LEGISLATIVE

RESEARCH COMMISSION

PUBLIC HEALTH SYSTEM ISSUES

REPORT TO THE
1993 GENERAL ASSEMBLY
OF NORTH CAROLINA

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January 27, 1993

TO THE MEMBERS OF THE 1993 GENERAL ASSEMBLY:

The Legislative Research Commission herewith submits to you for your consideration its final report on public health issues. The report was prepared by the Legislative Research Commission's Committee on Public Health Systems Issues pursuant to Section 2.1(11) and 2.1(63) of Chapter 754 of the 1991 Session Laws.

Respectfully submitted,

Daniel T. Blue, Jr.
Speaker of the House

Henson P. Barnes
President Pro Tempore

Cochairmen
Legislative Research Commission

1991-1992

LEGISLATIVE RESEARCH COMMISSION

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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 Legislative Research Commission combined the public health delivery system issues authorized by Sections 2.1(11) and the licensure of radiologic technologists authorized by 2.1(63), respectively, of Chapter 754 of the 1991 Session Laws (1991 Regular Session) into a public health issues study. Chapter 754 states that the Commission may consider Senate Bills 367, 407 and 738 and House Bill 467 in determining the nature, scope and aspects of the study. See Appendix A of this report. The Legislative Research Commission grouped this study in its Health and Human Resources area under the direction of Senator Russell Walker. The Committee was

chaired by Senator Roy Cooper and Representative Howard Barnhill. The full membership of the Committee is listed in Appendix B of this report. A Committee notebook containing the Committee minutes and all information presented to the Committee is filed in the Legislative Library.

HISTORY OF PUBLIC HEALTH IN NORTH CAROLINA

From the Outer Banks to the Great Smokies, North Carolina is a land of contrast; these contrasts are manifest in all aspects of the State's life including its health problems. The State, because of its rural nature, has some of the country's most difficult dilemmas and some of the most exciting solutions. In order to understand the progress made in public health, an understanding of history may be necessary.

The first substantial piece of health legislation was a quarantine law enacted in 1712 by the General Assembly of the Province of Carolina which included the states of North and South Carolina, Alabama, Tennessee, Kentucky, Georgia, Florida and ten other states. From this rather small beginning, the State has made tremendous strides in providing health services to its citizens.

In 1877, following severe yellow fever and smallpox epidemics, the State Board of Health was established. It had an annual appropriation of $100 and all of North Carolina's 150 doctors were members of the Board. In 1879, the annual appropriations were increased to $200 per year and a governing board of nine members with terms of six years was created. Provisions were also made for health boards in the 94 counties, and for the first time in North Carolina failure to comply with health regulations was a misdemeanor subject to fine ($25.00) or imprisonment. At this time the State Board examined water, gave some vaccinations, quarantined people with communicable diseases, gathered and registered vital statistics and distributed educational materials.

In 1885, annual appropriations jumped to $2,000 and by 1892 the Board had been authorized to inspect water and sewage facilities and inspect public institutions. The Board now had sections on epidemics, hygienics in public schools, climatology, adulteration of food and medicine, and sanitary conditions of State institutions.

In 1899, an epidemic of smallpox occurred in Wilson County and 1500-2000 people were striken. This led to the 1905 law by Hyde County which ordered vaccinations in schools in their county and led Washington County to order compulsory

vaccination and stipulated that if both pupils and teachers were not vaccinated, the schools would be closed. Several years later the State ordered smallpox vaccinations to become mandatory. In 1909, a full-time state health office was created and the total appropriations had increased to $10,500. By 1949 all counties in North Carolina had a local health department.

From its rather shaky start in the Colony of Carolina, this State has made tremendous strides in improving the health of the people of North Carolina. There has been the decline and practical elimination of malaria, polio, typhoid fever, endemic typhus, diphtheria, pellagra and whooping cough. There has been a marked decrease in tuberculosis, and in maternal and infant death rates.

Over the years there have been a number of administrative changes in public health in North Carolina. As a continual response to change, the 1973 General Assembly, directed the long and difficult process of consolidating most of the State's health functions into the Department of Human Resources. This department was placed under the direction of a Secretary who reported to the Governor. In 1989 the public health functions were removed from the Department of Human Resources and placed within a new Department of Environment, Health, and Natural Resources.

The delivery of public health services in North Carolina has become a complex process with the major emphasis placed on local health departments to deliver patient and community services. The public health system in North Carolina reflects the strong local government philosophy in North Carolina. The State and regional staff serve as a catalyst to the local departments to develop new programs and improve existing programs. The State establishes and verifies compliance with standards of care, acts as an administrator for federal and State funds, and provides technical support to the local health department. The relationship between State and local health departments is

predominantly a cooperative effort. In many instances, the local health department staff will act as agents of the State to carry out State requirements.

There are approximately 7,000 people providing delivery of public health services in this State with approximately 1,000 of them in State and regional offices and 6,000 in district and local health department settings.

Public health services are provided locally by counties, either through a county health department, in combination with other counties through a district health department, or through contract with the State. Staffing and budgeting of local health departments are ultimately under the control of the county commissioners. The county and district boards of health are appointed by the county commissioners and all of their recommendations are subject to budgetary control by the commissioners.

There are over 90 different health programs provided to the citizens of North Carolina, however, not all of these services are provided in every county. The programs most familiar to the public are:

1. Maternal and child care which includes maternity clinics, child health clinics, developmental disabilities clinics, WIC, and family planning;
2. Environmental health programs which include public water supply regulation, sanitation including inspection of food, lodging and on-site sewage disposal, and pest management;
3. Epidemiology which includes vital records, injury prevention and control, occupational health, communicable disease control including tuberculosis, AIDS and other sexually transmitted diseases, occupational health, and environmental epidemiology;
4. Dental health including preventive dental services, dental screening, and dental care of the elderly;

5. Adult health services which include health promotion and disease prevention, migrant health programs, home health care services, and cancer, diabetes and hypertension screening and control;
6. Chief medical examiner's office which includes investigation of deaths by injury, obscure causes and violence, and forensic toxicology services; and
7. Public health laboratories which include diagnostic and confirmatory laboratory testing.

North Carolina's health services have come tremendously far from the simple Moravian hospital in the Revolutionary War to the sophisticated facilities we enjoy today. The people have demanded services, and its leaders have responded. North Carolina has been among the leaders in public health in this country and the world and was one of the first states to establish a state and local health departments. In 1940 North Carolina founded the first state-supported school of public health. In the late 40's there arose the "Good Health Movement" during which time Kay Kaiser wrote the song Better Health for North Carolina which led to better training facilities. Also during this time Duke University developed the first hospital administration program in the country. The 70's saw the development of rural health clinics and physician's assistants and the extensive system of Area Health Education Centers.

Many of the major improvements in the health of North Carolinians have been accomplished through public health measures. Control of epidemic diseases, safe water and food, and maternal and child health services are only a few of public health's achievements. Public health is the unsung hero of the 19th and 20th centuries and suffers from its own great success. The public has come to take the success of public health for granted.

This situation is not only true for North Carolina but applies to the nation as a whole. The Institute of Medicine as part of the National Academy of Sciences advises

the U.S. Congress on health policy matters. In 1985 the IOM established a committee to look at the current state of public health in America and to outline recommendations for future directions. In an extensive two-year study, the committee reviewed the public health system in detail. The committee found that despite valiant efforts of many people and programs, the public health system is currently in disarray.

Public health personnel in North Carolina are concerned about the sense of malaise that hangs over public health in North Carolina. This malaise prevents attention to the need to maintain current preventive efforts and to sustain the capacity to meet future threats to the public's health. There is an even greater need now than at any other time in our history to mount an organized and sustained effort by the public sector to protect the nation's and the State's health. This study was created out of the desire of public health officials to bring the difficulties of public health to the attention of the State in order to mobilize action to strengthen public health.

COMMITTEE PROCEEDINGS

A. PROCEEDINGS OF THE FULL COMMITTEE

Recent data on the health of North Carolina's citizens suggest that the State public health system is not operating at maximum efficiency or effectiveness. Demands on financial resources to support State and local public health services have increased dramatically and are likely to increase further in the foreseeable future. The public health problems now facing the public are complex and diverse and, at the same time, these problems are not fully understood. In recognition of these issues, the 1989 General Assembly established an independent commission to investigate and report to the 1991 General Assembly. This report to the 1991 General Assembly requested that the work continue past the first biennium's work. Therefore, the 1991 General Assembly through Chapter 754 of the 1991 Session Laws authorized the continued study of public health issues by authorizing under the Legislative Research Commission the Committee on Public Health Systems Issues. The charge to the Committee was twofold: the first part required the study of the effectiveness and efficiency of the public health system's delivery of health services to the citizens of North Carolina; the second part required the study of licensure for radiation technologists. The Committee met six times as a full Committee on the following dates: January 16, 1992, February 27, 1992, March 23, 1992, April 22, 1992, August 4, 1992 and December 16, 1992. Two subcommittees were appointed by the cochairs, one to study the licensure of radiation technologists, and the other to draft a bill to establish by statute a permanent public health study commission.

The first three meetings were dedicated to organizational functions and Committee education regarding:

1. An orientation to public health which included its definition and history; and
2. State and local public health structure and financing issues.

As part of this background, Dr. Hugh Tilson, former State Health Director, presented the findings and recommendations contained in the Report on the Future of Public Health issued by the Institute of Medicine in 1988. This Report helped the Committee to understand the broader scope of the current dilemmas facing public health in America and North Carolina. Dr. Tilson's summary declared:

> "In North Carolina, we have a long and distinguished legacy of public health leadership. A strong county-based system provides an excellent building block for the embodiment of the public health services delivery system envisioned in the IOM report. A reunited state agency for health and environment similarly provides an excellent organizational platform upon which to build for our state's future. But, many of the challenges laid out in the Institute of Medicine report speak directly to us as well. To the extent that we have over-emphasized direct services (the assurance function) at the expense of the surveillance and assessment functions, we need now to build a statewide program to ensure full public accountability to help communities to hold themselves accountable. And can't the state support this delivery system better, and better assure adequately trained leadership? Insofar as we have rested on the comfortable laurels of doing what we have always done, we have yet to articulate the policies with which we can effect change. And, while many well-meaning and hard-working people have worked for many years to attempt to achieve equity of access to necessary services, the gaps in our service system and the shortfalls in the health objectives which it should serve are a painful evidence of the task ahead."

The Committee dedicated a number of meetings to help members understand the State and local public health structure. History and tradition in our State have determined that the role of the State public health agency is primarily to assist locally

autonomous local health departments to do the very best job they are capable of in serving their constituency. The State provides financial assistance, derived from State appropriations and federal grants, technical assistance and consultation on program design, implementation and evaluation, recruitment and orientation of local staff, supplies and equipment, including medications and vaccines. It serves as the fiscal intermediary for some third party payors on behalf of the local departments, returning their earned receipts to them to be used to enhance services. The State provides them extensive laboratory service at no cost; everything from Pap smears to virus cultures and mosquito identification. In a number of the environmental regulatory activities, such as restaurant sanitation, the local officials perform as agents of the State, placing the State public health agency in a supervisory relationship to some extent, even though these local officials are county employees.

