding school entry, the child will be given sixty days after school entry to obtain the examination. The new law does not apply to children enrolling in kindergarten in private church schools, schools of religious charter, or qualified nonpublic schools.

Another special provision in S.L. 2005-276 establishes the Governor's Vision Care Program, which will provide funds for early detection and correction of vision problems in children enrolled in kindergarten through third grade. Children will be eligible for the program if they have a family income that is less than 250 percent of the federal poverty guidelines, do not have private health insurance, and are not eligible for services under North Carolina Health Choice, Medicaid, or programs operated by the Commission for the Blind, VSP's Sight for Students program, or the Lions Club foundation. Funds appropriated to the program will be used to reimburse providers for conducting the comprehensive eye examinations required by new G.S. 130A-440.1 and for providing eyeglasses.

Medication Aides in Schools

Section 10.40D(f) of the 2005 appropriations act gives local boards of education the authority to adopt policies and procedures authorizing schools to use unlicensed personnel to administer medications to students. If a local board chooses to exercise this authority, its policies and procedures must address training and competency evaluations of the unlicensed personnel, requirements for listing the personnel in the medication aide registry established by new G.S. 131E-270,[5] and requirements for supervision of medication aides by licensed health professionals or qualified supervisory personnel.

[4] As this Bulletin was going to press, a superior court judge delayed implementation of the eye examination requirement until 2007. Lynn Bonner, *Judge Delays Eye Exams*, RALEIGH NEWS AND OBSERVER, Mar. 15, 2006, page 1A.

[5] Section 10.40D(f) actually refers to the medication aide registry established in G.S. 131E-271, but the citation is incorrect. The medication aide registry was established by another special provision, Section10.40C(c), and codified as G.S. 131E-270. The new legislation regarding medication aides is discussed later in this bulletin, under "Other Laws of Interest," "Medication Aides."

School-Based Child and Family Team Initiative

Another special provision in the 2005 appropriations act establishes the School-Based Child and Family Team Initiative to identify and coordinate community services for children at risk of school failure or out-of-home placement. Section 6.24 of S.L. 2005-276 has a stated goal of increasing schools' capacity to address academic, health, mental health, social, and legal needs of school children. The provision requires local health directors to serve on a local advisory committee for the initiative and local health departments to take the lead role in assisting children and families whose primary needs are health-related.

School Nurses

Section 10.53 of the 2005 appropriations act provides $2.5 million to pay for fifty additional permanent school nurse positions. The Division of Public Health will distribute the school nurse funds in conjunction with the Department of Public Instruction. The agencies must determine which areas have the greatest need for school nurses and the greatest inability to pay for them. The agencies must also consider local nurse-to-student ratios, economic status, and health needs of children. A nonsupplant clause requires communities to maintain their current levels of effort and funding for school nurses. School nurses funded through this appropriation are required to participate as needed in the School-Based Child and Family Team Initiative.

Students' Physical Activity

The General Assembly did not enact House Bill 865, which would have required local boards of education to adopt policies requiring physical activity for elementary and middle school children, but a State Board of Education policy adopted in April 2005 achieved the same effect. The board's policy number HSP-S-000 requires schools to provide students in kindergarten through eighth grade with thirty minutes of moderate to vigorous physical activity each school day. The requirement may be achieved through regular physical education classes or other activities such as recess or classroom energizers. Schools must implement the physical activity requirement by the 2006-07 school year.

School-Based Health Centers Study

Section 10.59G of S.L. 2005-276 authorizes the Legislative Research Commission to study and evaluate school-based and school-linked health centers in North Carolina.

Environmental Health

In the fall of 2004, North Carolina experienced an outbreak of *E. coli* that was eventually traced to a petting zoo exhibited at the 2004 state fair. The outbreak caused more than 100 cases of diarrheal illness, primarily in young children. Some of the children developed hemolytic uremic syndrome, a life-threatening complication of *E. coli* that can require long-term hospitalization and produce lasting health effects. The General Assembly responded to the outbreak by enacting S.L. 2005-191 (S 268), which was named "Aedin's Law" for one of the children who became seriously ill. The new law regulates animal exhibitions, defined to include agricultural fairs where animals are displayed for physical contact with humans. The law requires animal exhibitions to be inspected and permitted by the Commissioner of Agriculture. The commissioner is authorized to adopt rules, with the advice and approval of the State Board of Agriculture and in consultation with the North Carolina Division of Public Health. Among other things, the rules must include requirements for hand-washing facilities in animal exhibitions, animal care and management, and education and signs addressing health and safety issues. In the event the rules are violated, the commissioner is authorized to revoke an operator's permit and to assess a civil penalty of up to $5,000. The law became effective October 1, 2005.

