LEGISLATIVE

RESEARCH COMMISSION

CANCER CONTROL

REPORT TO THE
1993 GENERAL ASSEMBLY
OF NORTH CAROLINA

A LIMITED NUMBER OF COPIES OF THIS REPORT IS AVAILABLE FOR DISTRIBUTION THROUGH THE LEGISLATIVE LIBRARY.

ROOMS 2126, 2226
STATE LEGISLATIVE BUILDING
RALEIGH, NORTH CAROLINA 27611
TELEPHONE: (919) 733-7778

OR

ROOM 500
LEGISLATIVE OFFICE BUILDING
RALEIGH, NORTH CAROLINA 27603-5925
TELEPHONE: (919) 733-9390

TABLE OF CONTENTS

STATE OF NORTH CAROLINA

LEGISLATIVE RESEARCH COMMISSION

STATE LEGISLATIVE BUILDING

RALEIGH 27611

January 15. 1993

TO THE MEMBERS OF THE 1993 GENERAL ASSEMBLY:

The Legislative Research Commission herewith submits to you for your consideration its final report on cancer control. The report was prepared by the Legislative Research Commission's Committee on Cancer Control pursuant to G.S. 120-30.17(1).

Respectfully submitted.

Daniel T. Blue, Jr.
Speaker of the House

Henson P. Barnes
President Pro Tempore

Cochairs
Legislative Research Commission

1991-1992

LEGISLATIVE RESEARCH COMMISSION

MEMBERSHIP

President Pro Tempore of the Senate
Henson P. Barnes, Cochair

Senator Frank W. Ballance, Jr.
Senator Howard F. Bryan
Senator J. K. Sherron, Jr.
Senator Lura Tally
Senator Russell G. Walker

Speaker of the House of Representatives
Daniel T. Blue, Jr., Cochair

Rep. Marie W. Colton
Rep. W. Pete Cunningham
Rep. E. David Redwine
Rep. Frank E. Rhodes
Rep. Peggy M. Stamey

PREFACE

The Legislative Research Commission, established by Article 6B of Chapter 120 of the General Statutes, is a general purpose study group. The Commission is cochaired by the Speaker of the House and the President Pro Tempore of the Senate and has five additional members appointed from each house of the General Assembly. Among the Commission's duties is that of making or causing to be made, upon the direction of the General Assembly, "such studies of and investigations into governmental agencies and institutions and matters of public policy as will aid the General Assembly in performing its duties in the most efficient and effective manner" (G.S. 120-30.17(1)).

At the direction of the 1991 General Assembly and the cochairs of the Legislative Research Commission, the Commission has undertaken studies of numerous subjects. These studies were grouped into broad categories and each member of the Commission was given responsibility for one category of study. The Cochairs of the Legislative Research Commission, under the authority of G.S. 120-30.10(b) and (c), appointed committees consisting of members of the General Assembly and the public to conduct the studies. Cochairs, one from each house of the General Assembly, were designated for each committee.

The study of cancer control was authorized pursuant to G.S. 120-30.17(1) by the Cochairs of the Legislative Research Commission in a letter dated September 1, 1992. A copy of the letter and G.S. 120-30.17 are included in Appendix A. The Legislative Research Commission grouped this study in its Health and Human Resources area under the direction of Senator Russell G. Walker. The Committee was chaired by Senator Helen Rhyne Marvin and Representative Luther Reginald Jeralds.[1] The full membership of the Committee is listed in Appendix B of this report. A committee

---

1. Representative Jeralds died on December 13, 1992.

notebook containing the committee minutes and all information presented to the committee is filed in the Legislative Library.

COMMITTEE PROCEEDINGS

The Legislative Research Commission's Committee on Cancer Control met three times to consider problems with the coordination and financing of cancer control activities and services in North Carolina.

October 30, 1992

The Cancer Control Committee met and adopted its budget. The Committee heard the following presentations:

Carol Shaw, of the Fiscal Research Division of the General Assembly, gave the Committee an overview of the programs in the Department of Environment, Health, and Natural Resources that are responsible for cancer control, prevention and treatment services. Her discussion included the source of funds for five programs in the Division of Adult Health, the Cancer Registry, and the Cancer Cytology Section of the Public Health Lab. She pointed out that the funds appropriated to the Cancer Control Program in the Division of Adult Health run out before the fiscal year ends. In addition, she talked about the source and amount of the grants that East Carolina University Medical School has been awarded for cancer research.

Dr. John Kernodle, committee member and Public Issues Chair for the North Carolina Division of the American Cancer Society, spoke next. He presented a brief history of cancer control in the State, showing how North Carolina has been in the forefront of cancer treatment. He mentioned the following events: (1) establishment of the Cancer Control Program, funded by the General Assembly, (2) establishment of the

Cancer Registry, (3) passage of legislation in 1991 to mandate insurance coverage for mammography and pap smears, and (4) passage of legislation in 1992 for entitlement of payment under Medicaid for mammography. Although the State is doing many things, there are still a large number of people who are not being seen and the reasons for this are uncertain. As for the future goals of a cancer control commission, Dr. Kernodle said that there are many programs being developed for cancer control by State government, by the four comprehensive cancer centers, by local health departments, and by private research groups. He believes that a coordinating body is needed to oversee the many groups and make a plan to take advantage of all the resources.

The next speaker was Dr. Thad Wester of the Governor's Task Force for Health Objectives in the Year 2000. Recommendations developed by the task force emphasize the community as a key agent, in not only improving health but in preventing unnecessary loss of life and premature death and disability. The emphasis on cancer prevention and early detection must be at the community level, not at the state or federal level. He pointed out that as more responsibility falls on the individual and the community, the need for coordination among the various cancer services will increase greatly.

Dr. M. Robert Cooper, co-chair of the N.C. Medical Society Cancer Control Committee and Acting Director of the Bowman Gray Comprehensive Cancer Center, spoke next. Although the Cancer Control Program in North Carolina has been successful, there is still a need for some help in bringing together all of the components of the program. He told the Committee that the Cancer Registry is the centerpiece of the N.C. Cancer Control Program. The registry has been developing a database tracking the incidence of cancer since 1986. In 1993, for the first time, statistics on a county by county basis will be available for health planners. He wanted the Committee

to understand that the Cancer Registry is a powerful tool that is available for designing interventions specifically for persons who have an increased risk of cancer. He explained that there are differences in the incidence of cancer based on race and county of residence. He also echoed the idea that some kind of committee is needed to guide the future of cancer control in the State.

Next on the agenda, Dr. Albert Wiley, with the Leo Jenkins Cancer Center in Greenville, told the Committee about the cancer control programs at the comprehensive cancer centers. He emphasized the importance of having four comprehensive cancer centers across the State because of the regional differences in cancer control needs. He stated that the comprehensive cancer centers provide medical benefits because patients have access to all the different cancer treatments. In addition to the medical benefits, the areas where the centers are located enjoy economic benefits such as new jobs when the related biotechnology and pharmaceutical industries move in.

Mr. Bob Wooten, CEO of Brown Wooten Mills, Inc., explained how his company started a health care program six years ago in response to the increasing costs of health care. Ms. Alisa Cornetto, Occupational Health Director for Brown Wooten Mills, explained that the company started offering screenings for skin cancer, oral cancer, prostate cancer, cervical cancer, and breast cancer. As a result of the education, prevention and early detection programs offered by the company, neoplasms disappeared from the list of the most frequent in-patient diagnoses.

Next, Dr. Etta Pisano, member of the Lineberger Cancer Center and Director of Breast Imaging at UNC, spoke about the controversy concerning the advantages of mammography for women under 50. She endorses mammography for women under 50. Because the quality of mammograms varies, she encourages women to make sure that the mammography unit is accredited by the American College of Radiology and to

ask if the mammographer has passed the exam for radiology technologists in mammography.

The next speaker, Dr. Sig Tannenbaum, told the Committee that prostate cancer is second only to skin cancer as the most common cancer in American men. Among the deaths caused by cancer, prostate cancer is the second leading cause of death behind lung cancer. Dr. Tannenbaum explained how prostate cancer impacts Afro-American males more significantly than white males. He said that the Prostate Specific Antigen (PSA) test can detect prostate cancer much earlier when treatment options are greater.

Following Dr. Tannenbaum on the agenda was Mr. Eugene F. Corrigan, ACC Football Commissioner and prostate cancer survivor. Mr. Corrigan told how early detection by the PSA test had saved his life and the lives of his brothers. Because of the PSA test he and his brothers underwent successful operations to remove the cancer.

Next to speak was an oncologist in private practice, Dr. John Lusk. He stressed to the Committee that early detection is responsible for successful cancer treatment. With a few exceptions, treatment for cancer diagnosed in the latter stages is no more successful now than it was thirty years ago. He also repeated the need for a commission to advise, assess needs, make recommendations, and propose appropriate legislation and otherwise coordinate the cancer control efforts in the State.

Dr. Margaret L. Bertrand of the Bertrand Diagnostic Imaging and Breast Center followed. She told the Committee that women are not getting routine mammograms because of such barriers as cost, accessibility, and lack of knowledge about breast cancer. Her center has tried to overcome these barriers by offering free screening for economically disadvantaged women, extended evening hours, and a mobile mammography unit. The Committee wanted to know if the mobile units operating across the State had to meet any standards. Dr. Bertrand said that this was one area that a cancer control commission could examine.

Colon cancer was the topic of the next speaker, Dr. John Sessions. He said that it is important to know your family medical history because colon cancer is a hereditary disease. Dr. Sessions wanted to include educators on the commission because cancer education could be best handled in the schools. Following Dr. Sessions, Representative Pete Hasty described his personal experience with colon cancer. He felt that early detection was the most important thing and that people are reluctant to seek treatment because they are afraid of learning that they have cancer.

The next speaker, Dr. Wendy DeMark of Duke University, limited her remarks to the wide range of programs offered by the university for prevention, early detection and treatment of breast cancer. Duke University is especially concerned about two populations that are at greater risk of contracting and dying from breast cancer, older women and African-American women. She also supported a commission that would channel resources more productively so that fewer people would contract and die from cancer.

Dr. Georjean Stoodt, Chief of the Chronic Disease Section of the Department of Environment, Health, and Natural Resources, spoke next on cervical cancer. She stated that deaths from cervical cancer were preventable if we do the following: (1) educate women about behaviors that increase their chance of contracting the disease, (2) conduct regular screenings, (3) ensure appropriate follow-up when cervical cancer is suspected, (4) assure proper treatment is received, and (5) track patients to see that every woman follows the proper procedure. Dr. Stoodt also praised the work done by the Public Health laboratory in examining Pap smears from local health departments. She also mentioned the problems that the Public Health Laboratory has in recruiting and retaining cytotechnologists that result in delays in getting test results back to the patients.