In addition to the activities carried out in support of local government, the State public health agency engages in a number of direct services to the public in North Carolina. It operates the Medical Examiner System, which investigates all unexpected or unusual deaths and supports our law enforcement community; it maintains the safety of the public water supplies across the State whether they provide drinking water to a large municipality or a trailer park; it has an extensive dental public health program available across the State, primarily in behalf of our children; and it operates a regional network of clinics for the diagnosis and management of children with all types of developmental disabilities. It collects and maintains the vital records of the State, births, deaths, marriages and divorces, and functions as the State center for health statistics.

The authorized budget for these and all other activities of the State public health operation, housed since 1991 in the Department of Environment, Health, and Natural Resources, appears in Appendix C. The heading "Other Funds", where sources of the

1992 budget are listed, refers to such items as Medicaid receipts, revenues from fees and fines, foundation grants and refunds of payments to various health providers. Appendix D shows in the form of a pie-chart the sources of funds budgeted by local health departments in order to provide direct services to eligible clients at the community level.

The relationship between State and local public health can best be described as a partnership. Local Boards of Health choose their own health directors, with or without consultation from the State Health Director and without his approval. The State has no authority to compel counties with very small populations and inadequate tax bases to join with their neighbors to form a multi-county district health department, an action some counties have taken voluntarily, enabling them to have outstanding services in spite of being small and rural, while many struggle along alone with substandard pay plans, many vacancies in key positions, unprepared health directors, high staff turnover rates, and citizens deprived of services they deserve and need.

Local health departments are the critical components of the public health system that directly delivers public health services to citizens. Therefore the Committee, parallel with testimony about the State health function, devoted time and requested testimony concerning local health department issues, structure, and financing. Representatives from three counties spoke to the Committee and described their county's location, population, urban and rural areas, rate of unemployment, industry, and health care. The three counties used to illustrate the diversity of public health in this State were Catawba, Beaufort, and Wake Counties. The wealth of information about these Counties is on file with the Committee.

So that the Committee could actually see and experience how public health is delivered and with what range of physical facilities, the Committee on February 27, 1992 visited the Franklin County Health Department and the Wake County Health

Department. This provided an opportunity to visit one of the smaller public health departments and one of the more elaborate and attractive health department facilities in the country.

As a follow-up to the description of the three health departments and the site visits, the State Health Director and his staff were requested to select a representative sample of local health departments to help the Committee refine its understanding of the issues related to the operation and financing of local health departments. The State Health Director, Dr. Levine, presented a profile of ten local health departments, two small rural, three medium, two large rural, one urban and two district. For each of the ten counties selected, the Committee was provided pertinent statistical and profile information and public health services with sources of funding. (See Appendix E).

In its report to the 1991 General Assembly, the Public Health Study Commission stated that the effective delivery of public health services depends in large part upon a system-wide assessment of health status and health needs, and the efficient use of State, local and federal financial resources to address these needs. To effectuate this policy, House Bill 183 was introduced and passed by the 1991 General Assembly. It directed the Department of Environment, Health, and Natural Resources to conduct various public health related projects to help accomplish these ends. The bill directed the Department to:

1. Implement a plan to increase its capability and the capacity of local health departments to secure private sector financial resources to supplement public health activities and services mandated by the State;
2. Establish a statewide system for assessing health status and health needs in every county;

3. Develop a computerized statewide data collection and retrieval system to permit valid comparisons of State and local health data with those of the nation and other states and localities; and

4. Require the Commission for Health Services to adopt statewide health outcome objectives and delivery standards and the Department to implement these standards.

The bill also required the Department to report back to the successor committee on the progress on the four recommendations. The Department made its report on April 22, 1992. This report is attached as Appendix F.

There are other groups besides the Committees that are working and discussing these issues. A group of public health organizations was formed about a year ago to formulate proposals related to joint responsibilities and financing for North Carolina's public health system. The group was composed of the following:

Association of North Carolina Boards of Health

Department of Environment, Health and Natural Resources

N.C. Association of Environmental Health Supervisors

N.C. Association of Local Health Directors

N.C. Association of Public Health Nurse Administrators

N.C. Public Health Association

School of Public Health, University of North Carolina-Chapel Hill.

A representative of this consortium made a presentation to the Committee on August 4, 1992. The presentation is attached as Appendix G.

B. PROCEEDINGS OF THE SUBCOMMITTEE ON THE ESTABLISHMENT OF A PERMANENT PUBLIC HEALTH STUDY COMMISSION.

Because of the complexity of issues facing the public health system and the time required to address each of these issues adequately, the Committee decided that the

best way to fully study and address the issues was through the establishment of a permanent public health study commission. The cochairmen appointed a subcommittee to draft proposed legislation for this purpose. The membership of the subcommittee may be found in Appendix H of this report. The subcommittee met two times, first on November 12 to review similar legislation proposed by the 1989 Public Health Study Commission and to develop a new proposal, and again on December 4 to receive input from interested persons on the proposed new draft. Representatives from the Executive branch and from private health-related professional associations gave comment on the draft proposal. Most of the discussion centered around the membership of the permanent Commission in order to ensure both public health expertise and legislative committment to system improvement. At the December 4 meeting the subcommittee approved a draft proposal for presentation to the full Committee at its meeting on December 17, 1992.

C. PROCEEDINGS OF THE SUBCOMMITTEE ON LICENSURE OF RADIATION TECHNOLOGISTS

The second issue assigned to the Committee by the Legislative Research Commission pertained to the licensure of radiation technologists. Senate Bill 738 was introduced in the 1991 Session of the General Assembly and proposed to establish the Radiation Technology Practice Act which required licensure of radiation technologists and established a Board to oversee the licensure. As required by Article 18A of Chapter 120 of the General Statutes, a legislative proposal establishing a new licensing board must be assessed by the Legislative Committee on New Licensing Boards before the proposal may be considered by the General Assembly. Senate Bill 738 was, therefore, submitted to the Legislative Committee on New Licensing Boards. That Committee was unable to determine whether radiologic technologists should be licensed and requested that an interim study of the proposal be made and recommendations

reported back to the 1992 Session. (See Legislative Committee on New Licensing Boards' Final Assessment Report on licensure of radiologic technologists, June 18, 1991.) This interim study was assigned to the Public Health Systems Issues Committee. To execute this charge the Cochairs of the Public Health Systems Committee appointed a subcommittee composed of five members from the full Committee. Membership of the subcommittee is listed in Appendix I.

The subcommittee met two times before the convening of the 1992 short session, first on April 9, 1992 and next on April 14, 1992. The subcommittee presented its findings to the full Committee at its meeting on April 22, 1992. The subcommittee reported that evidence from previous years' testimony on this subject supported the enactment of legislation requiring licensure of radiation technologists. The subcommittee made two recommendations to the full Committee: (1) that Senate Bill 738 be ratified, and also that several amendments be made to that bill to ensure that it met its purpose and State policy, and (2) that if Senate Bill 738 was not acted upon by the 1991 General Assembly (Regular Session, 1992) then the Public Health Systems Issues Committee continue its study and make further recommendations regarding the licensure of radiation technologists so that such recommendations may be included in the Committee's final report to the Legislative Research Commission. At its April 22, 1992 meeting the full Committee adopted the subcommittee's recommendations. For the full text of the subcommittee's recommendations, see "Legislative Research Commission Public Health Systems Issues Report to the 1991 General Assembly of North Carolina, 1992 Session." The Legislative Research Commission received the Committee's report, and appended to that report a letter from the North Carolina Dental Society stating its opposition to the subcommittee's report.

Senate Bill 738 was not acted upon by the 1991 General Assembly, Regular Session 1992. Thus, the Cochairmen of the Public Health Systems Issues Committee

directed the subcommittee on licensure of radiation technologists to continue its study of this issue and report its findings and recommendations to the full Committee.

The subcommittee met three times after adjournment of the 1991 Session (Regular Session, 1992): August 19, 1992, September 23, 1992, and October 20, 1992. Since the subcommittee had already concluded that legislation was needed providing for licensure or certification of radiation technologists, the work that remained was how to fine-tune the legislative proposal to address the subcommittee's concerns and, if possible, to accommodate the concerns of professional groups affected by the legislation. At the September meeting the subcommittee heard from persons interested in having input into the development of such legislation. Persons who addressed the subcommittee in August and September included proponents of the legislation (the North Carolina Society of Radiation Technologists, persons employed as radiation technologists), and opponents of Senate Bill 738 and amendments recommended by the subcommittee (representatives of Dentists, Chiropractors, Physicians, the Medical Society, and written comments from the Hospital Association). After lengthy discussion, the subcommittee directed staff to draft legislation. The primary difference in the legislation proposed by the subcommittee and that of Senate Bill 738 was in the section pertaining to exemptions from licensure. In addition to the exemptions granted in Senate Bill 738, the subcommittee draft provided an exemption for personnel in a physician's private office who perform specified radiographic examinations. Senate Bill 738 did not exempt such personnel. The subcommittee engaged in much debate over the issue of exemptions in general, as well as this particular exemption. The subcommittee concluded that certain exemptions are justified so long as the persons exempt are required by other professional standards and oversight to demonstrate proficiency in the operation of radiographic equipment. (e.g. the Board of Dental Examiners regulates the standards for qualifications and training of a dental technician

who takes x-ray exams in a dentist's office.) At its October 20 meeting the subcommittee reviewed and approved its draft proposal for mandatory certification of radiation technologists.

FINDINGS AND RECOMMENDATIONS

RECOMMENDATION ONE

The General Assembly should enact legislation establishing a permanent, indepenent Public Health Study Commission for the purpose of studying the public health system and advising the General Assembly on changes needed to ensure efficient and effective long range operation of the system. The General Assembly should appropriate sufficient funds for this Commission to hire professional and clerical staff to assist the Commission in accomplishing its purpose. Legislation proposed by the Committee may be found in Appendix J.

FINDINGS AND CONCLUSIONS

The 1989 General Assembly established The Public Health Study Commission to "examine the need for improvement in the statewide public health delivery system through local communities," and to "develop legislation to meet those needs." Sec. 4.4, Chapter 802, 1989 S.L. This effort was continued by the 1991 General Assembly through the establishment of the Committee on Public Health Systems Issues under the Legislative Research Commission. Public health issues investigated by the 1989 Public Health Study Commission and its successor Committee included the following:

a. the system's inability to attract and retain qualified public health professionals;
b. inadequate financial resources;
c. inadequate facilities;
d. organization, structure, and governance;
e. lack of public identity.

The Committee has concluded, as did it's predecessor Commission, that the present public health system needs improvement and that achieving such improvement will require a substantial committment of State and local resources. This committment

can only be accomplished through the establishment of a permanent, independent public health study commission that can study and make recommendations over time.

RECOMMENDATION TWO

The LRC Committee on Public Health Systems Issues recommends that the General Assembly favorably consider legislation mandating the certification of radiation technologists. Legislation proposed by the Committee may be found in Appendix K of this report.

FINDINGS AND CONCLUSIONS

Legislative proposals for the licensure of radiation technologists have been introduced in the General Assembly in the 1983, 1985, 1987, 1989, and 1991 sessions. The subcommittee reviewed the comments, findings, and recommendations contained in legislative committee reports pertaining to these proposals. Based on presentations and written materials considered by the subcommittee in its study of radiation technology, the subcommittee is in agreement with and adopts certain of the findings and conclusions of the Legislative Committee on New Licensing Boards contained in that Committee's June 6, 1989 report. The following findings and conclusions are based, in large part, upon that Committee's 1989 report:

(1) The unregulated practice of radiologic technology will substantially harm or endanger the public health, safety or welfare and the potential for such harm is recognizable.