Part IV of S.L. 2005-386 (H 1096) amends the inspection schedule for food service establishments that is set forth in G.S. 130A-249. The former law required quarterly inspections of restaurants, except for temporary establishments. The new law directs the Commission for Health Services to establish a schedule for inspections of food service establishments. It requires the commission to take into account the risks to the population served by the establishment and the type of food and drink served by the establishment. The new schedule and implementing rules must be adopted by November 1, 2007.

A bill that public health officials monitored closely but that did not pass during the 2005 session

was House Bill 900.[6] Under present law, only a local health department may evaluate a proposed development site and issue an improvement permit authorizing the construction of an on-site wastewater system. House Bill 900 would have authorized private licensed soil scientists or professional engineers to perform this function. It also would have provided that if a local health department failed to act within ten days on an improvement permit application that was based on the evaluation of a licensed soil scientist or both a licensed soil scientist and a professional engineer, the site would be deemed permitted. The bill did not pass either chamber of the General Assembly during the legislative session, but the issue is expected to resurface in future sessions.

Public Health Authorities

In 1997 the General Assembly enacted a law that authorized counties to provide public health services through a single- or multi-county public health authority, rather than a traditional local health department.[7] Public health authority boards have different membership requirements than traditional boards of health and also have expanded powers and duties.

The 2005 General Assembly enacted two laws that affect the powers of public health authorities. S.L. 2005-326 (S 682) amends G.S. 105A-2(6) to add public health authorities to the list of local agencies that are permitted to use the set-off debt collection procedures that are currently available to North Carolina cities and counties.

S.L. 2005-459 (S 665) authorizes certain public health authorities to expand their board membership. Public health authority boards ordinarily may have no more than nine members for a single-county authority or eleven members for a multi-county authority. The new law amends G.S. 130A-45.1 to authorize public health authority boards that intend to pursue federally qualified health center status (or look-alike status) to have between nine and twenty-five members. S.L. 2005-459 also enacts new G.S. 130A-45.13, which authorizes public health authority boards to contract with private vendors to operate the authority's Medicaid billing system, permitting the authority to bypass the state's health services information system (HSIS) and bill Medicaid directly. However, any system used by a public health authority must still have the ability to interface with state public health data systems.

[6] An identical bill was introduced in the Senate (S 902). The Senate did not act on the bill during the 2005 session.

[7] S.L. 1997-502.

Medicaid

The 2005 General Assembly considered a number of alternatives for reducing eligibility or services under the Medicaid program. In the end, there was no major overhaul of Medicaid, but several significant changes to the program were enacted by the 2005 appropriations act.

Transfer of Children from Health Choice to Medicaid

One of the most significant changes was the transfer of children under the age of six from the state children's health insurance program (North Carolina Health Choice) to the Medicaid program. In the past, infants under the age of one in families with incomes at or below 185 percent of the federal poverty guidelines (FPG) have been eligible for Medicaid, as have children between the ages of one and five in families with incomes at or below 133 percent FPG. Children in each age group whose family incomes were higher than those limits but at or below 200 percent FPG have not been eligible for Medicaid but have been eligible for Health Choice. Section 10.11(m) of the 2005 appropriations act provides that children under the age of six in families with incomes of up to 200 percent FPG are eligible for Medicaid, effective January 1, 2006. Section 10.22 amends G.S. 108A-70.21 to reflect this change.

Medicaid Ticket to Work

Section 10.18 of the 2005 appropriations act enacts the Health Coverage for Workers with Disabilities Act, also known as the Medicaid Ticket to Work program, and appropriates $150,000 in recurring funds to support it, beginning July 1, 2006. The purpose of the new program is to allow low-income workers with disabilities to buy health insurance through the Medicaid program. A new statute, G.S. 108A-54.1, establishes the eligibility criteria for the program.