The last speaker, Sandy Babb, President of North Carolina Equity, said that the diversity of interests represented at the meeting underscored the need for a commission to oversee, guide, plan, and coordinate all of the diverse efforts in cancer control. A commission could make sure that all of the different pieces of cancer control are fitting together in the most effective way. Efforts need to be focused and streamlined, and duplication needs to be eliminated. She said that cancer control depends not only on early detection but prompt and appropriate treatment.

The Committee expressed interest in hearing about different models that they could pattern their commission on. The Committee also wanted to: (1) get information about increasing the number of cytotechnologists trained each year and problems with retention, (2) get information about the cost to the State to fund the Cancer Control Program for the entire fiscal year, (3) hear from a representative from business, and (4) hear from a representative from the Department of Public Instruction about how the schools could disseminate information to the students concerning their individual responsibility to improve their health.

November 30, 1992

To begin the meeting, Carol Shaw of the Fiscal Research Division of the General Assembly passed out two handouts. The first handout was a listing of the grants awarded to the University of North Carolina at Chapel Hill that deal with cancer research and prevention. The second handout addressed two questions that the Committee had asked at the previous meeting about estimates of the costs to expand the Diagnosis and Treatment Component of the State Cancer Control Program. The first question concerned the cost to fund the Cancer Control Program for the entire fiscal

year. The amount of additional needed funds is estimated to be $86,700. The second question concerned the cost to fund the program using 100% of the federal poverty level as a financial eligibility guideline, rather than the current 50% of the federal poverty level. The amount needed to fund the program at 100% of the federal poverty level is estimated to be an additional $1,664,000.

Dr. Samuel N. Merritt, Director of the Division of Laboratory Services of the Department of Environment, Health, and Natural Resources, spoke next. He told the Committee that problems with recruitment and retention at the State Laboratory of Public Health are caused primarily by low salaries. The salaries at the State Lab are about $5,000 less than market price, so cytotechnologists are going to the private sector. Staff shortages are causing delays in processing Pap smears sent to the lab by the local health departments. To reduce the delays, the State Lab has contracted with private labs to help process the Pap smears. He said that the State Lab is paying the private labs $95,000 to $100,000 to do the equivalent of one cytotechnologist's yearly output.

The next speaker was Ms. Sandra Renwick, Education Coordinator of the Cytology Training Program at UNC-CH. She told the Committee that programs have started at East Carolina University, Central Piedmont Community College, and Duke University within the past two years. Roche Biomedical Laboratories is helping to sponsor the Duke University and Central Piedmont Community College programs. She said that there are currently more applicants than spaces at the UNC program and that certified cytotechnologists have no problems finding jobs. Salaries are the main reason that the students were accepting jobs in other states.

Dr. Walter Shephard, Executive Director of the Governor's Commission on the Reduction of Infant Mortality, spoke next about promoting programs among business and industry. He said that businesses have been very responsive when they see how a

problem affects the bottom line. He suggested that a cancer control commission would need to show business and industry the savings that occur when employees stay healthy. A program has to be tailored to meet the individual needs of the business and the local community.

The next speaker was Dr. Robert Frye, Education Consultant in the Department of Public Instruction. He told the Committee that research has shown that the schools can have an impact on student behavior, but it takes a concentrated amount of time to change each behavior. The schools are trying to teach students to develop skills to manage their own behaviors.

The staff presented two models to the commission, a legislative commission patterned after the Aging Study Commission and an advisory committee within a department patterned after the Advisory Committee on Family-Centered Services. The staff pointed out the benefits and limitations of each type of commission. The Committee voted to pattern a cancer control committee after the Advisory Committee on Family-Centered Services and staff was asked to draft legislation creating the committee within the Department of Environment, Health, and Natural Resources.

The Committee asked for some draft legislation that would require cytotechnology graduates of state institutions to give some time back to the State, possibly working in the State Lab. The Committee also asked for a recommendation that would require the Secretary of the Department of Environment, Health, and Natural Resources to call a meeting of interested parties to address problems of cytotechnology training, recruitment, retention, and salaries.

December 17, 1992

The Committee observed a moment of silence in memory of Representative Jeralds, Committee cochair, who died on December 13, 1992. Afterwards, the Committee discussed and approved, as amended, the report and the proposed recommendations to the 1993 General Assembly.

FINDINGS

The Legislative Research Commission's Committee on Cancer Control finds that:

1. Cancer is the second leading cause of death in North Carolina and affects people of all ages. In 1992, 14,000 North Carolinians are predicted to die from cancer.
2. Thirty-four percent of the annual cancer deaths are premature deaths striking person between the ages of 20 and 64.
3. Death and disability from cancer are estimated to account for 10% of the total cost of disease in North Carolina. The costs of late-stage cancer treatment are greater than treatment in the initial stages. Other costs associated with cancer include lost wages, lost state income tax, and lost sales taxes.
4. The cancer mortality rate can be reduced by 50% through prevention, early detection, and prompt, appropriate treatment and follow-up.
5. The funds for the diagnosis and treatment component of the Cancer Control Program in the Department of Environment, Health, and Natural Resources have been depleted before the end of the fiscal year for the last four years. Additional funding is needed to keep the program going for the rest of this fiscal year.
6. Cancer control efforts are spread out within the Department of Environment, Health, and Natural Resources, as well as other State institutions and in many non-State institutions.
7. The State Laboratory of Public Health suffers from problems of recruiting and retaining cytotechnologists because salaries are lower than the market

price. Cytotechnologists are taking jobs with private labs in North Carolina or leaving to work in other states. Because the State Lab cannot attract and retain cytotechnologists, there are delays in processing Pap smears, and the delays are forcing the lab to contract out the work at higher rates.

RECOMMENDATIONS

RECOMMENDATION 1: The Committee on Cancer Control recommends that the 1993 General Assembly enact A BILL TO BE ENTITLED AN ACT TO ESTABLISH THE CANCER COORDINATION AND CONTROL PROGRAM AND TO ESTABLISH THE ADVISORY COMMITTEE ON CANCER COORDINATION AND CONTROL TO THE SECRETARY OF THE DEPARTMENT OF ENVIRONMENT, HEALTH, AND NATURAL RESOURCES. (Appendix D)

RECOMMENDATION 2: The Committee on Cancer Control recommends that the 1993 General Assembly enact A BILL TO BE ENTITLED AN ACT TO APPROPRIATE FUNDS FOR THE ADVISORY COMMITTEE ON CANCER COORDINATION AND CONTROL TO THE SECRETARY OF THE DEPARTMENT OF ENVIRONMENT, HEALTH, AND NATURAL RESOURCES. (Appendix E)

RECOMMENDATION 3: The Committee on Cancer Control recommends that the 1993 General Assembly enact A BILL TO BE ENTITLED AN ACT TO ESTABLISH AND APPROPRIATE FUNDS FOR NEED-BASED CYTOTECHNOLOGY SCHOLARSHIPS, AND TO DIRECT THE OFFICE OF STATE PERSONNEL TO REVIEW STATE CYTOTECHNOLOGIST SALARIES. (Appendix F)

RECOMMENDATION 4: The Committee on Cancer Control recommends that the 1993 General Assembly enact A BILL TO BE ENTITLED AN ACT TO AUTHORIZE THE DIRECTOR OF THE BUDGET TO ALLOCATE ADDITIONAL FUNDS FOR THE REMAINDER OF THE 1992-93 FISCAL YEAR. (Appendix G)

RECOMMENDATION 5: The Committee on Cancer Control recommends that the 1993 General Assembly enact A BILL TO BE ENTITLED AN ACT TO APPROPRIATE ADDITIONAL FUNDS FOR THE CANCER CONTROL PROGRAM IN THE DEPARTMENT OF ENVIRONMENT, HEALTH, AND NATURAL RESOURCES. (Appendix H)

RECOMMENDATION 6: The Committee on Cancer Control recommends that the 1993 General Assembly enact A BILL TO BE ENTITLED AN ACT TO APPROPRIATE FUNDS FOR THE CANCER CONTROL PROGRAM IN THE DEPARTMENT OF ENVIRONMENT, HEALTH, AND NATURAL RESOURCES TO COVER 100% OF THE FEDERAL POVERTY LEVEL. (Appendix I)

RECOMMENDATION 7: The Committee on Cancer Control recommends that the Secretary of the Department of Environment, Health, and Natural Resources call interested groups together to discuss how to reduce the turnaround time for the reading of Pap smears at the State Laboratory of Public Health and at other public laboratories in the State.

The Committee recommends that the Secretary of the Department of Environment, Health, and Natural Resources call representatives of interested groups together, including, but not limited to, representatives of the following organizations: the Division of Laboratory Services in the Department of Environment, Health, and Natural Resources, local public health departments, the University of North Carolina, the Department of Community Colleges, hospitals in the State, the North Carolina Society of Cytology, and the American Society of Clinical Pathology. The Secretary shall hold

one or more meetings by March 1, 1994, to discuss how to reduce the turnaround time for the reading of Pap smears at the State Laboratory of Public Health and at other public laboratories in the State. Issues to be addressed should include: the shortage of registered cytotechnologists at the State Laboratory of Public Health and the effects of that shortage; how the State's universities and community colleges could train more people to become cytotechnologists; and what steps the State could take to recruit registered cytotechnologists to, and keep them in, the State, especially at the State Laboratory of Public Health. The Secretary shall give a progress report to the Speaker of the House of Representatives and to the President Pro Tempore of the Senate, and to the appropriate committees of the General Assembly as the Speaker and President Pro Tempore determine, by May 1, 1994.

APPENDIX A

NORTH CAROLINA GENERAL ASSEMBLY

September 1, 1992

MEMORANDUM

TO: Terrence D. Sullivan, Director of Research

FROM: Daniel T. Blue, Jr., Speaker
Henson P. Barnes, President Pro Tempore
Cochairs, Legislative Research Commission

RE: Cancer Control Study

We, as cochairs of the Legislative Research Commission (LRC) and pursuant to G.S. 120-30.17(1), hereby create the Cancer Control Study Committee within the Legislative Research Commission's Health and Human Resources Study Grouping over which Senator Walker is responsible.

The Committee shall study cancer control activities and services in North Carolina and make recommendations that will assure coordinated and adequately financed statewide cancer control efforts.

We, as cochairs of the Legislative Services Commission, direct the transfer of $15,000 from the General Assembly's Reserve for Carry Forward to the LRC's Cancer Control Committee.

The Committee shall report its findings and recommendations to the Legislative Research Commission no later than Wednesday, January 6, 1993.

cc: Representative David Redwine
Ms. Elaine Robinson

§120-30.17. Powers and duties.

The Legislative Research Commission has the following powers and duties:

(1) Pursuant to the direction of the General Assembly or either house thereof, or of the chairmen, to make or cause to be made such studies of and investigations into governmental agencies and institutions and matters of public policy as will aid the General Assembly in performing its duties in the most efficient and effective manner.