Although the number of persons receiving x-ray examinations each year is increasing, only about fifty percent of the persons operating x-ray equipment have met the educational requirements for voluntary certification by the American Registry of Radiologic Technologists. Untrained, inexperienced, or incompetent operators of x-ray equipment may overexpose a patient to unnecessary radiation or may produce an x-ray the poor quality of which leads to a misdiagnosis by the attending physician. These

types of operator errors could be minimized by State licensure or certification requiring sufficient education, training, and examination to ensure the competency of each operator.

(2) The practice of radiologic technology requires specialized skill and training.

As reported by the North Carolina Society of Radiologic Technologists, the performance of even the most basic, routine x-ray studies requires essential knowledge and understanding of the safe operation of x-ray equipment, selection of exposure factors, selection of ancillary equipment (image recording systems), radiation beam adjustment and collimation, proper positioning of patients, and many other factors in order to produce an optimum diagnostic examination. Operator errors in any part of the imaging process result in poor quality studies, frequently requiring repeat examinations, which contributes unnecessarily to the patients' radiation exposure and exacerbates the cost of health care services.

(3) A substantial majority of the public does not have sufficient knowledge or experience to evaluate the competence of radiation technologists.

Most patients undergoing an x-ray examination or radiation treatment assume the individual administering the radiation is well-trained in the use and operation of x-ray equipment and the proper administration of radiation. However, there are no minimum qualifications of education, training, or experience for x-ray equipment operations, except for those who seek the voluntary certification offered by the American Registry of Radiologic Technologists. In most instances, a patient does not question the competency of an operator of x-ray equipment since the patient relies on the physician or other practitioner who orders the examination; however, the practitioner ordering the examination does not usually conduct the x-ray examination.

The Committee recognizes that licensing of radiation technologists may lead to increased costs for practitioners who are presently using nurses and other individuals

not as extensively trained as radiation technologist for the operation of x-ray equipment. However, the Committee believes that the possible dangers presented by inexperienced and untrained operators and the economical and biological costs of repeated examinations due to operator error offset the potential increased costs to practitioners.

APPENDIX A

CHAPTER 754
SENATE BILL 917

AN ACT TO AUTHORIZE STUDIES BY THE LEGISLATIVE RESEARCH COMMISSION, TO CREATE AND CONTINUE VARIOUS COMMITTEES AND COMMISSIONS, TO MAKE APPROPRIATIONS THEREFOR, TO DIRECT VARIOUS STATE AGENCIES TO STUDY SPECIFIED ISSUES, AND TO MAKE OTHER AMENDMENTS TO THE LAW.

PART I.-----TITLE

Section 1. This act shall be known as "The Studies Act of 1991."

. . . . .

PART II.-----LEGISLATIVE RESEARCH COMMISSION

Sec. 2.1. The Legislative Research Commission may study the topics listed below. Listed with each topic is the 1991 bill or resolution that originally proposed the issue or study and the name of the sponsor. The Commission may consider the original bill or resolution in determining the nature, scope, and aspects of the study. The topics are:

. . . . .

(11) Effectiveness and Efficiency of the Public Health System's Delivery of Health Services to the Citizens of the State -- study continued (H.B. 476 - Payne, S.B. 367 - Walker, S.B. 407- Walker),

. . . . .

(63) Licensure of Radiologic Technologists as requested in the Final Assessment Report on Senate Bill 738 by the Legislative Committee on New Licensing Boards,

. . . . .

PART XXI.-----EFFECTIVE DATE

Sec. 21.1. This act is effective upon ratification.

In the General Assembly read three times and ratified this the 16th day of July, 1991.

APPENDIX B

PUBLIC HEALTH SYSTEMS ISSUES
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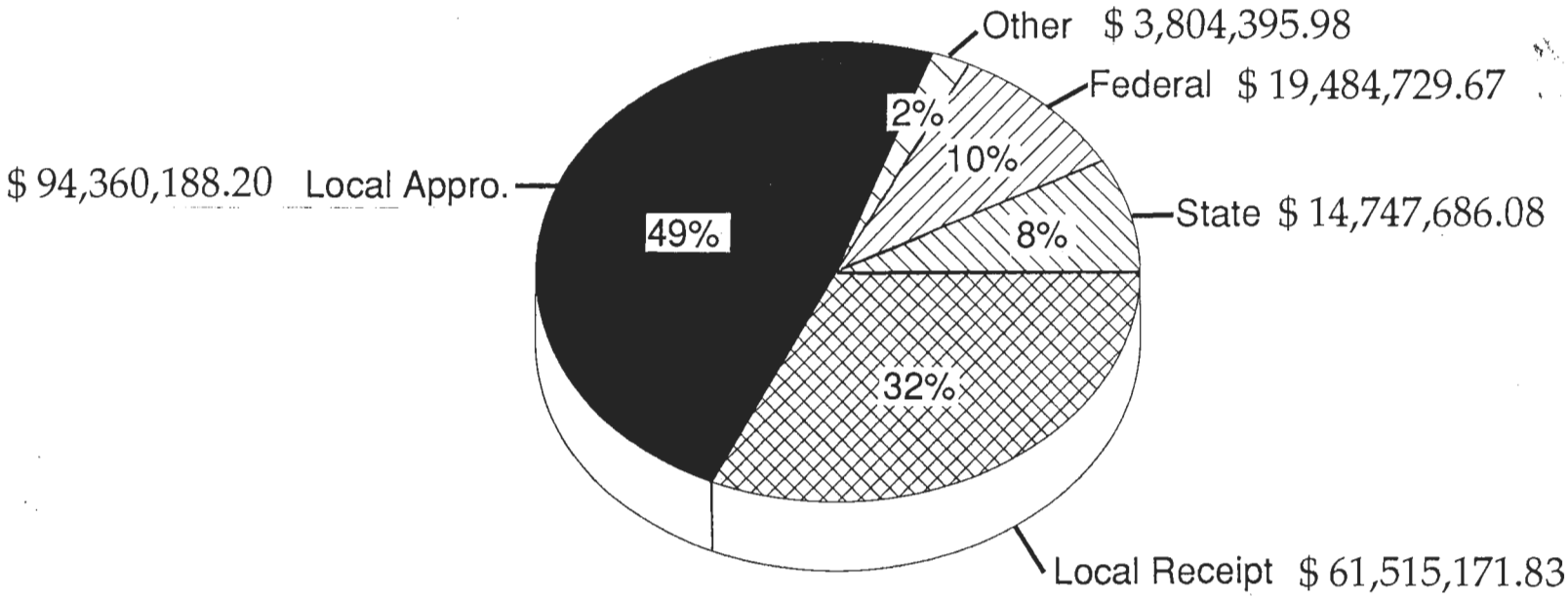
A. FINANCING: EH&NR Health and Environmental Divisions Budgets

AUTHORIZED 1992 BUDGETS

DIVISION/SECTION	APPROPRIATIONS	FEDERAL FUNDS	OTHER FUNDS	TOTAL
LOCAL HEALTH SERVICES	$4,585,457.00	$684,936.00	$13,854,121.00	$19,124,514.00
MEDICAL EXAMINERS OFFICE	$1,699,971.00	$0.00	$412,055.00	$2,112,026.00
HEALTH EDUCATION	$690,391.00	$0.00	$0.00	$690,391.00
OFFICE OF PUBLIC HEALTH NURSING	$139,290.00	$0.00	$0.00	$139,290.00
DIVISION OF DENTAL HEALTH	$3,888,862.00	$140,654.00	$116,422.00	$4,145,938.00
DIVISION OF EPIDEMIOLOGY	$12,306,006.00	$5,772,149.00	$7,367,328.00	$25,445,483.00
. INJURY CONTROL	$1,481,909.00	$419,393.00	$1,059,314.00	$2,960,616.00
. OCCUPATIONAL HEALTH	$959,632.00	$218,973.00	$797,414.00	$1,976,019.00
. ACUTE COMMUNICABLE DISEASE	$4,333,188.00	$3,926,679.00	$3,771,836.00	$12,031,703.00
. TB CONTROL	$3,396,224.00	$314,287.00	$0.00	$3,710,511.00
. SEXUALLY TRANSMITTED DISEASE	$898,902.00	$857,067.00	$0.00	$1,755,969.00
. VITAL RECORDS	$526,878.00	$0.00	$1,720,605.00	$2,247,483.00
. ENVIRONMENTAL EPIDEMIOLOGY	$709,273.00	$35,750.00	$18,159.00	$763,182.00
DIVISION OF ENVIRONMENTAL HEALTH	$6,307,728.00	$1,790,468.00	$412,347.00	$8,510,543.00
. ENVIRONMENTAL HEALTH	$2,822,256.00	$50,000.00	$0.00	$2,872,256.00
. PUBLIC HEALTH PEST MANAGEMENT	$1,004,045.00	$0.00	$0.00	$1,004,045.00
. SLEEP PRODUCTS	$0.00	$33,315.00	$336,544.00	$369,859.00
. WATER SUPPLY PROTECTION	$1,678,694.00	$1,707,153.00	$71,303.00	$3,457,150.00
. SHELLFISH SANITATION	$802,733.00	$0.00	$4,500.00	$807,233.00
DIVISION OF MATERNAL AND CHILD HEALTH:	$44,767,137.00	$81,091,478.00	$5,919,557.00	$131,778,172.00
. MCH	$65,220.00	$462,774.00	$214,398.00	$742,392.00
. MATERNAL HEALTH	$7,857,348.00	$4,985,919.00	$1,730,949.00	$14,574,216.00
. WOMEN'S PREVENTIVE HEALTH	$3,432,423.00	$4,288,191.00	$2,507,737.00	$10,228,351.00
. SICKLE CELL & GENETIC COUNSELING	$4,002,096.00	$348,498.00	$0.00	$4,350,594.00
. DEC's	$12,139,404.00	$1,990,983.00	$1,224,262.00	$15,354,649.00
. CHILDREN'S SPECIAL HEALTH SERVICES:	$8,733,405.00	$2,613,561.00	$92,925.00	$11,439,891.00
. CHILD HEALTH	$6,019,836.00	$5,443,327.00	$13,303.00	$11,476,466.00
. NUTRITION SERVICES	$2,517,405.00	$60,958,225.00	$135,983.00	$63,611,613.00
DIVISION OF ADULT HEALTH SERVICES	$11,032,340.00	$4,276,878.00	$588,338.00	$15,897,556.00
. OFFICE OF SMOKING AND HEALTH	$0.00	$262,569.00	$0.00	$262,569.00
. ADULT HEALTH PROMOTION	$3,963,297.00	$2,060,843.00	$451,915.00	$6,476,055.00
. ADULT HEALTH CARE	$7,069,043.00	$1,953,466.00	$136,423.00	$9,158,932.00
DIVISION OF PUBLIC HEALTH LABORATORY:	$5,686,062.00	$505,842.00	$1,843,652.00	$8,035,556.00
TOTAL	$91,103,244.00	$94,262,405.00	$30,513,820.00	$215,879,469.00

SOURCE: BD701 FOR PERIOD ENDING 11/30/91
RUN DATE, 12/18/91

LOCAL HEALTH DEPARTMENT EXPENDITURES FOR FISCAL YEAR 1991



Total = $193,912,172

Source: Special Purpose Budget Report - Expenditures (Fund, Objective, Program) for period ending 6/30/91 (rundate 7/19/91)