Proof of Residency

To be eligible to receive Medicaid in North Carolina, an applicant must be a resident of the state. A new statute, G.S. 108A-55.3, requires applicants to provide "satisfactory proof" of their residency by providing at least two documents from a specified list. If an applicant declares under penalty of perjury that he or she does not have two of the specified documents, other credible evidence of residency may be considered. Furthermore, applicants for emergency Medicaid will not be required to provide the documents. For emergency Medicaid applicants, a declaration, affidavit, or other statement from the applicant's employer, clergy, or another person with personal knowledge of the applicant's residency will be sufficient. Finally, the satisfactory proof requirement does not apply to a Medicaid applicant who qualifies for an exception from state residency requirements under federal law.

Additional Provisions

The 2005 appropriations act also makes the following changes to the Medicaid program:

- Freezes Medicaid provider reimbursement rates at 2004-05 amounts, meaning the reimbursement rates cannot be increased during fiscal year 2005-06 (however, the rates may be decreased).
- Provides $1.7 million in recurring funding for personal care services for residents of adult care home special care units, beginning October 1, 2006. At the same time, the act reduces funding for personal care services by $13.7 million in fiscal year 2005-06 and $16.1 million in 2006-07. Section 10.19(a) specifies that the Division of Medical Assistance must accomplish this reduction by implementing a utilization management system for personal care services that may include reducing personal care service hours or otherwise managing the services.
- Provides $2 million in recurring funding to increase Medicaid reimbursement rates for dental services.
- Increases to $3.00 the required co-payment for generic prescription drugs and for the following health care services: chiropractic, optical, podiatry, hospital outpatient, and nonemergency visits to hospital emergency departments. The increase was effective October 1, 2005.
- Decreases recurring funding to the Division of Medical Assistance by $2.7 million in fiscal year 2005-06 and $6.7 million in fiscal year 2006-07, in the expectation that the decrease will be offset by the use of drug utilization management measures. Such measures may include requirements for pre-authorization or reviews for particular drugs or limitations on drugs, drug classes, brands, or quantities. However, the Division of Medical Assistance is prohibited from imposing prior authorization requirements on certain categories of medications and may not limit the use of brand-name medications when the health care provider who prescribes the brand-name medication specifies that it is medically necessary.
- Decreases state funding to account for the Medicare Part D "clawback"—that is, the amount the Medicaid program will no longer pay when the new Medicare prescription drug program begins to pay for prescription medications for individuals who are eligible for both Medicaid and the Medicare benefit.
- Authorizes the Division of Medical Assistance to use up to $3 million each fiscal year to develop and implement Medicaid cost-containment activities, such as service limits, pre-authorization requirements, requirements that services be provided in the least costly settings, and medical necessity reviews. Before spending any funds to implement a cost-containment strategy, the division must submit a proposal specifying the cost of implementing the strategy and the expected cost savings to the Office of State Budget and Management and must receive its approval.
- Amends G.S. 108A-70.5, the provision that permits the Department of Health and Human Services to recover money spent on Medicaid from recipients' estates. The amended law authorizes DHHS to impose liens against real property, including a recipient's home, to the extent allowed by federal law. Additional new provisions require DHHS to postpone or waive claims against estates when enforcement of the claim would cause an undue hardship on an heir or a beneficiary of the Medicaid recipient (new G.S. 108A-70.6); require

DHHS to waive its claim or lien when recovery is not cost-effective (new G.S. 108A-70.7); require DHHS to give Medicaid applicants written notice that receipt of assistance may result in a claim or lien (new G.S. 108A-70.8); authorize DHHS to require county departments of social services to give DHHS information and assistance needed to recover funds; and require DHHS to pay the county 20 percent of the nonfederal share of the recovery (new G.S. 108A-70.9). The new laws are effective January 1, 2006, and apply to individuals who receive Medicaid on or after that date.

Another law extends the sunset on a 2003 law pertaining to hemophilia drugs. In 2003, the General Assembly enacted G.S. 108A-68.1, which provided that a health care provider does not have to obtain prior authorization from the state Medicaid program before prescribing certain brand-name drugs for hemophilia and blood disorders if no generic drug is available. The section was to expire on July 1, 2006. S.L. 2005-83 (H 916) extends the expiration date to July 1, 2009.

North Carolina Health Choice (Children's Health Insurance Program)

The most significant change to N.C. Health Choice was the transfer of all children under age six to the Medicaid program, as described above. In addition, the 2005 appropriations act provides funding to support increased enrollment in the Health Choice program for children ages six to eighteen.