(2) To report to the General Assembly the results of the studies made. The reports may be accompanied by the recommendations of the Commission and bills suggested to effectuate the recommendations.

(3), (4) Repealed by Session Laws 1969, c. 1184, s. 8.

(5), (6) Repealed by Session Laws 1981, c. 688, s. 2.

(7) To obtain information and data from all State officers, agents, agencies and departments, while in discharge of its duty, pursuant to the provisions of G.S. 120-19 as if it were a committee of the General Assembly.

(8) To call witnesses and compel testimony relevant to any matter properly before the Commission or any of its committees. The provisions of G.S. 120-19.1 through G.S. 120-19.4 shall apply to the proceedings of the Commission and its committees as if each were a joint committee of the General Assembly. In addition to the other signatures required for the issuance of a subpoena under this subsection, the subpoena shall also be signed by the members of the Commission or of its committee who vote for the issuance of the subpoena.

(9) For studies authorized to be made by the Legislative Research Commission, to request another State agency, board, commission or committee to conduct the study if the Legislative Research Commission determines that the other body is a more appropriate vehicle with which to conduct the study. If the other body agrees, and no legislation specifically provides otherwise, that body shall conduct the study as if the original authorization had assigned the study to that body and shall report to the General Assembly at the same time other studies to be conducted by the Legislative Research Commission are to be reported. The other agency shall conduct the transferred study within the funds already assigned to it. (1965, c. 1045, s. 8; 1969, c. 1184, s. 8; 1977, c. 915, s. 3; 1981, c. 688, s. 2; 1983, c. 905, s. 7; 1985, c. 790, s. 7.)

APPENDIX B

CANCER CONTROL STUDY COMMITTEE MEMBERSHIP - 1992

LRC Member: Sen. Russell Walker
1004 Westmont Drive
Asheboro, NC 27203
(919) 625-2574

President Pro Tempore's Appointments

Sen. Helen R. Marvin, Cochair
119 Ridge Lane
Gastonia, NC 28054
704-864-2757

Sen. James S. Forrester
P.O. Box 459
Stanley, NC 28164
704-263-4716

Dr. John R. Kernodle
2465 Edgewood Avenue
Burlington, NC 27216
919-227-3621

Sen. T. L. "Fountain" Odom
1100 South Tryon Street
Charlotte, NC 28203
704-372-4800

Sen. J. Clark Plexico
P.O. Box 1904
Hendersonville, NC 28793
704-696-9435

Sen. Aaron W. Plyler
2170 Concord Avenue
Monroe, NC 28110
704-289-3541

Mrs. Jo Ann Schoen
221 S. Lake Shore Drive
Whispering Pines, NC 28327
919-215-1521 (W)
919-949-3886 (H)

Speaker's Appointments

Rep. Luther R. Jeralds, Cochair
319 Jasper Street
Fayetteville, NC 28301
919-488-3542

Rep. J. Fred Bowman
814 N. Graham-Hopedale Road
Burlington, NC 27215
919-228-7521

Rep. W. W. Dickson
718 Avondale Road
Gastonia, NC 28054
704-864-1231

Rep. Theresa H. Esposito
207 Stanaford Road
Winston-Salem, NC 27104
919-765-5176

Rep. John R. Gamble, Jr.
P.O. Box 250
Lincolnton, NC 28093
704-735-5452

Rep. James P. Green, Sr.
P.O. Box 1739
Henderson, NC 27536
919-492-2161

Dr. James R. O'Rourke, Jr.
Raleigh Internal Medicine
3320 Wake Forest Road
Raleigh, North Carolina 27609
919-872-4850

Rep. Timothy N. Tallent
565 Windsor Place, NE
Concord, NC 28025
704-784-4101

Mr. Thomas E. Wright
317 S. 17th Street
Wilmington, NC 28403

Staff:
Ms. Lynn Marshbanks
Ms. Sara Kamprath
919-733-2578

Clerk:
Peggy Anne Hogan
919-733-5880

provide minimum protection against vicious dogs in all parts of the State — rural, urban, small villages and large cities. With more concentrated population, cities are justified in adopting stricter regulations for dogs. Thus, a city was authorized to require a higher standard of conduct or condition with respect to the keeping of dogs within its corporate limits than was required for the State generally. Pharo v. Pearson, 28 N.C. App. 171, 220 S.E.2d 359 (1975).

Violation of Safety Statute as Negligence Per Se. — The violation of a statute which imposes a duty upon the defendant in order to promote the safety of others, including the plaintiff, is negligence per se, unless the statute, itself, otherwise provides. Swaney v. Shaw, 27 N.C. App. 631, 219 S.E.2d 803 (1975).

Evidence Insufficient to Show Dog "Vicious". — Evidence that a small dog frequently dashed into the street to bark at and pursue motorcycles, automobiles, and other noisy vehicles was not sufficient to justify classifying him as a "vicious" animal and did not make him "a menace to the public health." Sink v. Moore, 267 N.C. 344, 148 S.E.2d 265 (1966); Gray v. Clark, 9 N.C. App. 319, 176 S.E.2d 16 (1970).

Canine courage in a contest for the championship of the neighborhood, together with determination to remain on possession of the field of battle "whence all but him had fled," was not evidence of a vicious character within the meaning of former statute. Sink v. Moore, 267 N.C. 344, 148 S.E.2d 265 (1966).

§§ 130A-201 through 130A-204: Reserved for future codification purposes.

ARTICLE 7.

Chronic Disease.

Part 1. Cancer.

§ 130A-205. Administration of program; rules.

(a) The Department shall establish and administer a program for the prevention and detection of cancer and the care and treatment of persons with cancer.

(b) The Commission shall adopt rules necessary to implement the program. (1945, c. 1050, s. 1; 1957, c. 1357, s. 1; 1973, c. 476, s. 128; 1981, c. 345, s. 2; 1983, c. 891, s. 2.)

§ 130A-206. Financial aid for diagnosis and treatment.

The Department shall provide financial aid for diagnosis and treatment of cancer to indigent citizens of this State having or suspected of having cancer. The Department may make facilities for diagnosis and treatment of cancer available to all citizens. Reimbursement shall only be provided for diagnosis and treatment performed in a medical facility which meets the minimum requirements for cancer control established by the Commission. The Commission shall adopt rules specifying the terms and conditions by which the patients may receive financial aid. (1945, c. 1050, s. 2; 1957, c. 1357, s. 1; 1973, c. 476, s. 128; 1981, c. 345, s. 2; 1983, c. 891, s. 2.)

Evidence Insufficient to Show Dog "Vicious". — Evidence that a small dog frequently dashed into the street to bark at and pursue motorcycles, automobiles, and other noisy vehicles was not sufficient to justify classifying him as a "vicious" animal and did not make him "a menace to the public health." Sink v. Moore, 267 N.C. 344, 148 S.E.2d 265 (1966); Gray v. Clark, 9 N.C. App. 319, 176 S.E.2d 16 (1970).

Canine courage in a contest for the championship of the neighborhood, together with determination to remain on possession of the field of battle "whence all but him had fled," was not evidence of a vicious character within the meaning of former statute. Sink v. Moore, 267 N.C. 344, 148 S.E.2d 265 (1966).

A-204: Reserved for future codifi-

ICLE 7.

c Disease.

. Cancer.

tion of program; rules.

ablish and administer a program for f cancer and the care and treatment

dopt rules necessary to implement 1; 1957, c. 1357, s. 1; 1973, c. 476, s. c. 891, s. 2.)

aid for diagnosis and treat-

vide financial aid for diagnosis and ent citizens of this State having or The Department may make facilities of cancer available to all citizens. Re- rovided for diagnosis and treatment y which meets the minimum require- blished by the Commission. The Com- ecifying the terms and conditions by ive financial aid. (1945, c. 1050, s. 2; 76, s. 128; 1981, c. 345, s. 2; 1983, c.

§ 130A-207. Cancer clinics.

The Department is authorized to provide financial aid to sponsored cancer clinics in medical facilities and local health departments. The Commission shall adopt rules to establish minimum standards for the staffing, equipment and operation of the clinics sponsored by the Department. (1945, c. 1050, s. 3; 1949, c. 1071; 1957, c. 1357, s. 1; 1973, c. 476, s. 128; 1981, c. 345, s. 2; 1983, c. 891, s. 2.)

§ 130A-208. Central cancer registry.

A central cancer registry is established within the Department. The central cancer registry shall compile, tabulate and preserve statistical, clinical and other reports and records relating to the incidence, treatment and cure of cancer received pursuant to this Part. The central cancer registry shall provide assistance and consultation for public health work. (1945, c. 1050, s. 7; 1957, c. 1357, s. 1; 1973, c. 476, s. 128; 1981, c. 345, s. 2; 1983, c. 891, s. 2.)

§ 130A-209. Incidence reporting of cancer.

A physician shall report to the central cancer registry each diagnosis of cancer in any person for whom the physician is professionally consulted. The reports shall be made within 60 days of diagnosis. Diagnostic, demographic and other information as prescribed by the rules of the Commission shall be included in the report. (1949, c. 499; 1957, c. 1357, s. 1; 1973, c. 476, s. 128; 1981, c. 345, s. 2; 1983, c. 891, s. 2.)

§ 130A-210. Medical facilities may report.

A medical facility may submit to the central cancer registry clinical, statistical and other records relating to the treatment and cure of cancer. (1981, c. 345, s. 2; 1983, c. 891, s. 2.)

§ 130A-211. Immunity of persons who report cancer.

A person who makes a report pursuant to G.S. 130A-209 or 130A-210 to the central cancer registry shall be immune from any civil or criminal liability that might otherwise be incurred or imposed. (1967, c. 859; 1969, c. 5; 1973, c. 476, s. 128; 1981, c. 345, s. 2; 1983, c. 891, s. 2.)

§ 130A-212. Confidentiality of records.

The clinical records or reports of individual patients shall be confidential and shall not be public records open to inspection. The Commission shall provide by rule for the use of the records and reports for medical research. (1981, c. 345, s. 2; 1983, c. 891, s. 2.)

§ 130A-213. Cancer Committee of the North Carolina Medical Society.

In implementing this Part, the Department shall consult with the Cancer Committee of the North Carolina Medical Society. The Committee shall consist of at least one physician from each congressional district. Any proposed rules or reports affecting the operation of the cancer control program shall be reviewed by the Committee for comment prior to adoption. (1945, c. 1050, s. 9; 1957, c. 1357, s. 1; 1973, c. 476, s. 128; 1981, c. 345, s. 2; 1983, c. 891, s. 2.)

§ 130A-214. Duties of Department.

The Department shall study the entire problem of cancer including its causes, including environmental factors; prevention; detection; diagnosis and treatment. The Department shall provide or assure the availability of cancer educational resources to health professionals, interested private or public organizations and the public. (1967, c. 186, s. 2; 1973, c. 476, s. 128; 1981, c. 345, s. 2; 1983, c. 891, s. 2.)