Special Report BHA-9201I for fiscal year 1991and 1992- Selected Contractors (rundate 1/10/91)

APPENDIX E

State of North Carolina
Department of Environment, Health, and Natural Resources
Division of Epidemiology

James G. Martin, Governor
William W. Cobey, Jr., Secretary

February 14, 1992

J. N. MacCormack, M.D., M.P.H.
Director

MEMORANDUM

TO: J.N. MacCormack, MD, MPH
Director
Division of Epidemiology

FROM: A. Torrey McLean, CRM ATM
State Registrar and Chief
Vital Records Section

SUBJECT: FY 91 Essential Public Health Program Services Reported to the Vital Records Section

The following FY 91 birth and death registration statistics are available for the following counties:

County	Total Births	% Filed w/in Required 10-Day Period	Ave. Filing Time (Days)	Total Deaths	% Filed w/in Required 5-Day Period	Ave. Filing Time (Days)
MEDIUM-1	3292	97.7%	2.4	2401	72.4%	4.8
URBAN	5845	89.2%	6.7	3690	29.4%	10.6
RURAL SMALL-1	1	100%	10.0	30	75.2%	5.1
RURAL LARGE-2	885	70.4%	9.0	219	40.7%	8.8
RURAL SMALL-2	2	50%	12.5	19	31.6%	7.6
OTHER	2890	92.6%	6.5	1252	37.4%	8.9
RURAL LARGE-1	2	0%	13.0	173	33.0%	9.2
MEDIUM-2	1222	77.5%	8.0	730	48.2%	7.2

ATM:la

REPLY TO: VITAL RECORDS SECTION
P.O. Box 29537, Raleigh, North Carolina 27626-0537 Telephone 919-733-3526

AID-TO-COUNTIES (6100) - BUDGETED FOR 1992

FUND	OBJECTIVE	PROGRAM	STATE	FEDERAL	MEDICAID FUNDS	INTERAGENCY TRANSFERS	USER FEES	OTHER	TOTAL
LOCAL HEALTH SERVICES - 1410	6100 & 6118	0092-4993 & 0091-5293	$4,302,015.00	$634,936.00	$16,796,311.00	$243,459.00	$0.00	$0.00	$21,976,721.00
MEDICAL EXAMINER'S OFF. - 1420	6100	0092	$104,000.00	$0.00	$0.00	$0.00	$0.00	$0.00	$104,000.00
CHEIF NURSE - 1430	6100	0092	$50,000.00	$0.00	$0.00	$0.00	$0.00	$0.00	$50,000.00
DENTAL HEALTH - 1435	6100	NA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
EPIDEMIOLOGY 1440 THUR 1526			$2,673,982.00	$1,160,349.00	$0.00	$0.00	$0.00	$420,032.00	$4,254,363.00
. INJURY CONTROL - 1440	6100	1311-3443	$0.00	$75,000.00	$0.00	$0.00	$0.00	$78,333.00	$153,333.00
. OCCUPATIONAL HEALTH - 1445	6100	NA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
. ACUTE COMMUNICABLE DIS. - 1450	6100	0090-4991	$621,838.00	$796,500.00	$0.00	$0.00	$0.00	$341,699.00	$1,760,037.00
. TB - 1455	6100	0092-1232	$2,052,144.00	$288,849.00	$0.00	$0.00	$0.00	$0.00	$2,340,993.00
. STD - 1460	6100	NA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
. VITAL RECORDS - 1465	6100	NA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
. ENVIRONMENTAL EPID. - 1470	6100	NA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
ENVIRONMENTAL HEALTH 1430 THUR 1495			$1,288,034.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1,288,034.00
. ENVIRONMENTAL HEALTH - 1430	6100	0092	$888,580.00	$0.00	$0.00	$0.00	$0.00	$0.00	$888,580.00
. PH PEST MANAGMENT - 1480	6100	0092	$399,514.00	$0.00	$0.00	$0.00	$0.00	$0.00	$399,514.00
. SLEEP PRODUCTS - 1485	6100	NA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
. WATER SUPPLY - 1490	6100	NA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
. SHELLFISH SANITATION - 1495	6100	NA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
MATERNAL AND CHILD HEALTH - 1505 THUR 1540			$14,792,283.00	$19,834,097.00	$201,150.00	$3,623,467.00	$0.00	$426,330.00	$38,877,327.00
. MATERNAL & CHILD HEALTH - 1505	6100	0092	$0.00	$0.00	$0.00	$0.00	$0.00	$213,180.00	$213,180.00
. MATERNAL HEALTH - 1510	6100	0091-8762	$4,302,220.00	$4,040,416.00	$201,150.00	$1,177,445.00	$0.00	$213,150.00	$9,934,381.00
* FAM NDOB	6114	0092	$840,000.00	$0.00	$0.00	$0.00	$0.00	$0.00	$840,000.00
. WOMEN'S PREV. HEALTH - 1515	6100	0092-4491	$2,395,680.00	$3,128,158.00	$0.00	$2,068,476.00	$0.00	$0.00	$7,592,514.00
* ADOLESCEN.	6103	0092-3492	$441,909.00	$0.00	$0.00	$257,016.00	$0.00	$0.00	$698,925.00
. SICKLE CELL & GENETICS - 1520	6100	0092	$25,197.00	$0.00	$0.00	$0.00	$0.00	$0.00	$25,197.00
. DEC* - 1525	6100	0092-1212	$813,489.00	$142,543.00	$0.00	$0.00	$0.00	$0.00	$956,031.00
. CSHS - 1530	6100	0092-7211	$658,231.00	$273,739.00	$0.00	$0.00	$0.00	$0.00	$931,970.00
. CHILD HEALTH - 1530	6100	0091-3850	$5,315,358.00	$5,113,343.00	$0.00	$0.00	$0.00	$0.00	$10,428,701.00
. NUTRITION SERVICES - 1540	6100	1601-4993	$0.00	$7,135,898.00	$0.00	$120,530.00	$0.00	$0.00	$7,256,428.00
ADULT HEALTH 1545, 1550 & 1551			$5,214,123.00	$2,615,625.00	$0.00	$0.00	$0.00	$0.00	$7,834,748.00
. OFF. OF SMOKING & HEALTH - 1545	6100	NA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
. ADULT HEALTH PROM. - 1550			$2,784,798.00	$1,473,188.00	$0.00	$0.00	$0.00	$0.00	$4,257,986.00
* A-T-C	6100	1081-1232	$0.00	$79,693.00	$0.00	$0.00	$0.00	$0.00	$79,693.00
* HLTH ED RISK RE	6108	0092-1232	$524,935.00	$897,473.00	$0.00	$0.00	$0.00	$0.00	$1,422,408.00
* ADULT HLTH	6109	0091-0092	$2,030,684.00	$0.00	$0.00	$0.00	$0.00	$0.00	$2,030,684.00
* HYPERTENSION	6110	0092-1232	$81,543.00	$496,022.00	$0.00	$0.00	$0.00	$0.00	$577,565.00
* ARTHRITIS	6111	0092	$147,636.00	$0.00	$0.00	$0.00	$0.00	$0.00	$147,636.00
. ADULT HEALTH CARE - 1551			$2,434,325.00	$1,142,437.00	$0.00	$0.00	$0.00	$0.00	$3,576,762.00
* A-T-C	6109	1131-1332	$0.00	$517,698.00	$0.00	$0.00	$0.00	$0.00	$517,698.00
* CANCER	6104	0091-0092	$0.00	$120,593.00	$0.00	$0.00	$0.00	$0.00	$120,593.00
* KIDNEY	6105	0092	$100,461.00	$0.00	$0.00	$0.00	$0.00	$0.00	$100,461.00
* MIGRANT HEALTH	6106	1092-1103	$15,000.00	$495,372.00	$0.00	$0.00	$0.00	$0.00	$510,372.00
* REFUGEE HEALTH	6107	1161-3832	$0.00	$8,774.00	$0.00	$0.00	$0.00	$43,952.00	$52,726.00
* EPILESPY	6112	0092	$63,831.00	$0.00	$0.00	$0.00	$0.00	$0.00	$63,831.00
* HOME HEALTH	6113	0092	$2,255,033.00	$0.00	$0.00	$0.00	$0.00	$0.00	$2,255,033.00
PUBLIC HEALTH LABORATORY - 1560	6100	NA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
TOTAL			$28,429,437.00	$24,245,007.00	$16,997,461.00	$3,866,926.00	$0.00	$846,362.00	$74,385,253.00

SOURCE: SPECIAL PURPOSE BUDGET REPORT---EXPENDITURES (FUND,OBJ,PROG)/DUMMCOS
FOR THE PERIOD ENDED 12/31/91, RUN DATE 1/14/92 (PAG)

FUNDING FOR LOCAL PUBLIC HEALTH SERVICES - STATE FISCAL YEAR 1991

HEALTH DEPARTMENT	BUDGETED LOCAL APPROPRIATIONS	PER CAPITA APPROPRIATIONS	APPROPRIATIONS PER $100,000 TAX VALUE	STATE & FEDERAL	PER CAPITA STATE & FEDERAL	MEDICAID	PER CAPITA MEDICAID	HOME HEALTH	PER CAPITA HOME HEALTH	OTHER	PER CAPITA OTHER	TOTAL BUDGET SFY 1991	PER CAPITA TOTAL
RURAL SMALL - 1	$61,456	$8.54	$22	$153,021	$21.27	$13,468	$1.87	NA	NA	$18,526	$2.57	$246,471	$34.26
RURAL SMALL - 2	$124,443	$13.23	$54	$184,317	$19.59	$7,500	$0.80	NA	NA	$3,250	$0.35	$319,510	$33.97
RURAL LARGE - 1	$481,845	$16.60	$44	$322,471	$11.11	$68,265	$2.35	$724,860	$24.98	$44,950	$1.55	$1,642,391	$56.59
RURAL LARGE - 2	$434,522	$16.16	$40	$468,455	$17.43	$92,709	$3.45	NA	NA	$106,566	$3.96	$1,102,252	$41.00
MEDIUM - 1	$3,469,350	$19.81	$71	$1,212,489	$6.92	$737,000	$4.21	$180,618	$1.03	$1,018,000	$5.81	$6,617,457	$37.78
MEDIUM - 2	$1,571,009	$23.75	$87	$742,066	$11.22	$101,750	$1.54	$822,530	$12.44	$212,440	$3.21	$3,449,795	$52.16
URBAN	$4,221,560	$15.84	$32	$1,100,590	$4.13	$101,630	$0.38	$2,596,000	$9.74	$172,436	$0.65	$8,192,216	$30.75
DISTRICT - 1	$521,468	$7.57	$21	$1,184,446	$17.20	$140,265	$2.04	$1,027,726	$14.92	$210,345	$3.05	$3,084,250	$44.78
DISTRICT - 2	$150,268	$2.45	$11	$2,010,853	$32.82	$181,736	$2.97	$825,780	$13.48	$598,523	$9.77	$3,767,160	$61.48
OTHER	$3,305,609	$27.39	$69	$1,039,595	$8.61	$104,958	$0.87	$1,267,510	$10.50	$256,020	$2.12	$5,973,692	$49.50

FOOTNOTE
. Budgeted Local Appropriations = Sum total of revenue from local ad valorem taxes and the county general fund budgeted for local public health services.
. Other = Funds budgeted from other third party receipts such as private insurance, environmental health fees, etc.
. NA = Local health department does not provide service or collect fees for this service.
. Appalachian District Health Department includes the following counties: Alleghany, Ashe and Watauga.
. PPCC District Health Department includes the following counties: Pasquotank, Perquimans, Camden and Chowan.