Effective January 1, 2006, the program is authorized to allow up to a 3 percent growth in enrollment every six months. Section 10.22(d) of S.L. 2005-276 adds new subsection (b1) to G.S. 108A-70.2, establishing payment rates for Health Choice providers. By January 1, 2006, Health Choice providers will be reimbursed at rates that are equivalent to 115 percent of Medicaid reimbursement rates. Effective July 1, 2006, Health Choice providers will be reimbursed at the same rates as Medicaid providers.

Identity Theft Protection Act and Government Agencies' Use of Social Security Numbers

Both private and public health care providers will be affected—though in somewhat different ways—by S.L. 2005-414 (S 1048). Some sections of the law impose requirements on businesses. "Business" is defined in a manner that captures nongovernmental health care providers, but the definition specifically excludes government agencies. Thus, the requirements applying to businesses will not apply to DHHS or local health departments. However, other sections of the act impose specific requirements on government agencies regarding the use of Social Security numbers (SSNs) and other personal identifying information. Those sections will apply to DHHS and local health departments. This summary addresses only the requirements for government agencies.

Section 4 of S.L. 2005-414 adds a new section to G.S. Chapter 132, North Carolina's public records law, that restricts government agencies' collection and use of Social Security numbers and certain other personal information.[8] These new requirements add to requirements already imposed upon government agencies by the Federal Privacy Act of 1974 and the state privacy act (G.S. 143-64.60). Under those laws, government agencies may not require individuals to provide their SSNs except in limited circumstances, must inform individuals whether provision of their SSNs is voluntary or mandatory, and must inform individuals of the uses that will be made of their SSNs.

Beginning December 1, 2005, state and local government agencies may not collect an SSN from an individual unless (1) the agency is specifically authorized by law to collect the SSN or (2) collection of the SSN is imperative for the performance of the agency's legally prescribed duties and responsibilities. An agency that collects SSNs must clearly document that it is authorized to collect SSNs under this standard, and any SSN collected must be relevant to the purpose for which it is collected.

In addition, an agency that is permitted to collect SSNs under this section must segregate the SSN from the rest of the record so that it can be readily redacted

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[8] Although the new section is part of the public records law, it appears to apply to all of the activities of government agencies, even when the records produced as a result of those activities are exempt from the public records act. Thus, the requirements imposed by the new section apply to local health departments' patient medical records, even though those records are not public records. G.S. 130A-12 provides that local health department records containing privileged medical information or information that is "protected health information" under the HIPAA Medical Privacy Rule are confidential and not public records as defined in G.S. 132-1.

in the event of a public records request and, upon request, must provide individuals with a statement of the purpose or purposes for which the SSN is being collected or used. (But note that agencies are already required by the state and federal privacy acts to notify individuals of the uses that will be made of their SSNs, whether or not an individual makes a specific request for the information.) Furthermore, agencies that are permitted to collect SSNs may not use SSNs for any purpose other than the stated purposes, nor may they intentionally communicate or otherwise make public SSNs or other personal identifying information.

All of the above provisions became effective December 1, 2005. Beginning July 1, 2007, government agencies that are permitted to collect SSNs may not

- Intentionally imprint or imbed an SSN on a card that is required to access government services.
- Require an individual to transmit his or her SSN over the Internet, unless the connection is secure or the SSN is encrypted.
- Require an individual to use his or her SSN to access a Web site, unless a password, unique personal identification number, or other authentication device is also required.
- Print an individual's SSN on materials mailed to the individual, unless required to do so by state or federal law. If a law requires the SSN to appear on the mailed materials, the mailing must be in an envelope and must not be visible unless the envelope is opened.

The prohibitions described above do not apply to

- SSNs or other identifying information that is disclosed to government agencies or employees if the disclosure is necessary for the receiving entity to perform its duties. However, the receiving entity must maintain the confidentiality of the SSN.
- SSNs or other identifying information that is disclosed pursuant to a court order, warrant, or subpoena.
- SSNs or other identifying information disclosed for public health purposes, in accordance with G.S. Chapter 130A.
- Certified copies of vital records.
- Any recorded document in the official records of the register of deeds or any document filed in the official records of a court. However, as of December 1, 2005, persons who prepare documents for recording or filing by the register of deeds or the courts must not include any person's SSN or certain other identifying information unless they are expressly required to do so by law or court order, or by the state registrar for a record of a vital event.