§ 130A-215. Reports.

The Secretary shall make a report to the Governor and the General Assembly specifying the activities of the cancer control program and its budget. The report shall be made to the Governor annually and to the General Assembly biennially. (1981, c. 345, s. 2; 1983, c. 891, s. 2.)

§§ 130A-216 through 130A-219: Reserved for future codification purposes.

Part 2. Chronic Renal Disease.

§ 130A-220. Department to establish program.

(a) The Department shall establish and administer a program for the detection and prevention of chronic renal disease and the care and treatment of persons with chronic renal disease. The program may include:

(1) Development of services for the prevention of chronic renal disease;

(2) Development and expansion of services for the care and treatment of persons with chronic renal disease, including techniques which will have a lifesaving effect in the care and treatment of those persons;

(3) Provision of financial assistance on the basis of need for diagnosis and treatment of persons with chronic renal disease;

(4) Equipping dialysis and transplantation centers; and

(5) Development of an education program for physicians, hospitals, local health departments and the public concerning chronic renal disease.

(b) The Commission is authorized to adopt rules necessary to implement the program. (1971, c. 1027, s. 1; 1973, c. 476, s. 128; 1983, c. 891, s. 2.)

SECTION .0400 - CANCER PROGRAM

15A NCAC 16A .0400 has been transferred from the Department of Human Resources and recodified as follows: 15A NCAC 16A .0401 - .0408 from 10 NCAC 8A .0401 - .0408 and 15A NCAC 16A .0409 - .0412 from 10 NCAC 8A .0413 - .0416, effective April 4, 1990.

.0401 GENERAL

(a) The cancer program provides financial assistance for the medical care of indigent patients requiring inpatient or outpatient:

(1) diagnostic services for cancer; or

(2) treatment services for cancer.

(b) The cancer program is administered by the Health Care Section, Division of Adult Health, Department of Environment, Health, and Natural Resources, P.O. Box 27687, Raleigh, NC 27611-7687.

History Note: Statutory Authority G.S. 130A-205;
Eff. February 1, 1976;
Readopted Eff. December 5, 1977;
Amended Eff. September 1, 1990; July 1, 1985; September 1, 1979.

.0402 DIAGNOSTIC SERVICES

(a) Financial assistance shall be provided for primary diagnostic services, up to two visits on an outpatient basis or up to one day on an inpatient basis per year for each patient, subject to determination of patient eligibility and availability of funds. The actual number of outpatient visits or inpatient days authorized for reimbursement shall be determined by the physician consultant to the program, based on the medical condition of the patient, the procedure to be performed, and a reasonable recovery from the procedure.

(1) Applications for inpatient diagnostic services will be considered only when accompanied by a written statement from the attending physician listing:

(A) the medical reason inpatient services are required, and

(B) the medical reason such services cannot be performed on an outpatient basis.

(2) The statement in (a)(1) of this Rule may be in the form of workup protocol, clinical notes, medical history, or other medical document in lieu of a separately prepared statement; however, any such documentation must give adequate information to justify an inpatient admission, and must bear the name of the attending physician.

(3) The statement in (a)(1) of this Rule shall be reviewed by the physician consultant to the cancer program who shall assess the medical need for inpatient diagnostic services.

(4) If the physician consultant to the cancer program does not recommend inpatient services for a patient, the cancer program shall only authorize reimbursement for outpatient diagnostic services, and only to the extent recommended by the physician consultant.

(b) Bills for authorized diagnostic services will be paid, but the cancer program shall not pay for any services rendered that are not authorized.

(c) The following diagnostic procedures and accompanying biopsy, when appropriate, will be covered by the cancer program on an outpatient basis in a physician's office, emergency, or outpatient department whenever possible. These procedures shall be performed only by a physician and reimbursement only to those physicians listed on a roster with the cancer control program. Requests for inclusion on the roster shall be sent to the cancer control program at the principal address of the Division and shall include an indication of the availability of equipment necessary to complete the procedure. The letter must be signed by the physician, or by each physician requesting rostering in a group practice. Rosterable procedures include:

(1) bronchoscopy,

(2) colonoscopy,

(3) colposcopy,

(4) cryosurgery of the cervix,

(5) cystoscopy,

(6) esophagogastroscopy,

(7) rectosigmoidoscopy.

(d) Any diagnostic procedure that is medically indicated and not otherwise available at a local health department is sponsorable without a rostering requirement, except for those diagnostic procedures specifically stated in (c) of this Rule.
(e) Sputum cytology, urine cytology and biopsy examination must be done by a pathologist.

History Note: Statutory Authority G.S. 130A-220;
Eff. February 1, 1976;
Readopted Eff. December 5, 1977;
Amended Eff. September 1, 1990; October 1, 1983; October 1, 1982; October 1, 1981.

.0403 TREATMENT SERVICES
(a) Financial assistance is provided for treatment services, up to 8 days of inpatient service or up to 16 outpatient visits per year for each patient, subject to determination of patient eligibility and availability of funds. The actual number of inpatient days or outpatient visits authorized for reimbursement shall be determined by the physician consultant to the program, based on the medical condition of the patient, the procedure to be performed, and a reasonable recovery from the procedure.
(b) Bills for authorized treatment services will be paid, but the cancer program shall not pay for any services rendered that are not authorized.

History Note: Statutory Authority G.S. 130A-205;
Eff. February 1, 1976;
Readopted Eff. December 5, 1977;
Amended Eff. September 1, 1990; October 1, 1983; October 1, 1982; October 1, 1981.

.0404 COVERED SERVICES
(a) An eligible patient may be sponsored for the treatment of cancer by surgery, radiation therapy, chemotherapy, or immunotherapy.
(b) Physical therapy following surgery, where medically indicated, is an approved treatment service on an inpatient and outpatient basis. Hospitals and physicians are encouraged to utilize home health agencies for this service whenever possible. Advance application should be made by local home health agencies for sponsorship of this service.
(c) Service Restrictions:
(1) The Cancer program will not sponsor palliative treatment of any kind.
(2) The Cancer program will not pay for blood, but may cover the cost of blood administration.
(3) Dental surgery is not sponsored, but nondental oral surgery performed for the diagnosis or treatment of cancer is sponsorable.
(4) The Cancer program shall not sponsor late discharge fees, transportation, telephone calls, or other miscellaneous charges while the patient is receiving services.
(5) Cosmetic surgery is not sponsored unless performed in conjunction with the removal of cancerous tissue.
(6) Ancillary diagnostic studies shall be authorized only when they are directly related to the confirmation of a diagnosis of cancer, as determined by the physician consultant to the program.
(7) The program shall not authorize reimbursement for routine follow-up office visits after completion of a definitive course of diagnostic studies or treatment. However, the program may consider a request for the definitive diagnosis or treatment of a recurrent disease.
(8) Colposcopy must be performed on all sponsorable patients to determine appropriate therapy for cervical intraepithelial neoplasia. Local cervical therapy must be used when colposcopic findings confirm this as appropriate. Diagnostic or therapeutic conizations of the cervix will be approved only after colposcopic findings indicate this is absolutely necessary, and only on an outpatient basis unless extreme circumstances are documented. Conization of the cervix will be sponsored if one or more of the following conditions are met and documented:
(A) Unsatisfactory colposcopy due to the lesion extending into the endocervical canal;
(B) Positive endocervical curretage; or
(C) Cytologic or histologic suspicion for invasive cancer.
Hysterectomy will not be sponsored as a primary therapy for cervical intreapithelial neoplasia.
(d) Chemotherapy may be authorized for testicular carcinoma, Hodgkin's disease, histiocytic lymphoma, choriocarcinoma in women, Wilm's Tumor, and breast cancer. Other conditions will be

evaluated on an individual basis. All requests for chemotherapy shall be accompanied by a protocol describing the treatment being requested.

(e) Overnight accommodations in a residential care facility (motel, home, boarding house, ambulatory care facility, etc.) and meals for patients receiving cancer diagnostic or treatment services on an outpatient basis shall be sponsored by the cancer program under the following conditions:

(1) The patient's residence must be at least 50 miles from the medical facility providing the outpatient services.
(2) The residential care facility must be approved for participation by the cancer program.
(3) The patient must meet all medical eligibility requirements as stated in Rule .0406, and all financial eligibility requirements as stated in 15A NCAC 24A.
(4) Reimbursement for actual expenses shall not exceed the maximum allowable subsistence (lodging and meals) for state employees in the course of their official duties, based on those rates of reimbursement in effect at the time of the authorization of residential care by the cancer program.
(5) The cancer program shall not reimburse for any incidental expenses incurred as a result of the use of a residential care facility, including transportation, telephone, etc.
(6) Cancer program authorization of residential care shall be limited to the maximum number of days of coverage as provided by Rules .0402(a) or .0403(a) of this Subchapter, except that the cancer program shall sponsor continuous (weekend) coverage of residential care during the period in which outpatient services are being rendered, provided that when residential care begins or ends on a Saturday or Sunday, reimbursement for those weekend days shall not be sponsored.
(7) Applications for authorization requesting residential care shall state the number of days such residential care which will be required, as well as the dates of service during which outpatient diagnostic or treatment services shall be rendered.

History Note: Statutory Authority G.S. 130A-205;
Eff. February 1, 1976;
Readopted Eff. December 5, 1977;
Amended Eff. September 1, 1990; October 1, 1982; April 1, 1982; January 1, 1982.

.0405 FINANCIAL ELIGIBILITY

Financial eligibility for the cancer program shall be determined in accordance with rules found in 10 NCAC 4C.

History Note: Statutory Authority G.S. 130A-205;
Eff. February 1, 1976;
Readopted Eff. December 5, 1977;
Amended Eff. July 1, 1981; September 1, 1979; April 15, 1979.

.0406 MEDICAL ELIGIBILITY

(a) To be medically eligible for diagnostic authorization, a patient must have a condition strongly suspicious of cancer which requires outpatient or inpatient services to confirm the preliminary primary diagnosis. The program shall authorize only those services deemed medically necessary to confirm a preliminary primary diagnosis as determined by the physician consultant to the program.

(b) Cervical intraepithelial neoplasia, defined as any condition suggestive of preinvasive cervical cancer (mild dysplasia, moderate dysplasia, severe dysplasia, or carcinoma in situ), is suspicious of cancer or its precursors and may be sponsored by the cancer program on the basis of cytologic or histologic evidence of cervical intraepithelial neoplasia.

(c) Before treatment services can be authorized by the cancer program, all cases must be proven cancerous (positive pathology report).

(d) Before the cancer program can authorize treatment services, the attending physician must certify that there is a reasonable chance the cancer can be cured or arrested.