Injury Prevention Programs in Ten Local Health Departments, 1992

	Car seats	Seat-belts	Water Safety	Health* Promotion	Bicycle Safety	Poison Prevention	Smoke detectors	Home Safety
URBAN	X	X		X			X	
OTHER		X	X		X			X
MEDIUM-1	X	X				X		
DISTRICT-1	X			X				
RURAL SMALL-1	X	X						
RURAL LARGE-2	X							
RURAL SMALL-2	X							
RURAL LARGE-1	X							
DISTRICT-2			X					
MEDIUM-2								

*General health promotion programs or parenting classes that include information on injury prevention.

Division of Dental Health

Report of FY91 Services for the Legislative Study Commission

	K-5 Pop'n	Screening Services	Educational Services	Fl. Mouthrinse	Numbers of K-12 Clinical Care Services***	
		Percentages of K-5 populations			Sealants	Other
DISTRICT-1	4511	85%	97%	26%	3529	2687
MEDIUM-1 *	10238	41%	22%	97%	*	*
URBAN **	17929	52%	95%	36%	0	0
RURAL SMALL-1	582	98%	17%	0%	0	0
RURAL LARGE-2	1624	87%	98%	47%	381	207
RURAL SMALL-2	717	98%	98%	98%	438	274
OTHER	8754	98%	98%	91%	1284	2659
RURAL LARGE-1	2008	98%	98%	98%	136	36
DISTRICT-2	5451	58%	40%	16%	2239	3072
MEDIUM-2	5550	67%	75%	65%	0	0

*Buncombe County's dental program is locally funded and does not report in the same format as the Division.

**Forsythe County's dental program is locally funded

***Clinical Services data not available by grade level

The activities of the Division of Dental Health promote oral health through prevention and education services, with an emphasis on elementary school children. As demonstrated above, dental services vary dramatically from county to county. The Division of Dental Health has only 43 field-based dental hygienists and 13 dentists to cover 94 counties. Six of the larger counties (including Buncombe and Forsythe) fund their own dental programs. There are no Division staff assigned to these counties.

During FY92, we have been implementing a team approach to begin to address these inequities. Our small number of staff, coupled with recent cuts in travel funding, limits our ability to do so.

Division of Adult Health Program Services
Selected Counties
State Fiscal Year 1992

The Division of Adult Health provides financial assistance and technical assistance and consultation services to local health departments in a number of program areas related to health promotion and chronic disease prevention and control.

Table I provides a summary of Division of Adult Health funded programs in ten selected local health departments. Table II provides a summary of key service/outcome indicators for State Fiscal Year 1991. Table III provides a Statement of Purpose for each Program.

TABLE I
Funded Programs/By County

COUNTY	ADULT HEALTH	ARTHRITIS	EPILEPSY		HEALTH CARE SERVICES	HEALTH PROMOTION	HOME HEALTH SERVICES	HYPERTENSION	MIGRANT	RENAL DISEASE PREVENTION
			Clin	Med						
DISTRICT-1	X					X	X			
MEDIUM-1	X	X				X	X			
URBAN						X	X			X
RURAL SMALL-1						X				
RURAL LARGE-2	X	X		X		X				X
RURAL SMALL-2	X	X				X		X		
OTHER	X		X	X		X	X	X		
DISTRICT-2	X	X	X	X	X	X	X		X	
RURAL LARGE-1						X	X			
MEDIUM-2	X					X	X			

MATERNAL AND CHILD HEALTH SERVICES
PERCENTAGE OF SERVICE NEEDS MET BY SERVICE CATEGORY

HEALTH DEPARTMENT	MATERNAL HEALTH	WOMEN'S PREVENTIVE HEALTH	WIC WOMEN	WIC INFANTS & CHILDREN	CHILD HEALTH	CHILD SERVICE COORDINATION
RURAL SMALL-1	0%	76%	62%	80%	50%	31%
RURAL SMALL-2	62%	35%	52%	57%	47%	6%
RURAL LARGE-1	62%	42%	61%	68%	27%	6%
RURAL LARGE-2	60%	36%	80%	68%	25%	90%
MEDIUM-1	80%	46%	54%	47%	43%	29%
MEDIUM-2	68%	50%	67%	71%	11%	14%
URBAN	16%	26%	24%	26%	1%	26%
DISTRICT-1	70%	28%	78%	69%	37%	19%
DISTRICT-2	71%	55%	58%	66%	49%	34%
OTHER	25%	28%	70%	68%	12%	16%

FOOD AND LODGING SANITATION PROGRAM

HEALTH DEPARTMENT	RESTAURANTS	MEAT MARKETS	SCHOOL LUNCHROOMS	ALL FACILITIES
RURAL SMALL-1	81%	50%	33%	69%
RURAL SMALL-2	45%	33%	21%	38%
RURAL LARGE-1	96%	100%	100%	98%
RURAL LARGE-2	98%	100%	100%	99%
MEDIUM-1	95%	82%	98%	93%
MEDIUM-2	84%	95%	54%	83%
URBAN	65%	53%	55%	61%
DISTRICT-1				
COUNTY-1	99%	84%	100%	98%
COUNTY-2	100%	100%	100%	100%
COUNTY-3	100%	100%	100%	100%
DISTRICT-2				
COUNTY-1	99%	100%	100%	99%
COUNTY-2	100%	100%	100%	100%
COUNTY-3	99%	97%	100%	99%
COUNTY-4	94%	100%	100%	96%
OTHER	100%	95%	84%	98%

County or District	Population	Number of EHS*	EHS* Authorized for OSWW**/10,000	Number of New IP*** Issued From 7/1/90-6/30/91	Number of New IP*** issued per Capita for 7/1/90-6/30/91	Site Evaluations conducted for 7/1/90-6/30/91
Rural Small-1	7195	0	0	134	.0186	99
Rural Small-2	9407	1	1.063	94	.0099	110
Rural Large-1	29022	4	1.378	664	.0221	948
Rural Large-2	26844	6	2.235	222	.0082	630
Medium-1	175173	6	0.342	1050	.0059	2118
Medium-2	66145	5	0.75	236	.0035	601
Urban	266443	11	0.412	432	.0016	854
District-1	68870	8	1.16	704	.0102	1222
District-2	61275	6	0.979	435	.0070	699
Other	120691	13	1.07	236	.0019	462

*Environmental Health Specialists
**On-Site Wastewater
***Improvement Permits

Level of Public Health Swimming Pool Sanitation Services
in
Selected County/District Health Departments

County/District	Pools	No. Inspections FY 1990-91	Frequency of Inspections
DISTRICT-1	66	120	1/yr - 2-3/yr
DISTRICT-1/CO-1	(5)	(5)	(1/year)
DISTRICT-1/CO-2	(2)	(2)	(1/year)
DISTRICT-1/CO-3	(59)	(113)	(2-3/year)
MEDIUM-1	160	300	2-3/year
URBAN	277	500	2/year
RURAL SMALL-1 *			
RURAL LARGE-2	74	128	2.6/year
RURAL SMALL-2	3	2	1/year
OTHER	236	334	1/year
DISTRICT-2	20	7	1/year
DISTRICT-2/CO-3	(13)	(5)	(1/year)
DISTRICT-2/CO-4	(4)	(0)	(1/year)
DISTRICT-2/CO-1	(0)	(0)	
DISTRICT-2/CO-2	(3)	(2)	(1/year)
RURAL LARGE-1	20	14	2/year
MEDIUM-2	40	40	1/year

* No records - possibly 3 pools - per Rachel Carpenter

2/25/92

Level of Private Water Supply Sanitation Services
in
Selected County/District Health Departments

Counties/Districts With Local Rules and Program

URBAN

OTHER

Counties/Districts Without Local Rules and Program

DISTRICT-1

DISTRICT-2

RURAL SMALL-1

RURAL SMALL-2

RURAL LARGE-1

RURAL LARGE-2

MEDIUM-1

MEDIUM-2

2/25/92

Level of Private Water Supply Sanitation Services
in
Selected County/District Health Departments

Counties/Districts With Local Rules and Program

URBAN

OTHER

Counties/Districts Without Local Rules and Program

DISTRICT-1

DISTRICT-2

RURAL SMALL-1

RURAL SMALL-2

RURAL LARGE-1

RURAL LARGE-2

MEDIUM-1

MEDIUM-2

2/25/92

Level of Milk Sanitation Services
in
Selected County/District Health Departments

DISTRICT-1

- Has 1 milk distributor permitted in the District.
- Samples are collected a minimum of 4 times in any consecutive 6-month period.
- Inspection of the distributor's facilities is conducted by the District.
- Inspections of dairy farms are conducted by the Department of Environment, Health, and Natural Resources.

MEDIUM-1

- As of January 1, 1992, the Department of Environment, Health, and Natural Resources has assumed the responsibility for the milk program except for the laboratory support.

URBAN

- Has 1 milk plant - performs quarterly equipment tests, inspects quarterly, and collects milk samples monthly.
- Inspects 85 dairy farms on a quarterly basis - none of these farms are located in Forsyth County.
- Maintains the records for the milk plant and the Carolina Virginia Milk Producers Association Bulk Tank Unit consisting of 170 farms - DEHNR inspects the other 85 farms.
- Inspects 2 single-service manufacturers quarterly.
- Provides laboratory support for the milk program in Forsyth County in addition to contracting with other counties for services.

RURAL SMALL-1

- Has no dairy farms, milk plants, single-service manufacturers, or distributors permitted.

RURAL LARGE-2

- Has no milk plants, single-service manufacturers, or distributors permitted.
- Has 1 dairy farm which is inspected by DEHNR.

RURAL SMALL-2

- Has no dairy farms, milk plants, single-service manufacturers, or distributors permitted.

OTHER

- Has no dairy farms, milk plants, single-service manufacturers, or distributors permitted.

DISTRICT-2

- Has 2 milk distributors permitted.
- Inspections of distributors' facilities are quarterly.
- Samples are collected a minimum of 4 times in any consecutive 6-month period.
- Provides laboratory support for the program.

RURAL LARGE-1

- Has no milk plants, single-service manufacturers, or distributors permitted.
- Has 1 dairy farm which is inspected by Craven County Health Department.

MEDIUM-2

- Has no dairy farms, milk plants, single-service manufacturers, or distributors permitted.

COMMUNITY AND PATIENT EDUCATION

Activities in Selected Counties

County Health Department	Community Education	Patient Education	Remarks
MEDIUM-1	Injury prevention education, smoking prevention, education to day care personnel, school health education, substance abuse preventive education and explaining services and health problems.	Prenatal care education, parenting skills, smoking cessation, preventing teen pregnancies and patient counseling re their conditions.	
RURAL SMALL-1	Practically none, except some explanation of services and problems in connection with Public Health Week.	Prenatal classes, parenting classes, nutrition education, exercise classes and patient counseling in some programs.	
URBAN	Workshops for community leaders on variety of topics; teen initiative project with emphasis on communication and decision-making skills and self-esteem; support groups for teen males with adult male volunteers, coordination with adolescent prevention council; geriatric education in housing projects; county employees health promotion education; and AIDS prevention education.	Classes and individual counseling for clients and patients in most areas of public health activities.	Have a ratio of one health educator to every 22,225 of the population. This is an excellent ratio.