Section 5 of S.L. 2005-414 enacts new G.S. 120-61, which requires state government agencies to evaluate their efforts to reduce the dissemination of personal identifying information and make an annual report to the General Assembly. Agencies must give special attention to their collection and use of SSNs. The section further provides that if the collection of an SSN is found to be unwarranted, the state agency must immediately discontinue the collection of SSNs for that purpose. This requirement became effective December 1, 2005.

Other Laws of Interest

Medication Aides

The North Carolina Board of Nursing and DHHS have been working together for several years to develop standards for non–health care providers who administer medications in health care facilities, correctional facilities, and schools. After jointly conducting a pilot project, the board and DHHS recommended legislation to set standards for training, competency, and registration of medication aides. In March 2005, identical bills that would have authorized and regulated the use of unlicensed personnel as medication aides were introduced in the House (H 783) and Senate (S 662). As initially drafted, those bills would have

- explicitly authorized the use of medication aides in health care facilities licensed under G.S. Chapter 131E, Articles 5 (hospitals), 6 (nursing homes, home care agencies, and ambulatory surgical facilities), and 10 (hospice facilities); in adult care homes licensed under G.S. Chapter 131D; in facilities offering mental health, developmental disabilities, and substance abuse services; in schools; and in Department of Correction facilities;
- authorized the North Carolina Board of Nursing to develop standards for medication aide training; and
- established a medication aide registry listing all persons who have successfully completed

the medication aide program and passed a state competency exam.

Both bills were referred to the health committees in their respective chambers but were not acted on further. However, the 2005 appropriations act includes a special provision that contains some of the provisions of those bills.

Section 10.40C(b) of S.L. 2005-276 requires the North Carolina Board of Nursing to establish standards for medication aide training. Section 10.40C(c) enacts new G.S. 131E-270, which requires DHHS to establish and maintain a medication aide registry that contains the names of all persons who have successfully completed a training program approved by the Board of Nursing and passed a competency exam. Some health care facilities must not employ or use a person as a medication aide without first verifying that the person is listed on the registry. [9] A separate special provision, section 10.40D(f), authorizes local boards of education to adopt policies and procedures permitting unlicensed health care personnel to administer medications in schools. That section—which is described in more detail under "School Health," above—also refers to the new registry and training requirements set forth in new G.S. Chapter 131E.

Finally, subsection (b) of new G.S. 131E-114.2 requires the Medical Care Commission to adopt rules addressing the training and competency of medication aides, requirements for listing in the medication aide registry, and requirements for the supervision of medication aides by licensed health professionals or qualified supervisory personnel.

Section 10.40D of S.L. 2005-276 directs the Secretary of Health and Human Services and the President of the Community Colleges System to convene a study group to make recommendations to the 2006 session of the General Assembly regarding the training, evaluation, and supervision of medication aides. In addition, DHHS must continue its pilot program on the use of medication aides and report on the program's status.

Methamphetamine Lab Prevention Act

S.L. 2005-434 (H 248) restricts the sale of pseudoephedrine, a popular over-the-counter decongestant that can be used to manufacture methamphetamine. The restrictions include the following:

- Pseudoephedrine products in tablet or caplet form must be stored and sold from behind a pharmacy counter.
- Nonprescription pseudoephedrine products may be sold only to individuals age eighteen and older. Retailers must require purchasers

[9] It is not clear which health care facilities are affected. Section 10.40C addresses medication aides in nursing homes, but it is unclear whether and to what extent the section affects medication aides in other health care facilities. The new statute that requires DHHS to establish the medication aide registry and employers to consult it appears in Article 16 of G.S. Chapter 131E, Miscellaneous Provisions. However, the use of medication aides is addressed only in a new section added to Article 6, Part 1, of G.S. Chapter 131E, which governs the licensure of nursing homes. The first sentence of subsection (a) of new G.S. 131E-114.2 states that facilities licensed under Part 1—that is, nursing homes—may use medication aides to perform the technical aspects of medication administration. It does not address the use of medication aides in health care facilities licensed under other parts of G.S. Chapter 131E. However, subsection (a)(1) refers to the use of medication aides in facilities licensed under Article 5 (hospitals) and Article 10 (hospice facilities), as well as those licensed under Article 6, Part 1. Those health care facilities, as well as others not named, have long had a practice of using unlicensed personnel as medication aides. See N.C. Board of Nursing, Fact Sheet: Medication Aide Project, available on the Internet at http://www.ncbon.org/education-factsheet.asp.