(e) All requests for treatment shall be reviewed by the physician consultant to the program. Such requests shall be authorized only after a determination by the physician consultant that there is a reasonable chance of cure or arrest of the disease and that the services to be provided are medically necessary and reasonable. In making this determination, the physician consultant may confer with the patient's attending physician, members of the Cancer Committee of the North Carolina Medical Society, and other physicians trained in the treatment of cancer.

History Note: Statutory Authority G.S. 130A-205;
Eff. February 1, 1976;
Readopted Eff. December 5, 1977;
Amended Eff. October 1, 1982; April 1, 1982; October 1, 1981; September 11, 1980.

.0407 PROVIDERS PARTICIPATING IN THE CANCER PROGRAM

(a) To be eligible for participation in the cancer program, a hospital must have facilities to treat cancer with surgery, radiation, and radium. Hospitals with only two treatment modes but with an established referral system for the third mode are also eligible. Interim approval for participation may be granted by the head of the cancer program, with final approval pending review by the cancer committee of the North Carolina Medical Society. Services may also be provided in a physician's office or other outpatient facility.

(b) A patient may receive services in the hospital or physician's office of his choice provided that hospitals services are rendered in a hospital that has been approved in accordance with Paragraph (a) of this Rule. A list of such hospitals may be obtained from the head of the cancer program at the principal address of the Division of Adult Health.

(c) When a request for authorization is approved, a copy of the authorization will be returned to the provider of record (hospital or physician whose name appears on the request for authorization). The provider of record shall forward copies of the authorization to all other providers of those services listed in the request for authorization.

(d) The provider of record shall inform all other known providers of services listed in the request for authorization of any action taken by the cancer program or the office of purchase of care services including the authorization or denial of the request, issuance of case and authorization numbers, billing instructions, or any other communication from or action taken by the Division of Adult Health concerning cancer program reimbursement.

(e) All claims for authorized services rendered shall be processed in accordance with rules found in 15A NCAC 24A.

(f) Assistant surgeon's fees will be paid on those authorized cases in which the procedures cannot be performed without surgical assistance. The bill for the assistant surgeon's fee should be submitted jointly with the surgeon's bill.

(g) Claims for payment should be sent to the office of purchase of care services at the principal address of the Department.

History Note: Statutory Authority G.S. 130A-205;
Eff. February 1, 1976;
Readopted Eff. December 5, 1977;
Amended Eff. September 1, 1990; April 1, 1982; October 1, 1981; July 1, 1981.

.0408 PATIENT APPLICATION PROCESS

(a) Application forms approved by the Division may be requested by the provider from the cancer program at the principal address of the Division.

(b) The authorization and financial certification forms are to be completed in accordance with the rules found in 15A NCAC 24A and the directions printed on the forms.

(c) The authorization request form must be received with all pertinent information completed. All request forms that are received that are incorrect or incomplete will be returned unauthorized to the provider of record for correction or completion. All requests for authorization must contain the following information:

(1) Requests for diagnosis must contain all patient biographical information; where services are to be given and date of first service; preliminary primary diagnosis; services to be rendered; medical justification if inpatient services are being requested: and attending physician name, office address, telephone number and signature.

(2) Requests for treatment services must contain all patient biographical information; where services are to be given and date of first service; pathological diagnosis and stage of disease; five-year survival rate of disease and declaration that the disease has a reasonable chance of cure: services to be rendered: and attending physician name, office address, telephone number, and signature.

(d) Separate applications for authorization are necessary for diagnosis or treatment.

(e) In cases in which it is difficult to determine whether the services to be rendered are diagnostic or treatment, such as the removal of an entire tumor for biopsy, an application for diagnostic services should be submitted first.

(f) When treatment is being requested, a copy of a positive pathology report stating the cytologic or histologic presence of cancer, and dated no more than 30 days prior to initiation of the requested services, must accompany the request for authorization. The program has the right to request additional medical documents that are deemed necessary for a proper determination of medical eligibility prior to authorization. The patient signature on the financial eligibility form shall serve as a valid patient release for such medical information to be submitted to the program.

(g) The original completed forms, and copies of any medical documents, should be forwarded to the cancer program. In accordance with the rules found in 15A NCAC 24A, the cancer program will inform the provider of record whether the application is authorized. Providers are encouraged to retain copies of all materials sent to the cancer program pending authorization or denial.

(h) For emergency authorization, call (919) 733-7081. Emergency admissions are rarely approved and only for extreme causes. Interim approval can be granted over the telephone provided the patient meets all eligibility requirements. However, the written application must be reviewed before final authorization can be granted. Information required during a telephone request for emergency authorization will include, at least, the following information:

(1) patient biographical information,
(2) where services are to be provided,
(3) nature of emergency,
(4) services being requested,
(5) name and telephone number of caller,
(6) name and telephone number of admitting physician.

All telephone requests for emergency authorization shall be reviewed by and receive concurrence from the physician consultant to the cancer program after a telephone conference with the admitting physician. If a request for an emergency authorization is not approved, the cancer program will consider authorization on a routine basis. If the information that is communicated in the telephone request is not substantiated in the written authorization request, the emergency authorization shall immediately be cancelled.

(i) The cancer program is not responsible for any case which has not been requested and authorized, nor for any approved services that are not specifically requested and authorized.

(j) The program will not authorize services that are submitted on authorization forms that are not currently in use; all requests submitted on outdated or invalid forms will be returned unauthorized to the provider of record, accompanied by a supply of current forms for resubmission of the request and submission of future requests.

History Note: Statutory Authority G.S. 130A-205;
Eff. February 1, 1976;
Readopted Eff. December 5, 1977;
Amended Eff. September 1, 1990; October 1, 1982; October 1, 1981; April 15, 1979.

.0409 REPORTING OF CANCER

Every physician shall report cancers as required by G.S. 130A-209, in the manner prescribed by 15A NCAC 26.

History Note: Statutory Authority G.S. 130A-209;
Eff. February 1, 1976;
Readopted Eff. December 5, 1977;
Amended Eff. October 1, 1984; April 15, 1982.

.0410 CANCER REGISTRY

Rules governing the administration of the central cancer registry are found in 15A NCAC 26.

History Note: Statutory Authority G.S. 130A-205;
Eff. February 1, 1976;
Readopted Eff. December 5, 1977;
Amended Eff. January 1, 1982.

.0411 CONFIDENTIALITY

(a) The clinical records of individual patients submitted to the cancer control reimbursement program shall be confidential and shall not be public records open to inspection. Only personnel authorized by the head of the cancer control program and other individuals authorized by the head of the cancer control program or his designee pursuant to Paragraph (c) of this Rule shall have access to the records.

(b) The information contained in the clinical records of individual patients may be transferred to computer-compatible means of data entry. Only personnel authorized by the head of the cancer control program to use computers, terminals, programs, data files, and other computer hardware or software, involved in maintaining patient information shall have access to them.

(c) Clinical information in possession of the cancer control reimbursement program may be disclosed in the following circumstances when authorized by the head of the cancer control program or his designee:

(1) A patient shall have access to review or obtain copies of his records;

(2) A person who submits a valid authorization for release shall have access to review or obtain copies of the information described in the authorization for release;

(3) Information may be disclosed in response to a valid court order.

(d) The cancer control program may release statistical information and data based on client information so long as no information identifying individual patients is released.

(e) The head of the cancer control program shall make known to all individuals with access to patient information submitted to the cancer control program the privileged and confidential nature of such information.

History Note: Statutory Authority G.S. 130A-205;
Eff. October 1, 1981;
Amended Eff. January 1, 1982.

.0412 REIMBURSEMENT RATES

(a) The cancer control reimbursement program shall reimburse providers of authorized services to eligible patients as follows:

(1) Inpatient hospitalization services shall be reimbursed at the medicaid rate in effect at the time the claim is received by the Division. When the medicaid per diem rate changes to the "excess days" per diem rate as provided in the medicaid reimbursement plan in effect at the time the claim is received by the Division, the cancer program shall reimburse at the "excess days" rate.

(2) Professional services, outpatient services, and all other services not covered by Subparagraph (a)(1) of this Rule shall be reimbursed at the medicaid rate in effect at the time the claim is received by the Division.

(3) Services for which the medicaid program does not have a reimbursement rate shall be reimbursed according to a schedule of payments developed by the Division. Copies of this schedule may be inspected at or obtained from the Office of Medical Care Services.

(b) If a provider has accepted partial or total payment from the cancer program for particular services, the Division's reimbursement rate for those services shall be considered payment in full for those authorized services.

History Note: Statutory Authority G.S. 130A-205;
Eff. October 1, 1982;
Amended Eff. September 1, 1990.

CHAPTER 26 - INFORMATION SERVICES

SUBCHAPTER 26A - STATE CENTER FOR HEALTH STATISTICS

.0001 CHARGES

Upon request, the State Center for Health Statistics (SCHS) will undertake special computer runs for data not in a published form. The SCHS may charge the requestor for the cost of the computer run, including staff and support time.

History Note: Statutory Authority G.S. 12-3.1(c); 130A-5(3);
Eff. December 1, 1980;
Transferred and Recodified from 10 NCAC 5C .0007 Eff. April 4, 1990;
Amended Eff. August 1, 1991.

.0002 RELEASE OF MEDICAL RECORDS FOR RESEARCH PURPOSES

(a) A person may request the State Center for Health Statistics to release for bona fide research purposes medical records of individual patients which identify the individual described in the record. The request shall be in writing and shall contain the following information:

(1) name of organization requesting the data;
(2) names of principal investigators;
(3) name of project;
(4) purpose of project;
(5) if the project is being conducted for a governmental agency, the name of the agency and a contact person within the agency;
(6) description of proposed use of the data, including protocols for contacting patients, relatives, service providers, etc.;
(7) description of measures to protect the security of the data;
(8) an assurance that the data will not be used for purposes other than those described in the protocol;
(9) an assurance that the data will be properly disposed of upon completion of the project; and
(10) an assurance that the results of the project will be provided to the State Center for Health Statistics.

(b) The Director of the State Center for Health Statistics shall grant or deny the request for release of medical records within 15 days after receipt of the information described in Paragraph (a) of this Rule. The decision will be in writing and will be based upon the following:

(1) do the objectives of the project require patient identifying data;
(2) can the objective of the project be reached with the use of the data;
(3) does the objective of the project have a reasonable chance to answer a legitimate research question;
(4) will the project jeopardize the ability of the State Center for Health Statistics to collect data in the future;
(5) will the project place the patient in jeopardy; and
(6) is the patient's right to privacy adequately protected.

(c) If a request for release of medical records is denied, the applicant may appeal the decision in writing to:

State Health Director
P.O. Box 2091
Raleigh, North Carolina, 27602-2091.

Appeals shall be conducted in accordance with G.S. 130A-24(a) and 10 NCAC 1B .0200.