County Health Department	Community Education	Patient Education	Remarks
RURAL LARGE-2	School employees on the prevention of heart disease, explaining services mainly through use of volunteers and through Public Health Week.	Patient counseling by nurses or nutritionists depending on condition.	Small volume of community and patient education.
RURAL SMALL-2	Practically none.	Sporadic counseling to patients by nurses in connection with testing or screening.	No health education professional is employed by the local health department.
DISTRICT-1	Most activities are for school populations; explanation of services, especially during Public Health Week.	Limited patient education and counseling.	Has 1.2 full time equivalent health educators. This represents a ratio of one health educator to every 57,280 population.
OTHER	Bicycle safety, preventing children's injuries, injury prevention in older adults, male involvement in preventing adolescent pregnancies, cancer prevention.	Counseling for high blood pressure patients, prenatal education classes, family planning classes, counseling on disease conditions.	A fair volume of health education is provided in both community and patient education. The department does excellent community organization in connection with its health education efforts.

County Health Department	Community Education	Patient Education	Remarks
MEDIUM-2	Family life education in schools, including parental involvement and teacher training; teen pregnancy prevention; Community Health Advocacy Program; wellness education to three work sites.	Maternity classes, family planning education; parenting skills; individual counseling on diseases and their risks in most personal health programs.	The department provides a high volume of health education services; has a ratio of one health educator to every 22,000 of population.
DISTRICT-2	Educating county employees in five counties for prevention of heart disease; prevention of drowning. Other activities include presentations on request from community groups.	Maternity education; educating high risk pregnant women; counseling patients with problems.	
RURAL LARGE-1	Community Health Advocacy Program; wellness education to county employees; wellness education in selected black churches on prevention of heart disease.	Prenatal classes; diabetes classes; family planning classes; patient counseling relevant to patient's problem.	

State of North Carolina
Department of Environment, Health, and Natural Resources
512 North Salisbury Street • Raleigh, North Carolina 27611

James G. Martin, Governor

William W. Cobey, Jr., Secretary

April 22, 1992

Representative Howard C. Barnhill, Co-Chairman
Legislative Research Commission's
Committee on Health Systems Issues
2123 State Legislative Building
Raleigh, NC 27601-1096

Senator Roy A. Cooper, III, Co-Chairman
Legislative Research Commission's
Committee on Health Systems Issues
1406 State Legislative Building
Raleigh, NC 27601-1096

Dear Co-Chairmen:

Pursuant to the requirement set forth in HB 183, the Department of Environment, Health, and Natural Resources submits a status report on our progress in conducting various health related projects to improve the State's public health system. Thirty copies are enclosed for distribution to committee members. Please refer any questions you might have concerning its content to Dr. Thad Wester, Deputy State Health Director.

Sincerely,

William W. Cobey Jr.

WWCjr/TBW

P.O. Box 27687, Raleigh, North Carolina 27611-7687 Telephone 919-733-4984

STATUS REPORT ON HOUSE BILL 183
SUBMITTED BY
THE DEPARTMENT OF ENVIRONMENT, HEALTH, AND NATURAL RESOURCES

I. FINANCIAL RESOURCE DEVELOPMENT FOR LOCAL HEALTH DEPARTMENTS

The Office of the State Health Director has expanded its responsibilities to include non-traditional financial resource development. The goal is to strengthen the capacity of local health departments and EHNR health divisions to obtain public and private funds. The financial resource development functions include, but are not limited to, the following:

. identifying public (discretionary grants and contracts) and private (national and regional foundation, corporate) resources which may be available to carry out public health activities and services;
. establishing and maintaining a routine process to communicate opportunities for public and private funding;
. providing technical support (consultation and technical assistance) to develop applications, proposals and contracts for submission to prospective funding sources;
. providing or arranging for grantsmanship training;
. developing and maintaining a grantsmanship data bank/reference center; and
. developing on-going relationships with potential funding sources.

As requested, all of the above activities have been initiated this fiscal year. Beginning July 1, 1992 we expect to provide local health departments with a monthly notice of federal and state funding opportunities. This notice will also include a listing of upcoming foundation proposal submission deadlines and opportunities for grantsmanship training.

II. STATEWIDE SYSTEM FOR ASSESSING HEALTH STATUS AND HEALTH NEEDS

Every two years, EHNR asks each county to undertake a community diagnosis and to provide their findings to the State Health Director. This process, which began in 1974, continues to provide valuable baseline data on the health needs and health status of the residents of North Carolina. The importance of the information is evidenced by the FY 1992 requirement that all local health departments must undertake a community diagnosis and furnish their findings to the State Health Director. This requirement became effective for local health departments in their FY 1992 contracts.

The procedures used by local health departments to define their priority health needs continue to evolve. Most health departments initially relied on staff analysis to determine community health priorities. Now many use more inclusive strategies to assess health needs. They range from community surveys to development of community advisory committees or task forces to help analyze health data and establish an order of needs.

A parallel process begun this fiscal year will serve as an adjunct to community diagnosis. Healthy People 2000, a health plan under the aegis of the Governor's Commission on the Year 2000 Health Objectives, offers communities outcome-based objectives to develop approaches to meet the public health needs.

The Commission on the Year 2000 Health Objectives, formed by executive order on September 6, 1992, is charged with the responsibility of establishing a health agenda for the residents of North Carolina. The plan, now in its final stages of public review, includes targeted health outcomes which address a variety of health concerns to be met by the year 2000.

The plan was developed with in-put from a cross-section of North Carolinians. It is designed to provide guidance and a model for local initiatives. Phase II of the planning process focuses on activities at the community level and emphasizes the importance of total community involvement. It is anticipated that the Commission will share the results of its work in September - October, 1992.

A staff position in the State Health Director's Office will coordinate the community diagnosis process and work with and monitor the progress of local communities in formulating their own Year 2000 plans.

III. STATEWIDE INFORMATION AND RETRIEVAL SYSTEM

The State Center for Health and Environmental Statistics (SCHES) designed and piloted a revised health information system (HSIS) this fiscal year. The goal of the new system is to operate a statewide management information system that collects client and service data on the essential public health services. Based on needs expressed by local health department administrators, the new system will be able to carry out some basic administrative functions (e.g., patient registration, appointment scheduling, etc). The existing HSIS system collects statistics only on certain programs within health departments and has no feedback reporting capacity. The new system will emphasize:

. capturing information on all clients rather than just those in selected programs;
. ease and flexibility for local health departments;
. electronic transmission of data; and
. local reporting capacity.

Wilson and Onslow counties began using the pilot project software in February/March 1992. A third county will be added to pilot test in May. Results from the pilot test will be used to make refinements in the software before its release statewide. It is anticipated that feedback from the pilot test will provide data on the usefulness of the software to local health departments, ease of use, operational costs and response time. Based on this evaluation, if appropriate, the system will be expanded statewide as soon as funds are available.

In addition to the above capabilities, the Department's goal is to expand the software to eventually include all aspects of local health department functions. On the immediate horizon are the addition of WIC, communicable disease, environmental health, immunization tracking and community-based services modules to the software. These will be added as funds become available.

The pilots will continue through the end of July. At that time, and based upon the results from the pilot test, an implementation schedule will be developed.

IV. PROCESS TO MONITOR AND EVALUATE HEALTH OUTCOME STANDARDS

A task force under the leadership of the State Health Director is being established to evaluate the present accountability system and recommend strategies for improvement. The task force, composed of state and local public health officials, will include in their deliberations how to use health status outcomes as markers for accountability.

In addition, proposed rules defining essential public health services have been drafted. Public hearings on these rules are scheduled through April and the Commission for Health Services will consider their adoption at the May 6, 1992 meeting.

PROPOSAL FOR JOINT RESPONSIBILITIES AND FINANCING FOR NORTH CAROLINA'S PUBLIC HEALTH SYSTEM

PRESENTED TO
THE LEGISLATIVE RESEARCH COMMISSION'S
PUBLIC HEALTH SYSTEM ISSUES COMMITTEE

by

Association of North Carolina Boards of Health

Department of Environment, Health and Natural Resources

North Carolina Association of Environmental Health Supervisors

North Carolina Association of Local Health Directors

North Carolina Association of Public Health Nurse Administrators

North Carolina Public Health Association

School of Public Health, University of North Carolina-Chapel Hill

July 23, 1992

PROPOSAL FOR JOINT RESPONSIBILITIES AND FINANCING FOR NORTH CAROLINA'S PUBLIC HEALTH SYSTEM

Rationale

Representatives from the North Carolina Public Health Association, North Carolina Association of Local Health Directors, Association of North Carolina Boards of Health, North Carolina Association of Public Health Nurse Administrators, North Carolina Association of Environmental Health Supervisors, the Department of Environment, Health and Natural Resources, and the University of North Carolina-Chapel Hill, School of Public Health offer the following proposal for consideration by the Legislative Research Commission's Committee on Public Health System Issues. This proposal seeks to preserve local and state governments' shared responsibility for providing essential public health services, while reducing service inequities between counties.

Part One: State and Local Government Responsibilities for the Public Health System

Agreed to be a strength of North Carolina's current public health system, the public health representatives **propose state and local governments continue sharing responsibility for service delivery.**

1. **The state should increase its financial support for the delivery of essential public health services by becoming an equal partner with local government in financing the public health system.**

   * There is tremendous unmet need among North Carolina citizens for public health services.
   * The combined state and local appropriations for public health are inadequate to meet this need.
   * Even at current service delivery levels, the state's funding share must increase drastically to reach an equitable funding ratio with local government appropriations.
   * Both state and local government appropriations will need to increase to meet the unmet needs for public health services.

   Since some counties currently lack the capacity to provide essential public health services, *the goal is to improve the service delivery system.* In ten years, state and local governments should equally contribute to financing essential services. Of North Carolina's total budget for essential public health services, 50% in the aggregate should be made up of the counties' combined contributions and the remaining 50% should

be the state's contribution. Local and state representatives should develop a funding formula which follows these guidelines:

A. Of North Carolina's total budget for *legislatively defined* essential public health services, (not including federal money, fees, fines or penalties,) half should be financed by local government appropriations and half by state government appropriations.

B. Local health appropriations = funding ratio for local
State health appropriations health departments

should be determined on basis of local need, population, and local county/counties ability to pay

C. State financial assistance to local health departments should be in the form of unrestricted public health block grants for essential services.

2. Local government should provide:

A. Facilities for public health delivery (with assistance from the state described in 3.B. below)

B. Administrative support for local health departments (for example, county personnel, bookkeeping, finance office)

C. Local health assessment, policy-development and assurance (as defined in the Institute of Medicine Report)

3. State government should provide:

   A. Laboratory support

   B. Matching funds to assist with construction and renovation of local health department facilities. The funds should be derived from a special capped capital reserve consisting of a portion of state appropriations to DEHNR that would otherwise revert to the general fund at the end of the fiscal year.

   C. Local health appropriations = funding ratio for local
   State health appropriations health departments

   A more favorable ratio for counties with populations of 25,000 or less that agree to join with one or more counties to form a district health department (special state appropriation).

   D. Film library

   E. Consultation and technical assistance for public health management and direct services

   F. Assistance with recruitment, orientation and continuing education for local public health departments

   G. Accountability for standards, contracts and state rules (HB 183)

   H. State-wide health assessment, policy-development and assurance (as defined in the Institute of Medicine Report)

I. Comprehensive, compatible, state-wide, computerized information network system (HB 183)

J. State-wide public health information system to monitor and assure the General Assembly that funding improves services and outcomes (HB 183)

Part Two: Local Health Departments' Obligations for Receiving Public Health Block Grants

1. Within two years, local health departments should be required to adhere to at least 90% of the state pay plan for local government employees.