Errors in references to specific sections of G.S. Chapter 131E contribute to the confusion. G.S. 131E-114.2(b) refers to the medication aide registry "as provided for under G.S. 131E-271," but section 10.40C(c) established the registry in G.S. 131E-270. Furthermore, Section 10.40D(f), which authorizes school boards to adopt policies permitting the use of unlicensed personnel as medication aides, refers to G.S. 131E-270 as the source of the training requirements that are actually contained in G.S. 131E-114.2 and that appear to apply only to nursing homes. The original medication aide bills, Senate Bill 662 and House Bill 783, would have placed the training requirements in G.S. 131E-270 and established the registry in G.S. 131E-271. Since that is the case, it appears that the General Assembly's decision to put the training requirements in the nursing home licensure act rather than in the miscellaneous provisions portion of G.S. Chapter 131E was deliberate, but it is not clear what that implies for other health care facilities whose use of medication aides is implicitly acknowledged by the reference in G.S. 131E-114.2(a) to facilities licensed under other articles.

to furnish photo identification showing date of birth.

- Retailers must keep a record of disposition of pseudoephedrine products that records the name and address of each purchaser, identifies each product purchased, and specifies the amount of grams purchased and the purchase date. Each purchaser must sign the record at the time of purchase. The retailer must maintain records for two years and make them available for inspection by authorized law enforcement officials.
- Individuals are prohibited from purchasing or attempting to purchase over-the-counter more than two packages containing a total of six grams of pseudoephedrine in a single purchase and from purchasing or attempting to purchase over-the-counter more than three packages containing a total of nine grams in a thirty-day period.

The restrictions do not apply to pseudoephedrine products in the form of liquid, liquid capsule, or gel capsule; nor do they apply to pediatric products labeled and intended for administration to children under age twelve.

The law also requires retailers who sell pseudoephedrine products covered by the restrictions to post signs about the restrictions and to require their employees to participate in a training program. There are criminal penalties for retailers, employees, and purchasers who willfully and knowingly violate the restrictions.

State Veterinarian's Authority to Control Contagious Animal Diseases

In 2001, in response to an epidemic of foot and mouth disease among animals in Europe, the General Assembly enacted legislation strengthening the authority of the State Veterinarian to respond to contagious animal diseases with the potential for serious and rapid spread. Among other things, S.L. 2001-12 authorized the State Veterinarian to stop and inspect vehicles transporting animals, to quarantine areas to prevent the spread of contagious animal diseases, and to order that infected animals be destroyed. The original law had a sunset date of April 1, 2003. In 2003 the General Assembly extended the sunset to October 1, 2005.[10] S.L. 2005-21 (S 210) extends the sunset again, to October 1, 2009.

[10] S.L. 2003-6.

Immunity from Liability for Volunteer Emergency Responders

S.L. 2005-273 (H 1297) amends G.S. 1-539.10 to provide qualified immunity from liability for Medical Reserve Corps members, members of Community Emergency Response Teams, and other volunteers engaged in providing emergency services. The law also defines "emergency services" in G.S. 1-539.11 as "the preparation or carrying out of functions to prevent, minimize, and repair injury and damage resulting from natural or man-made disasters," including medical, health, and rescue services (among others).

2005-2007 Budget

The 2005 appropriations act, S.L. 2005-276, provides funding for a number of new and continuing public health programs. The act allocates $2 million in nonrecurring funds for the Community-Focused Eliminating Health Disparities Initiative. This program will provide grants to community organizations, including faith-based organizations. Grant recipients must use the funds to develop programs focused on reducing certain health problems in minority communities, including infant mortality, HIV/AIDS, sexually transmitted diseases, cancer, diabetes, homicides, and motor vehicle–related deaths.

In 2004 the General Assembly created the School Health Nurse Initiative and appropriated $4 million in recurring funds to pay for eighty school nurse positions across the state (S.L. 2004-124). The 2005 appropriations act provides an additional $2.5 million in recurring funds to continue this effort and pay for fifty additional permanent school nurse positions. The use of these funds is addressed in the section on School Health, above.