History Note: Statutory Authority G.S. 130A-374;
Eff. January 1, 1985;
Transferred and Recodified from 10 NCAC 5C .0008 Eff. April 4, 1990.

SUBCHAPTER 26B - CANCER REGISTRY

.0001 GENERAL

(a) The purpose of the central cancer registry is to receive and to compile, tabulate, and preserve statistical, clinical, and other reports and records relating to the incidence, treatment and cure of cancer, and to provide assistance and consultation for public health work. The statistical reports and records, and the assistance rendered to hospitals, health planning agencies and research facilities are intended to improve cancer treatment, extend the life of the cancer patient, identify high risk groups or areas of the state and attempt to lower the morbidity and mortality of cancer in North Carolina.

(b) The central cancer registry is administered by the Division of Statistics and Information Services, North Carolina Department of Environment, Health, and Natural Resources, P.O. Box 27687, Raleigh, North Carolina 27611-7687.

History Note: Statutory Authority G.S. 130A-205;
Eff. January 1, 1982;
Amended Eff. July 1, 1985;
Transferred and Recodified from 10 NCAC 8A .0801 Eff. April 4, 1990;
Amended Eff. December 1, 1990.

.0002 DEFINITIONS

The following definitions shall apply throughout this Section:

(1) "Abstract" refers to a document or documents containing information drawn from a cancer patient's medical record.

(2) "Death match" refers to the procedure of comparing registry cases with death certificate information, for confirmation of the reported death of any cancer patient, and to determine if the cancer constituted the cause of death.

(3) "Definitive treatment" refers to treatment anticipated for complete removal or destruction of a malignancy.

(4) "Follow-up" is a request sent to a physician for current information on a cancer patient whose abstract was submitted to the registry in the past.

(5) "Identifying information" is any portion of any abstract or incidence report that might reveal the personal identity of a cancer patient.

(6) "Incidence report" refers to a document or documents containing information reporting the diagnosis of a case of cancer to the registry by a physician.

(7) "Morphologic information" refers to pathology or cytology readings identifying cell types of malignant neoplasms.

(8) "Palliative treatment" refers to treatment that is not intended to effect a cure, but the treatment procedure is expected to improve "quality of life" by temporarily relieving distressing symptoms.

(9) "Participating hospital" is a medical facility which submits abstracts to the registry.

(10) "Pathology report" is the written report generated by a pathologist, stating the diagnostic interpretation of tissue samples or cellular material examined by the pathologist.

(11) "Personnel" means persons who are employees of the Department of Human Resources, or who are persons who provide services to the central cancer registry through a written contract.

(12) "Positive pathology report" is a pathology report confirming the presence of cancer.

(13) "Registrar" is an employee of a medical facility who prepares abstracts of medical records.

(14) "Registry" is the central cancer registry. The registry is administratively assigned to the Division of Statistics and Information Services, Department of Environment, Health, and Natural Resources.

(15) "Statistical report" refers to a report generated by the registry for informational or educational purposes. A statistical report does not contain identifying information.

(16) "Tumor registrar" is a registrar who abstracts information from the medical records of cancer patients.

History Note: Statutory Authority G.S. 130A-205;
Eff. January 1, 1982;
Amended Eff. October 1, 1983;
Transferred and Recodified from 10 NCAC 8A .0802 Eff. April 4, 1990;

Amended Eff. December 1, 1990.

.0003 CONFIDENTIALITY

(a) The clinical records of individual patients submitted to the registry shall be confidential and shall not be public records open to inspection. Only personnel authorized by the head of the cancer control program and other individuals authorized by the head of the cancer control program or his designee pursuant to Paragraph (c) of this Rule shall have access to the records.

(b) The information contained in the clinical records of individual patients submitted to the registry may be transferred to computer-compatible means of data entry. Only personnel authorized by the head of the cancer control program to use computers, terminals, programs, data files, and other computer hardware or software involved in maintaining patient information shall have access to them.

(c) Clinical information in possession of the registry may be disclosed in the following circumstances when authorized by the head of the cancer control program or his designee:

(1) A patient shall have access to review or obtain copies of his records;

(2) A person who submits a valid authorization for release shall have access to review or obtain copies of the information described in the authorization for release;

(3) Information may be disclosed in response to a valid court order;

(4) Information may be disclosed as provided in Rule .0806 of this Section;

(5) Information contained in death certificates on file with the division (but not actual copies of death certificates) may be released to a participating hospital when the hospital requests a death match for confirmation of the reported or suspected deaths of cancer patients treated at that hospital. Death match information released by the registry shall include only that information contained in the death certificates.

(d) The cancer control program may release statistical information and data based on client information so long as no information identifying individual patients is released.

(e) Photocopying or other reproduction of any clinical records or reports containing identifying information, except as may be required in the conduct of the official business of the registry, is prohibited.

(f) Any legible documents other than the original incidence reports and abstracts, such as computer printouts or photocopies of any documents containing identifying information, shall also be considered confidential material while in active use, and shall be destroyed immediately upon termination of their use by the registry.

(g) Original copies of reports and abstracts, and follow-up information received thereunto, shall be retained for 5 years by the registry.

(h) The head of the cancer control program shall make known to all individuals with access to patient information submitted to the cancer control program the privileged and confidential nature of such information.

History Note: Statutory Authority G.S. 130A-205;
Eff. January 1, 1982;
Amended Eff. October 1, 1982;
Transferred and Recodified from 10 NCAC 8A .0803 Eff. April 4, 1990;
Amended Eff. December 1, 1990.

.0004 REPORTING OF CANCER

(a) Any report of cancer required by G.S. 130A-209 to be reported to the registry shall contain at least the following information:

(1) name, address, zip code, and county of residence of the patient;

(2) date of birth, race and sex of the patient;

(3) pathologic diagnosis; and

(4) the name of the physician submitting the report.

(b) A physician may delegate the clerical tasks of incidence reporting of cancer to office or hospital staff, but the physician cannot delegate the legal responsibility for the incidence reporting of cancer to others.

(c) A report of cancer shall be submitted to the registry by either of the following methods:

(1) by submission of a positive pathology report containing the information required in Paragraph (a) of this Rule, to be retained for five years by the registry; or

(2) by submission of a hospital computer billing tape containing the information required in Paragraph (a) of this Rule. The tape shall be copied by the registry and returned to the hospital.

(d) Because in some circumstances it is difficult to obtain complete residence information required in Subparagraph (a)(1) of this Rule, the incidence report shall be conditionally acceptable for submission provided reasonable steps are taken to obtain the missing information. The physician submitting the report shall forward this information to the registry when it becomes available.

(e) The following documents shall not constitute an incidence report of cancer:

(1) an abstract submitted to the registry by a participating hospital;

(2) a death certificate;

(3) a request for authorization submitted to the Cancer program requesting third party reimbursement for treatment of cancer, although a positive pathology report is required by 10 NCAC 8A .0408(f).

(f) Reports shall be forwarded to the following address: Central Cancer Registry, Division of Statistics and Information Services, Department of Environment, Health, and Natural Resources, P.O. Box 27687, Raleigh, North Carolina 27611-7687.

History Note: Statutory Authority G.S. 130A-205;
Eff. January 1, 1982;
Amended Eff. October 1, 1984; October 1, 1982;
Transferred and Recodified from 10 NCAC 8A .0804 Eff. April 4, 1990;
Amended Eff. December 1, 1990.

.0005 HOSPITALS PARTICIPATING WITH THE CENTRAL CANCER REGISTRY

(a) Any hospital or other medical facility that is staffed and equipped for the diagnosis, treatment or follow-up care of cancer patients may participate with the registry in the exchange of information regarding the referral, treatment, maintenance or cure of cancer.

(b) The registry shall cooperate and consult with participating hospitals and medical facilities to the end that tumor registries in such facilities may provide the most accurate data available and may otherwise operate in the best interest of the cancer patients being treated therein. The registry will provide:

(1) Quality control reports to assure the computerized data utilized for statistical information and data compilation is correct;

(2) The most accurate and effective treatment, survival and comparative information available;

(3) Educational information available from registry, morbidity and mortality statistics upon request of a professional staff;

(4) Assistance to medical facilities by providing appropriate data and consultation to help the facilities meet the requirements for accreditation as a cancer treatment center, and to assist in the maintenance of such accreditation;

(5) Confirmation of the reported or presumed deaths (including such causes of deaths) of cancer patients to assist medical facilities to more accurately assess patient survival and to conduct more efficient long-term follow-up of cancer patients.

(c) A medical facility may provide to the registry abstracts on all cancer inpatient records and those cancer outpatient records the medical staff deems appropriate. The abstracts shall contain at least the following information:

(1) Name, address, zip code, and county of residence of the patient;

(2) Date of birth, race, and sex of the patient;

(3) Date of original diagnosis;

(4) Diagnoses, including primary site, extent of disease, basis of diagnosis and morphologic information;

(5) Date of hospital admission, or first date of treatment as applies to outpatient treatment;

(6) Date of hospital discharge or date of last contact with medical staff or date of death if death occurs during the abstracted inpatient stay;

(7) Selected pertinent treatment information, including:

(A) dates of treatment;

(B) definitive and palliative surgical procedures;

(C) radiation treatment, including total radiation dosage, dosage (rads) per treatment, and sites of body treated;

(D) chemotherapy or hormone treatments, including names of drugs administered, ideal dosage and schedule of treatment;

(E) if no treatment given, the abstract shall indicate why no treatment was administered.

(d) Abstracts shall be forwarded to the following address: Central Cancer Registry, N.C. Division of Statistics and Information Services, P.O. Box 27687, Raleigh, N.C. 27611-7687.

History Note: Statutory Authority G.S. 130A-205;
Eff. January 1, 1982;
Amended Eff. October 1, 1983; October 1, 1982;
Transferred and Recodified from 10 NCAC 5A .0805 Eff. April 4, 1990;
Amended Eff. December 1, 1990.

.0006 RELEASE OF CENTRAL CANCER REGISTRY DATA FOR RESEARCH

(a) The registry may release statistical data to any person or agency for the following purposes:
(1) medical research or education;
(2) epidemiological studies;
(3) health education;
(4) health planning or administration;
(5) required statistical reports; and
(6) other statistical reports by written request for research, information or education.

(b) A medical researcher may request the release of clinical records from the registry by the submission of a written research proposal to the registry containing the following information:
(1) purpose of the research;
(2) research design;
(3) proposed benefits to be derived from such research;
(4) a statement of compliance with all applicable state and federal requirements regarding the confidentiality of patient records; and
(5) if the research is to be credited toward a degree to the researcher, or if the research is being otherwise conducted by an institution of higher learning, the proposal shall contain a statement, signed by the dean of the school, or his designee, declaring that the proposed research is in compliance with all applicable research criteria of the institution.