2. When service delivery is jointly funded by state and local appropriations, any fees generated by essential health services should be used for local public health purposes, and they should not supplant local funds for public health (prior year's local appropriations serve as base.)

3. Local public health facilities should meet minimum standards developed jointly by representatives of local and state public health professionals.

Part Three: Other Recommendations

1. Require the State Health Director to report annually to the General Assembly on the status of Public Health in North Carolina.

2. Require that the State Health Director be an MD, and have an MPH with three years of public health management experience, or an MD with five years of public health management experience.

3. Continue to refine, strengthen, and monitor the state organization for public health.

APPENDIX H

MEMBERSHIP OF THE SUBCOMMITTEE ON PUBLIC HEALTH STUDY COMMISSION

MEMBERS:

Dr. Richard House, Chair
Chapel Hill, NC

Senator Roy Cooper, Jr.
Rocky Mount, NC

Representative Howard Barnhill
Charlotte, NC

Senator Russell Walker
Asheboro, NC

APPENDIX I

MEMBERSHIP OF
SUBCOMMITTEE ON RADIOLOGIC TECHNOLOGY

Members:

Ms. Ruth Cook, Chair
3309 Ridgecrest Court
Raleigh, NC 27607

Rep. Julia C. Howard
203 Magnolia Avenue
Mocksville, NC 27028
(704) 634-3754

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

Rep. Carolyn B. Russell
304 Glen Oak Drive
Goldsboro, NC 27534
(919) 736-2665

Dr. John Tart, President
Johnston Community College
P.O. Box 2350
Smithfield, NC 27577

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1993

S/H D

93-LN-011A
(THIS IS A DRAFT AND NOT READY FOR INTRODUCTION)

Short Title: Public Health Study. (Public)

Sponsors:

Referred to:

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH THE PUBLIC HEALTH STUDY COMMISSION.

Whereas, recent data on the health status of North Carolina citizens suggest that the State and local public health systems are not operating at maximum efficiency and effectiveness; and

Whereas, demands on financial resources to support State and local public health have increased dramatically, while the State's percentage of financial support to local public health efforts has decreased; and

Whereas a strong county-based public health system has been the entry point for the delivery of public health and primary care services to the citizens of North Carolina; and

Whereas, prevention, surveillance, assessment, and education are major tasks and strengths of the public health system; and

Whereas, the public health system must be incorporated into health care reform and cost control strategies; and

Whereas, the structure, financing, accessibility, and accountability of the public health system needs close and continued scrutiny to ensure that the system keeps pace with the needs of society and with current health care reform efforts; Now, therefore,

The General Assembly of North Carolina enacts:

Section 1. Chapter 120 of the General Statutes is amended by adding the following new Article to read:

"ARTICLE 22.

"The Public Health Study Commission.

"**§ 120-195. Commission created; purpose.**

There is established the Public Health Study Commission. The Commission shall examine the public health system to determine its effectiveness and efficiency in assuring the delivery of public health services to the citizens of North Carolina.

"**§ 120-196. Commission duties.**

The Commission shall study the availability and accessibility of public health services to all citizens throughout the State. In conducting the study the Commission shall:

(1) Evaluate whether the current organizational structure of the public health system is effective in meeting public health needs and the likelihood that such structure will be able to achieve the State's public health mandate in the future;

(2) Determine whether the public health services currently available in each county or district health department conform to the mission and essential services established under G.S. 130A-1.1;

(3) Study the workforce needs of each county or district health department, including salary levels, professional credentials, and continuing education requirements, and determine the impact that shortages of public health professional personnel have on the delivery of public health services in county and district health departments;

(4) Review the status and needs of local health departments relative to facilities, and the need for the development of minimum standards governing the provision and maintenance of these facilities;

(5) Propose a long-range plan for funding the public health system, which plan shall include a review and evaluation of the current structure and financing of public health in North Carolina and any other recommendations the Commission deems appropriate based on its study activities;

(6) Study and make recommendations on the role of the public health system in health care reform efforts; and

(7) Conduct any other studies or evaluations the Commission considers necessary to effectuate its purpose.

"**§ 120-197. Commission membership; vacancies; terms.**

(a) The Commission shall consist of 17 members, one of whom shall be the State Health Director. The Speaker of the House of Representatives shall appoint seven members, two of whom shall be selected from among the following: the UNC School of Public Health, the North Carolina Primary Care Association, the North Carolina Home Care Association, the North Carolina Pediatric Society, and the North Carolina Citizens for Public Health. Five of the Speaker's appointees shall be persons who are members of the House of Representatives at the time of their appointment, one of the five being the Representative who chairs the House standing committee related to health matters. The President Pro Tempore of the Senate shall appoint seven members, two of whom shall be selected from among the following: the North Carolina Health Directors' Association, the North Carolina Public Health Association, the Association of Public Health Nurses, the North Carolina Environmental Health Supervisors' Association, and the North Carolina Association of Public Health Educators. Five of the President Pro Tempore's appointees shall be persons who are members of the Senate at the time of their appointment, one of the five being the Senator who chairs the Senate standing committee related to health matters. The Governor shall appoint one member from either the North Carolina Medical Society or the North Carolina Hospital Association. The Lieutenant Governor shall appoint one member from either the North Carolina Association of County Commissioners or the Association of North Carolina Boards of Health.

(b) Vacancies shall be filled by the official who made the initial appointment using the same criteria as provided by this section. All initial appointments shall be made within one calendar month from the effective date of this Article.

(c) Legislative members appointed by the Speaker and the President Pro Tempore shall serve two year terms. The public members initially appointed by the Speaker and the President Pro Tempore shall each serve a three year term. The members initially appointed by the Governor and the Lieutenant Governor shall each serve a one year term. Thereafter, the terms of all Commission members shall be for two years.

"**§ 120-198. Commission meetings.**

The Commission shall have its first meeting not later than sixty days after adjournment of the 1993 General Assembly, first

session, at the call of the President Pro Tempore of the Senate and the Speaker of the House of Representatives. The President Pro Tempore of the Senate and the Speaker of the House of Representatives shall each appoint one legislative member of the Commission to serve as cochair. The Commission shall meet upon the call of the cochairs.

"**§ 120-199. Commission reimbursement.**

The Commission members shall receive no salary as a result of serving on the Commission but shall receive necessary subsistence and travel expenses in accordance with the provisions of G.S. 120-3.1, 138-5, and 138-6, as applicable.

"**§ 120-200. Commission subcommittees; non Commission membership.**

The Commission cochairs may establish subcommittees for the purpose of making special studies pursuant to its duties, and may appoint non Commission members to serve on each subcommittee as resource persons. Such resource persons shall be voting members of the subcommittee and shall receive subsistence and travel expenses in accordance with G.S. 138-5 and G.S. 138-6.

"**§ 120-201. Commission authority.**

The Commission has the authority to obtain information and data from all State officers, agents, agencies and departments, while in discharge of its duties, pursuant to the provisions of G.S. 120-19, as if it were a committee of the General Assembly. The Commission shall also have the authority to call witnesses, compel testimony relevant to any matter properly before the Commission, and subpoena records and documents, provided that any patient record shall have patient identifying information removed. The provisions of G.S. 120-19.1 through G.S. 120-19.4 shall apply to the proceedings of the Commission as if it were a joint committee of the General Assembly. In addition to the other signatures required for the issuance of a subpoena under this section, the subpoena shall also be signed by the cochairs of the Commission. Any cost of providing information to the Commission not covered by G.S. 120-19.3 may be reimbursed by the Commission from funds appropriated to it for its continuing study.

"**§ 120-202. Commission reports.**

The Commission shall report to the General Assembly, the Governor, and the Lieutenant Governor the results of its study and recommendations. The Commission shall submit its written report not later than 30 days after the convening of each biennial session of the General Assembly.

"**§ 120-203. Commission staff; meeting place.**

The Commission may contract for clerical and professional staff or for any other services it may require in the course of its ongoing study.

The Commission may, with the approval of the Legislative Services Commission, meet in the State Legislative Building or the Legislative Office Building."

Sec. 2. There is appropriated from the General Fund to the Legislative Services Commission the sum of ninety two thousand sixteen dollars ($92,016) for the 1993-94 fiscal year and the sum of one hundred three thousand nine hundred four dollars ($103,904) for the 1994-95 fiscal year to fund the first two years of the Commission's study established by this act.

Sec. 3. This act becomes effective July 1, 1993.

SUMMARY
PROPOSED LEGISLATION FOR
ESTABLISHMENT OF A
PERMANENT PUBLIC HEALTH STUDY COMMISSION
(93-LN-011A)

This legislation establishes a permanent public health study commission, sets out the commission's purpose, duties, and membership, and appropriates money to support the commission for the 1993 fiscal biennium. Following is a section-by-section analysis of the proposed bill:

Section #

The "Whereas" clauses on page one of the bill summarize the need for the legislation.

Section 1 codifies the Commission in Chapter 120 of the General Statutes:

§120-195 Creates the Commission and establishes its purpose to determine the public health system's effectiveness and efficiency in assuring the delivery of public health services to North Carolina citizens.

§120-196 Sets forth the Commission's duties to: evaluate the system's organizational structure; determine whether the system is currently meeting its statutory mission and essential services requirements; study local workforce needs in view of public health personnel shortages; review status and needs of local health departments regarding facilities; develop a long-range plan for funding the system; study the role of public health in health care reform efforts; and conduct any other activities necessary to carry out the Commission's purpose.

§120-197 Provides for the appointment of members to the Commission. 17 members: State Health Director, 5 members of House of Representatives, 5 members of the Senate, and six public members to be selected from designated public health groups. Appointments are made by Speaker of the House, President Pro Tempore of the Senate, Governor and Lieutenant Governor.

§120-198 First meeting must be convened not later than 60 days after adjournment of 1993 long session; Speaker and President Pro Tempore appoint co-chairs from among legislative members.

§120-199 Commission members receive no salary but travel and subsistence reimbursement for attending meetings.

§120-200 Authorizes Commission co-chairs to establish subcommittees and to appoint persons who are not members of the Commission to serve on the subcommittees.

§120-201 Authorizes Commission to request and receive information from other State agencies, and to issue subpoenas.

§120-202 Requires Commission to provide regular written reports to the General Assembly and to the Governor and Lieutenant Governor.

§120-203 Authorizes Commission to contract for professional and clerical staff services, and to meet in the Legislative Building or Legislative Office Building.

Section 2. Appropriates funds in each year of the 1993 biennium for Commission support.

Section 3. Act becomes effective July 1, 1993.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1993

S/H D

93-LN-006
(THIS IS A DRAFT AND NOT READY FOR INTRODUCTION)

Short Title: Rad Tech Practice Act. (Public)

Sponsors:

Referred to:

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH THE RADIATION TECHNOLOGY PRACTICE ACT.

The General Assembly of North Carolina enacts:

Section 1. Chapter 90 of the General Statutes is amended by adding a new Article to read:

"ARTICLE 28

"Radiation Technology Practice Act.

"**§ 90-405. Short title.**

This Article may be cited as the 'Radiation Technology Practice Act'.