The act appropriates a little more than $4 million in nonrecurring funds to the North Carolina Division of Public Health to develop and implement the Health Information System, an automated data system for monitoring, reporting, and billing services provided in local health departments, children's developmental services agencies, and the state public health lab. The system is intended to replace the Health Services Information System that is currently in use.

S.L. 2005-276 provides a substantial amount of nonrecurring funding to automate the state's vital records system. The Office of Vital Records will receive $100,000 in fiscal year 2005-06 and $1.4 million in fiscal year 2006-07 to carry out this effort.

The act also appropriates about $75,000 in recurring funds to establish two new staff positions to process vital records.

Section 10.9 of S.L. 2005-276 provides that $2 million of the recurring funds appropriated for community health grants must be used for federally qualified health centers, rural health centers, local health departments, and other community health centers to

1. increase access to preventive and primary care by uninsured or medically indigent patients in existing or new health centers;
2. establish community health center services in counties without these services;
3. create new services or augment existing services for uninsured or medically indigent patients, including primary care and preventive services and dental, pharmacy, and behavioral health services; and
4. increase capacity to serve the uninsured by enhancing or replacing facilities, equipment, or technologies.

Section 10.57 of the appropriations act directs the North Carolina Division of Public Health to develop a pilot program to place automated external defibrillators (AEDs) in public buildings, including public gymnasiums. The division must use $17,000 of the funds appropriated to it for 2005-06 and $6,000 of the funds appropriated for 2006-07 to purchase AED units, conduct training in their use at the pilot sites, and provide ongoing education and awareness campaigns for the general public.

Other key public health initiatives that received appropriations in 2005 include

- $700,000 in recurring funds to provide staff and other resources for the new local health department accreditation program described above.
- $5 million in recurring funds for the provision of services under the state's early intervention program. Section 10.54A of the 2005 appropriations act enacts G.S. 130A-126, which transfers rule-making authority for the birth to three-year-old early intervention program from the Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services to the Commission for Health Services. Another special provision, Section 10.54, requires the North Carolina Division of Public Health to evaluate and report on early intervention services. The report must analyze the funding for the children with special needs program and develop a plan to use those funds within the early intervention program.
- A $1 million increase in recurring funds for the AIDS Drug Assistance Program, a program that pays for prescription drugs to treat individuals with HIV or AIDS who have family incomes at or below 125 percent of the federal poverty guidelines. A special provision, Section 10.59, prohibits the Department of Health and Human Services (DHHS) from extending eligibility for the program to individuals with incomes above 125 percent of the federal poverty guidelines during the 2005-07 fiscal biennium.
- $250,000 in recurring funds for a pilot program to pay for interpreter services in local health departments. Local health departments are required by federal civil rights laws to provide interpretation services to their limited-English proficient clients, and they are prohibited by the same laws from charging the clients for the services.
- $1 million in recurring funds for continued support of North Carolina's public health incubators. The public health incubator program was established by the 2004 appropriations act (S.L. 2004-124) to promote collaboration among local health departments and build capacity in the state's public health system.[11]
- $100,000 in recurring funds for the Healthy Carolinians program. The act also provides $400,000 in nonrecurring funds for the program for fiscal year 2005-06.

The 2005 appropriations act reduces the state appropriation for the State Public Health Laboratory by about $370,000 in the expectation that the reduction will be offset by an increase in the fee for

[11] The 2004 appropriations act appropriated $1 million in nonrecurring funds to the North Carolina Institute for Public Health to establish the incubator program. The institute then allocated funds to four incubators: the Northeastern North Carolina Partnership for Public Health (composed of ten local health departments serving nineteen counties), the South Central Incubator (composed of eight local health departments serving eight counties), the Western Incubator (composed of thirteen local health departments serving seventeen counties), and the Region III Northwest Incubator (composed of eight local health departments serving ten counties).

required newborn screening tests. On September 1, 2005, the fee rose from $10 to $14.

The 2005 appropriations act did not reduce funding for chronic disease prevention activities, but a special provision, Section 10.56, appears to signal that cuts may be forthcoming. Section 10.56 directs DHHS to inventory all chronic disease prevention activities, funding, staffing, and other resources "in order to reduce costs and eliminate duplication of effort." The inventory must include programs in heart disease, stroke, diabetes, osteoporosis, and cancer. In addition, DHHS must create a plan to combine task forces and activities for chronic disease prevention and explore collapsing those activities into the Healthy Carolinians structure.

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