(c) The clinical records or reports of the individual patients may be disclosed to research staff for the purpose of medical research, provided that the registry has determined that:
(1) disclosure of this information is deemed necessary to accomplish the purposes of the research;
(2) the research warrants the risk to individual patients of the potential disclosure of their medical records; and
(3) adequate safeguards to protect the clinical records or identifying information are established or maintained.

(d) The registry shall consult with the chairman of the committee on cancer of the North Carolina Medical Society in determining whether to release information as provided in Paragraphs (b) and(c) of this Rule. The registry shall forward the research proposal to the chairman for review. The chairman may forward the proposal to any or all members of the committee for comment.

(e) Any copies of reports or records provided to the researcher by the registry shall be destroyed upon termination of the research.

(f) Upon completion of the study, the researcher shall submit one copy of the completed research paper to the registry. The registry shall transmit the paper to the chairman of the cancer committee of the North Carolina Medical Society for review, to be returned to the registry for file. If the chairman deems the research to be of importance to the practicing physicians of the state, then the chairman may recommend with the concurrence of the researcher, the research agency or institution, that the abstract of the research paper be published in the "North Carolina Medical Journal."

History Note: Statutory Authority G.S. 130A-205; 130A-209 through 130A-212;
Eff. January 1, 1982;
Amended Eff. October 1, 1983;
Transferred and Recodified from 10 NCAC 5A .0806 Eff. April 4, 1990.

.0007 CODING OF INCIDENCE REPORTS AND ABSTRACTS

The registry shall code the information contained in incidence reports, and shall accept abstracts that have been coded according to the current revision of the International Classification of Diseases (clinical modification).

History Note: Statutory Authority G.S. 130A-205; 130A-209 through 130A-212;
Eff. January 1, 1982;
Transferred and Recodified from 10 NCAC 8A .0807 Eff. April 4, 1990.

.0008 ASSISTANCE AND CONSULTATION FOR PUBLIC HEALTH WORK

(a) The registry shall provide assistance and consultation for public health work.

(b) The registry shall accept requests for assistance and consultation for any agency, facility or organization actively engaged in the effort to reduce the incidence of cancer, whether through direct service to or the education of cancer patients and their families, the public, or the medical professions.

(c) The registry may accept requests from students requesting assistance with research projects in accordance with the provisions of .0806 of this Subchapter and the availability of staff time and resources.

History Note: Statutory Authority G.S. 130A-205; 130A-209 through 130A-212;
Eff. January 1, 1982;
Transferred and Recodified from 10 NCAC 8A .0808 Eff. April 4, 1990.

APPENDIX D

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1993

H **D**

91-RSZ-11
THIS IS A DRAFT 28-DEC-92 09:48:44

Short Title: Cancer Coordination and Control Act. (Public)

Sponsors:

Referred to:

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH THE CANCER COORDINATION AND CONTROL PROGRAM AND TO ESTABLISH THE ADVISORY COMMITTEE ON CANCER COORDINATION AND CONTROL TO THE SECRETARY OF THE DEPARTMENT OF ENVIRONMENT, HEALTH, AND NATURAL RESOURCES.

Whereas, 13,198 people died in 1990 from cancer in North Carolina and 24,131 new cases of cancer were reported to the Central Cancer Registry in 1990; and

Whereas, cancer is the second leading cause of death in North Carolina; and

Whereas, cancer affects people of all ages; and

Whereas, North Carolina's 1984 costs of foregone family wages, state income tax, and sales taxes surpassed six hundred and eighty-nine million dollars ($689,000,000) due to lives lost between ages 18 and 64; and

Whereas, the National Cancer Institute has estimated that the mortality rate from cancer can be reduced by 50% through prevention, early detection, and prompt, appropriate treatment and follow-up; and

Whereas, it is estimated that 900,000 North Carolinians have no health insurance on any given day; and

Whereas, the costs of late-stage cancer treatment and palliative care are great to the private and public sectors; and

Whereas, statewide comprehensive, coordinated, state-of-the-art cancer prevention and control can improve the health and quality of life of North Carolinians, reduce suffering, and provide economic and social return to the State; and

Whereas, the prevention and control of cancer require planned, coordinated, and systematically implemented public and professional education, screening, diagnosis, treatment, and follow-up that are available, accessible, and affordable to all North Carolinians; Now, therefore,

The General Assembly of North Carolina enacts:

Section 1. Article 1B of Chapter 130A of the General Statutes is amended by adding a new part to read:

"Part 4. Cancer Coordination and Control Act.

"§ 130A-33.50. Cancer Coordination and Control Program established; purpose.

(a) There is established the Cancer Coordination and Control Program of the Department of Environment, Health, and Natural Resources. The Program shall be phased in over a four-year period, beginning with fiscal year 1993-94. By the end of the four-year phase-in period, and to the extent that funds are made available, there will be a coordination of all State and local organizations providing cancer control services.

(b) The purpose of the Cancer Coordination and Control Program is to maximize the coverage of cancer control programs in the State and to minimize the overlap of funding and other resources for cancer control.

(c) The Secretary of the Department of Environment, Health, and Natural Resources shall be responsible for the development and implementation of the Cancer Coordination and Control Program. The Secretary, with the advice of the Advisory Committee on Cancer Coordination and Control, shall plan for the coordination of efforts to control cancer. The Secretary shall ensure the cooperation of the agencies within the Department and shall seek cooperation from other departments and agencies in State government. The Secretary shall also solicit ideas and cooperation from private organizations involved in cancer control efforts. The Secretary shall, with the advice of the Advisory Committee on Cancer Coordination and Control and where needed, report to

appropriate committees of the General Assembly with recommendations as to what statutory changes need to be made to ensure that the purpose expressed in subsection (b) is met.

"§ 130A-33.51. Advisory Committee on Cancer Coordination and Control; establishment, membership, compensation.

(a) The Advisory Committee on Cancer Coordination and Control is created in the Department of Environment, Health, and Natural Resources.

(b) The Committee shall have twenty-four members. Except for the Secretary of the Department of Environment, Health, and Natural Resources, the members shall be appointed for staggered four-year terms and until their successors are appointed and qualify. The Governor may remove any member of the Committee from office in accordance with the provisions of G.S. 143B-13. Members may succeed themselves for one term and may be appointed again after being off the Committee for one term. Six of the members shall be legislators appointed by the General Assembly, three of whom shall be recommended by the Speaker of the House of Representatives, and three of whom shall be recommended by the President Pro Tempore of the Senate. Two members who are cancer survivors shall be appointed by the General Assembly from the public at large, one of whom shall be recommended by the Speaker of the House of Representatives, and one of whom shall be recommended by the President Pro Tempore of the Senate. The remainder of the members shall be appointed by the Governor as follows:

(1) One member from the Department of Environment, Health, and Natural Resources;

(2) Three members, one from each of the following: the Department of Human Resources, the Department of Public Instruction, and the North Carolina System of Community Colleges;

(3) Four members representing the cancer control programs at North Carolina medical schools, one from each of the following: the University of North Carolina at Chapel Hill School of Medicine, the Bowman-Gray School of Medicine, the Duke University School of Medicine, and the East Carolina University School of Medicine;

(4) One member who is an oncology nurse representing the North Carolina Nurses' Association;

(5) One member representing the Cancer Committee of the North Carolina Medical Society;

(6) One member representing the Old North State Medical Society;

(7) One member representing the American Cancer Society, North Carolina Division, Inc.;

(8) One member representing the North Carolina Hospital Association;

(9) One member representing the North Carolina Association of Local Health Directors;

(10) One member who is a primary care physician licensed to practice medicine in North Carolina.

The Secretary of the Department of Environment, Health, and Natural Resources shall chair the Committee. The members of the Committee shall elect a vice-chair from among the Committee membership. The Committee shall meet at the call of the chair.

(c) The General Assembly and the Governor shall make their appointments to the Committee not later than thirty days after the adjournment of the 1993 Regular Session of the General Assembly. A vacancy on the Committee shall be filled by the original appointing authority, using the criteria set out in this section for the original appointment.

(d) To the extent that funds are made available, members of the Committee shall receive per diem and necessary travel and subsistence expenses in accordance with G.S. 138-5.

(e) A majority of the Committee shall constitute a quorum for the transaction of its business.

(f) The Committee may use funds allocated to it to employ an administrative staff person to assist the Committee in carrying out its duties. The Secretary of Environment, Health, and Natural Resources shall provide clerical and other support staff services needed by the Committee.

"§ 130A-33.52. Advisory Committee on Cancer Coordination and Control; responsibilities.

(a) The Advisory Committee on Cancer Coordination and Control has the following responsibilities:

(1) To recommend to the Secretary a plan for the statewide implementation of an inter-agency comprehensive coordinated cancer control program;

(2) To identify and examine the limitations and problems associated with existing laws, regulations, programs, and services related to cancer control;

(3) To examine the financing and access to cancer control services for North Carolina's citizens, and advise the Secretary on a coordinated and efficient use of resources;

(4) To identify and review health promotion and disease prevention strategies relating to the leading causes of cancer mortality and morbidity;

(5) To recommend standards for:

a. Oversight and development of cancer control services;

b. Development and maintenance of inter-agency training and technical assistance in the provision of cancer control services;

c. Program monitoring and data collection;

d. Statewide evaluation of locally-based cancer control programs;

e. Coordination of funding sources for cancer control programs; and

f. Procedures for awarding grants to local agencies providing cancer control services.

(b) The Committee shall submit a written report not later than May 1, 1994, and not later than October 1 of each subsequent year, to the Governor and to the Joint Legislative Commission on Governmental Operations. The report shall address the progress in implementation of a cancer control program. The report shall include an accounting of funds expended and anticipated funding needs for full implementation of the program.

"**§ 130A-33.53. Grants and loans to Department.**

The Department may accept grants and loans from the federal government and other sources for carrying out the purposes of this Part, and shall adopt reasonable policies governing the administration and distribution of funds to units of local government, other State agencies, and private agencies, institutions or individuals."

Sec. 2. Section 1 of this act becomes effective October 1, 1993, if and only if specific funds are appropriated for the implementation of the Committee established in Section 1 of this act. Funds appropriated for the 1993-94 fiscal year or for any fiscal year in the future do not constitute an entitlement to services beyond those provided for that fiscal year. Nothing in this act creates any rights except to the extent that funds are appropriated by the State to implement its provisions from year to year and nothing in this act obligates the General Assembly to appropriate funds to implement its provisions.

ANALYSIS OF LEGISLATIVE PROPOSAL

Section 1 establishes the Cancer Coordination and Control Program in the Department of Environment, Health, and Natural Resources. The purpose of the program is to maximize the coverage of cancer control programs in the State and to minimize the overlap of funding and other resources for cancer control. The Advisory Committee on Cancer Coordination and Control is also established; it has twenty-four members, including the Secretary of the Department of Environment, Health, and Natural Resources. Its responsibilities include, among others, recommending to the Secretary a plan for implementing an inter-agency comprehensive coordinated cancer control program. It will report to the Governor and to the Joint Legislative Commission on Governmental Operations. The Department may accept grants and loans to carry out the purposes of this act.

Section 2 provides that the act will become effective October 1, 1993, only if funds are appropriated for the Advisory Committee.

APPENDIX E

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1993

D

92d-RJZ-001
THIS IS A DRAFT 28-DEC-92 09:48:17

Short Title: Funds/Cancer Cont. Advis. Comm. (Public)

Sponsors:

Referred to:

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS FOR THE ADVISORY COMMITTEE ON CANCER COORDINATION AND CONTROL TO THE SECRETARY OF THE DEPARTMENT OF ENVIRONMENT, HEALTH, AND NATURAL RESOURCES.

The General Assembly of North Carolina enacts:

Section 1. There is appropriated from the General Fund to the Department of Environment, Health, and Natural Resources the sum of one hundred thousand dollars ($100,000) for the 1993-94 fiscal year, and the sum of one hundred thousand dollars ($100,000) for the 1994-95 fiscal year, to establish the Advisory Committee on Cancer Coordination and Control to the Secretary of the Department, as provided by the Cancer Coordination and Control Act, G.S. 130A-33.50 et seq..

Sec. 2. This act becomes effective July 1, 1993.

ANALYSIS OF LEGISLATIVE PROPOSAL

Section 1 appropriates $100.000 from the General Fund to the Advisory Committee on Cancer Coordination and Control for 1993-94.

Section 2 provides that the act will become effective July 1, 1993.

APPENDIX F

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1993

H **D**

House Bill 91-RSZ-12.5
THIS IS A DRAFT 31-DEC-92 09:45:40

Short Title: Need-Based Cytotech. Schol. (Public)

Sponsors:

Referred to:

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH AND APPROPRIATE FUNDS FOR NEED-BASED CYTOTECHNOLOGY SCHOLARSHIPS. AND TO DIRECT THE OFFICE OF STATE PERSONNEL TO REVIEW STATE CYTOTECHNOLOGIST SALARIES.

The General Assembly of North Carolina enacts:

Section 1. Article 7 of Chapter 130A of the General Statutes is amended by adding a new Part to read:

"Part 1A. Need-Based Cytotechnology Scholarships.

"§ 130A-216. Need-based cytotechnology scholarships fund.

(a) The following definition applies in this Part:

(1) Cytotechnology. The scientific study of cells, their origin, structure, and functions.

(b) There is created a need-based scholarship loan fund for cytotechnology students. Need-based scholarship loans shall be available for study in cytotechnology programs offered by community colleges and the University of North Carolina, and by private colleges which offer cytotechnology programs. Part-time students and nontraditional students who have post-secondary

degrees are eligible to receive need-based cytotechnology scholarship loans.

(c) Need-based cytotechnology scholarship loan funds shall be administered by the State Board of Community Colleges, the Board of Governors of the University of North Carolina, and the State Education Assistance Authority. The State Board of Community Colleges and the Board of Governors of the University of North Carolina shall allocate the scholarship loan funds among their respective constituent institutions that have programs of education leading to a certificate in cytotechnology. Distribution shall be in a manner determined by the appropriate governing body. The State Education Assistance Authority shall distribute scholarship loan funds to private nonprofit colleges that offer cytotechnology programs. Distribution shall be in a manner determined by the Board of the State Education Assistance Authority after consultation with the North Carolina Association of Independent Colleges and Universities.

(d) The State Education Assistance Authority shall carry out the following functions in implementing the need-based cytotechnology scholarship loan program:

(1) Promulgate the rules and regulations necessary to implement the scholarship program;

(2) Disburse, collect, and monitor scholarship loan funds;

(3) Establish the terms and conditions of promissory notes executed by loan recipients;

(4) Approve service repayment agreements;

(5) Collect cash repayments required when service repayment is not completed; and

(6) Adopt rules to allow for the forgiveness of scholarship loans if it determines that it is impossible for the recipient to practice cytotechnology in North Carolina for a sufficient time to repay the loan because of the death or permanent disability of the recipient within ten years following graduation or termination of enrollment in a cytotechnology education program.

(e) Each institution to which scholarship loan funds are allocated shall publicize the availability of, shall disseminate, receive and review applications for, and shall select the recipients of scholarship loans. Scholarship loans shall be made only to prospective and enrolled cytotechnology students under the terms and conditions established for the need-based cytotechnology scholarship loan program by the State Education Assistance Authority."

Sec. 2. There is appropriated from the General Fund to the Board of Governors of the University of North Carolina the sum of twenty-four

thousand dollars ($24,000) for the 1993-94 fiscal year, and the sum of twenty-four thousand dollars ($24,000) for the 1994-95 fiscal year, to be used for funding need-based scholarship loans for cytotechnology students. Of the funds appropriated to the Board of Governors, twelve thousand dollars ($12,000) shall be allocated for each fiscal year to the State Education Assistance Authority for allocation to private colleges in North Carolina that have cytotechnology programs.

Sec. 3. There is appropriated from the General Fund to the State Board of Community Colleges the sum of six thousand dollars ($6,000) for the 1993-94 fiscal year, and the sum of six thousand dollars ($6,000) for the 1994-95 fiscal year, to be used for funding need-based scholarship loans for cytotechnology students.

Sec. 4. There is appropriated from the General Fund to the Board of Governors of The University of North Carolina the sum of five thousand dollars ($5,000) for the 1993-94 fiscal year, and the sum of five thousand dollars ($5,000) for the 1994-95 fiscal year, to be used to enable the State Education Assistance Authority to provide staff and administrative support in carrying out the provisions of this Article.

Sec. 5. The Office of State Personnel shall review State cytotechnologist pay scales and report its findings to the Joint Legislative Commission on Governmental Operations and, to the Secretary of the Department of Environment, Health, and Natural Resources by November 1, 1993.

Sec. 6. This act is effective upon ratification.

ANALYSIS OF LEGISLATIVE PROPOSAL

Section 1 creates a need-based scholarship loan fund for cytotechnology students, to be administered by the State Board of Community Colleges, the Board of Governors of the University of North Carolina, and the State Education Assistance Authority.

Section 2 appropriates $24,000 from the General Fund to the Board of Governors for 1993-94 and 1994-95, for funding need-based scholarship loans. Of that amount, $12,000 each year goes to the State Education Assistance Authority for allocation to private colleges in North Carolina with cytotechnology programs.

Section 3 appropriates $6,000 from the General Fund to the State Board of Community Colleges for 1993-94 and 1994-95, for funding need-based scholarship loans.

Section 4 appropriates $5,000 from the General Fund to the Board of Governors for 1993-94 and 1994-95, for the State Education Assistance Authority to provide staff and administrative support to carry out this act.

Section 5 requires the Office of State Personnel to review State cytotechnologist pay scales and report by November 1, 1993, to the Joint Legislative Committee on Governmental Operations and to the Secretary of the Department of Environment, Health, and Natural Resources.

Section 6 provides that the act will become effective upon ratification.

APPENDIX G

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1993

D

92d-RJZ-002
THIS IS A DRAFT 30-DEC-92 16:15:09

Short Title: Cancer Cont. Funds/92-93. (Public)

Sponsors:

Referred to:

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE THE DIRECTOR OF THE BUDGET TO ALLOCATE ADDITIONAL FUNDS FOR THE REMAINDER OF THE 1992-93 FISCAL YEAR.

The General Assembly of North Carolina enacts:

Section 1. Notwithstanding the provisions of G.S. 143-23, the Director of the Budget may authorize the Department of Environment, Health, and Natural Resources to use up to one hundred thousand dollars ($100,000) of funds available to the department for the 1992-93 fiscal year for the State Cancer Control Program to ensure that the diagnosis and treatment component of the State Cancer Control Program is adequately funded for the remainder of the 1992-93 fiscal year.

Sec. 2. This act is effective on and after January 1, 1993.

ANALYSIS OF LEGISLATIVE PROPOSAL

Section 1 allows the Director of the Budget to authorize the Department of Environment, Health, and Natural Resources to allocate up to $100,000 from available funds to adequately fund the Cancer Control Program for the remainder of the 1992-93 fiscal year.

Section 2 provides that the act is effective on and after January 1, 1993.

APPENDIX H

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1993

D

92d-RJZ-003
THIS IS A DRAFT 30-DEC-92 13:04:13

Short Title: Cancer Cont. Funds/93-95. (Public)

Sponsors:

Referred to:

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE ADDITIONAL FUNDS FOR THE CANCER CONTROL PROGRAM IN THE DEPARTMENT OF ENVIRONMENT, HEALTH, AND NATURAL RESOURCES.

The General Assembly of North Carolina enacts:

Section 1. There is appropriated from the General Fund to the Department of Environment, Health, and Natural Resources the sum of one hundred thousand dollars ($100,000) for the 1993-94 fiscal year, and the sum of one hundred thousand dollars ($100,000) for the 1994-95 fiscal year, to expand the diagnosis and treatment component of the State Cancer Control Program.

Sec. 2. This act becomes effective July 1, 1993.

ANALYSIS OF LEGISLATIVE PROPOSAL

Section 1 appropriates an additional $100.000 from the General Fund to the Department of Environment. Health. and Natural Resources for the State Cancer Control Program to expand the diagnosis and treatment component of the program for the 1993-94 fiscal year and the 1994-95 fiscal year.

Section 2 provides that the act will become effective July 1. 1993.

APPENDIX I

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1993

D

92d-RJZ-004
THIS IS A DRAFT 30-DEC-92 16:20:49

Short Title: Cancer Cont. Funds/Increase Elig. (Public)

Sponsors:

Referred to:

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS FOR THE CANCER CONTROL PROGRAM IN THE DEPARTMENT OF ENVIRONMENT, HEALTH, AND NATURAL RESOURCES TO COVER 100% OF THE FEDERAL POVERTY LEVEL.

The General Assembly of North Carolina enacts:

Section 1. There is appropriated from the General Fund to the Department of Environment, Health, and Natural Resources the sum of one million six hundred sixty-four thousand dollars ($1,664,000) for the 1993-94 fiscal year, and the sum of one million six hundred sixty-four thousand dollars ($1,664,000) for the 1994-95 fiscal year, to expand the diagnosis and treatment component of the State Cancer Control Program to provide coverage for persons at or below 100% of the Federal Poverty Level for Financial Eligibility.

Sec. 2. This act becomes effective July 1, 1993.

ANALYSIS OF LEGISLATIVE PROPOSAL

Section 1 appropriates $1,664,000 from the General Fund to the Department of Environment, Health, and Natural Resources for the State Cancer Control Program for the 1993-94 fiscal year and the 1994-95 fiscal year to cover persons at or below 100% of the federal poverty level.

Section 2 provides that the act will become effective July 1, 1993.