"**§ 90-406. Policy and purpose.**

In order to protect the public health and safety, it is the policy of the State of North Carolina to reduce the harmful effect of excessive and improper exposure to ionizing radiation during medical diagnosis and treatment. The General Assembly of North Carolina finds that mandatory certification of persons who engage in the practice of radiation technology is necessary to ensure minimum standards of competency and to provide the public with safe care.

"**§ 90-407. Definitions.**

In this Article, unless the context requires otherwise, the following definitions shall apply:

(1) 'Certificate' means a certificate issued by the Council to an individual to practice as a

radiologic technologist (radiographer), nuclear medicine technologist, or radiation therapy technologist.

(2) 'Commission' means the North Carolina Medical Care Commission, created by Part 10 of Article 3 of Chapter 143B of the General Statutes.

(3) 'Council' means the North Carolina Council on Radiation Technology, created by G.S. 90-408.

(4) 'Educational program' means an educational program in North Carolina that:

a. Offers to prepare persons to meet the educational requirements for certification under this Article; and

b. Is a program in Radiation Technology that is accredited by the Committee on Allied Health Education and Accreditation (CAHEA) upon recommendation of the Joint Review Committee on Education in Radiologic Technology or Nuclear Medicine Technology, and that is recognized by the Council on Postsecondary Accreditation and the United States Office of Education.

(5) 'Individual' means a human being.

(6) 'Ionizing radiation' means gamma rays, X rays, alpha particles, beta particles, neutrons, high-speed electrons, high-speed protons and other nuclear particles.

(7) 'Licensed practitioner' means an individual licensed or otherwise authorized by law to practice medicine, dentistry, osteopathy, chiropractic, or podiatry in North Carolina.

(8) 'Nuclear medicine technologist' means an individual who is certified under this Article for the administration of radionuclides to human beings for diagnostic and/or therapeutic purposes while under the supervision of a licensed practitioner.

(9) 'Person' means an individual, corporation, partnership, association, unit of government, or other legal entity.

(10) 'Radiation technologist' means an individual, other than a licensed practitioner, who administers ionizing radiation to human beings for medical purposes and practices radiation technology,

nuclear medicine technology, or radiation therapy technology.

(11) 'Radiation technology' means the direct application of ionizing radiation using imaging techniques, modalities, and therapeutic procedures to render diagnostic information or treatment, under the supervision of a licensed practitioner.

(12) 'Radiation therapy technologist' means an individual who is licensed under this Article for the technical application of ionizing radiation to human beings for therapeutic purposes while under the supervision of a licensed practitioner.

(13) 'Radioactive material' means material that spontaneously, or as applied, emits ionizing radiation to a medically significant extent.

(14) 'Radionuclides' means a species of atom whose nucleus disintegrates spontaneously, emitting radiation in the form of alpha, beta, or gamma radiation.

(15) 'Radiologic technologist' or 'radiographer' means an individual who is certified under this Article for the technical application to a human being of ionizing radiation other than radioactive materials, for diagnostic purposes while under the supervision of a licensed practitioner.

"§ 90-408. Council on Radiation Technology created.

(a) The North Carolina Council on Radiation Technology is created.

(b) Composition. The Council shall consist of eight members including four radiation technologists, two of whom shall be radiologic technologists, one of whom shall be a nuclear medicine technologist, and one of whom shall be a radiation therapy technologist, one hospital administrator, one primary care physician, one board certified radiologist, and one person who is a radiation technology educator.

(c) Appointment. Council members shall be appointed as follows: The General Assembly upon the recommendation of the Speaker of the House of Representatives shall appoint two radiologic technologists, one nuclear medicine technologist, and one radiologist to the Council. One of the radiologic technologists shall serve for a term of three years, and the other radiologic technologist and the radiologist shall each serve for a term of two years. The nuclear medicine technologist shall serve for a term of one year.

The General Assembly upon the recommendation of the President Pro Tempore of the Senate shall appoint one physician to serve for a term of one year, one radiation technology educator to serve for a term of two years, one hospital administrator to serve for a term of one year, and one radiation therapy technologist to serve for a term of three years.

(d) Qualifications. The four radiation technologist members shall hold current certificates and shall reside in North Carolina. They shall each have at least five years' experience in radiation technology practice, education, administration, or radiation technology training, including the three years immediately preceding appointment to the Council, and shall continue such practice, administration, or education and training while on the Council. The radiation technologists appointed initially shall, upon their appointment and qualification, immediately become certified as radiation technologists by complying with the provisions of this Article.

(e) Vacancies. Vacancies shall be filled in the same manner as the original appointment except that all unexpired terms on the Council shall be filled in accordance with G.S. 120-122 and shall be filled within 45 days after the vacancy occurs. Appointees to fill vacancies shall serve the remainder of the unexpired term and until their successors have been duly appointed and qualified.

(f) Removal. The Council may remove any of its members for neglect of duty, incompetence, or unprofessional conduct. A member subject to disciplinary proceedings shall be disqualified from Council business until the charges are resolved.

(g) Compensation. Each member of the Council shall receive per diem compensation and reimbursement for travel and subsistence as set forth in G.S. 93B-5.

(h) Officers. The officers of the Council shall be a chairman, who shall be a certified radiation technologist, a vice-chairman. and other officers deemed necessary by the Council to carry out the purposes of this Article. All officers shall be elected annually by the Council for one-year terms and shall serve until their successors are elected and qualified.

(i) Immunity from Suit. Individual Council members shall be immune from civil liability arising from activities performed within the scope of their official duties.

(j) Meetings. The Council shall hold at least two meetings each year to conduct business and shall establish procedures governing the calling, holding, and conducting of regular and

special meetings. A majority of the Council members shall constitute a quorum.

"§ 90-409. Powers and Duties of the Council.

(a) The Council shall have the following general powers and duties:

(1) Administer this Article.

(2) Recommend to the Commission the rules necessary to carry out the provisions of this Article, including provisions for supervision, continuing education, fees, educational requirements in accordance with G.S. 90-407(4)(b), disciplinary actions and certification examinations in accordance with G.S. 90-417 and G.S. 90-418 for adoption by the Commission.

(3) Establish qualifications of, employ, and set the compensation of the executive director who shall be a radiologic technologist and shall not be a member of the Council.

(4) Employ and fix the compensation of other personnel that the Council determines are necessary to carry into effect the provisions of this Article and incur other expenses necessary to effectuate this Article.

(5) Examine or cause examinations to be given, determine qualifications and fitness, and renew the certificates of duly qualified applicants for certification or recertification.

(7) Issue, renew, deny, suspend, or revoke certificates to practice radiation technology and carry out the disciplinary actions authorized by this Article.

(8) Recommend accredited educational programs, in accordance with G.S. 90-407(4)(b).

(9) Conduct investigations for the purpose of determining whether violations of this Article or grounds for disciplining certificate holders exist.

(10) Conduct investigations to determine the workforce need for radiation technologists in North Carolina.

(11) Maintain a record of all proceedings and make available to certificate holders and other concerned parties an annual report of Council action.

(12) In accordance with G.S. 90-413, set fees for certification, certificate renewal, examination,

reexamination, and other services deemed necessary to carry out the purposes of this Article.

(13) Adopt a seal containing the name of the Council for use on all certificates and official reports issued by it.

(b) The powers and duties enumerated above are granted for the purpose of enabling the Council and the Commission to protect the public health, welfare, and safety against unqualified or incompetent practitioners of radiation technology and shall be liberally construed to accomplish this objective.

"§ 90-410. Executive Director.

The Executive Director shall perform the duties prescribed by the Council, serve as treasurer to the Council, and furnish a surety bond as required by the Council. The bond shall be made payable to the Council.

"§ 90-411. Custody and use of funds.

The Executive Director shall deposit in financial institutions designated by the Commission as official depositories all fees payable to the Council. The funds shall be deposited in the name of the Council and shall be used to pay all expenses incurred by the Council in carrying out the purposes of this Article. Such funds shall be annually audited by the State Auditor.

"§ 90-412. The Council and Commission may accept contributions, etc.

The Council and the Commission may accept grants, contributions, devises, bequests, and gifts that shall be kept in a separate fund and shall be used by it to enhance the practice of radiation technology.

"§ 90-413. Expenses and fees.

(a) All salaries, compensation, and expenses incurred or allowed for the purpose of carrying out the purposes of this Article shall be paid by the Council exclusively out of the fees received by the Council as authorized by this Article, or funds received from other sources. In no case shall any salary, expense, or other obligations of the Council be charged against the State treasury.

(b) The schedule of fees shall not exceed the following:

(1)	Each application for examination (including the cost of examination)	$70.00
(2)	Certificate without examination	50.00
(3)	Each application for reexamination (including the cost of examination)	55.00
(4)	Certificate renewal	35.00

(5) Reinstatement of lapsed certificate to practice 50.00

(6) Reasonable charges for duplication services and material.

"**§ 90-414. Technologists previously registered.**

The Council shall issue a certificate to practice as a radiation technologist to any individual who applies to the Council within one year from the effective date of this Article and furnishes to the Council on a form approved by the Council proof of employment either as a radiologic technologist, radiation therapy technologist, or nuclear medicine technologist. In addition, the following must be shown for each specialty:

(1) Radiologic Technologist. A current certificate from the American Registry of Radiologic Technologists in radiologic technology (radiography).

(2) Radiation Therapy Technologist. A current certificate from the American Registry of Radiologic Technologists in radiation therapy.

(3) Nuclear Medicine Technologist. A current certificate from the American Registry of Radiologic Technologists in nuclear medicine or the Nuclear Medicine Technology Certification Board.

"**§ 90-415. Technologists not registered.**

Individuals who have been engaged in the practice of radiation technology under the supervision of a licensed practitioner for four years before January 1, 1993 and have continued to practice under such conditions up to the time of application under this section, shall be eligible for certification without examination in their specialty of radiologic technology (radiography), radiation therapy technology, or nuclear medicine technology by meeting the following criteria:

(1) Proof of good moral character; and

(2) Proof of practice in North Carolina for the two years immediately preceding the effective date of this Article.

Any application made pursuant to this section must be filed with the Council on or before January 1, 1994.

"**§ 90-416. Certification without examination.**

The Council may issue a certificate to practice, without examination, to an applicant:

(1) Who is duly licensed or certified in good standing under the laws of another state when that state's requirements for licensure or certification as a

radiation technologist are substantially equivalent to or exceed the certification requirements of the State of North Carolina at the time the applicant was initially licensed or certified, and when in the Council's opinion, the applicant is competent to practice as a radiation technologist; or

(2) Who has met all criteria for certification by examination in North Carolina and who is registered in good standing in conformance with the appropriate criteria established in G.S. 90-414(1), (2), or (3).

"**§ 90-417. Certification by examination.**

Effective January 1, 1994, a person who desires to be certified and who does not qualify under G.S. 90-414, 90-415, or 90-416, must submit a fee and an application on a form approved by the Council, and must demonstrate proof of (i) good moral character, (ii) graduation from an educational program accredited in radiation technology by the Committee on Allied Health Education and Accreditation in Radiation Technology, Radiation Therapy, or Nuclear Technology, and (iii) shall pass the examination developed by the American Registry of Radiologic Technologists for certification in the appropriate specialty as provided by G.S. 90-418.

"**§ 90-418. Examination.**

At least three times each year, the Council shall cause the examination required under G.S. 90-417(iii) to be given to applicants for certification at a time and place to be announced by the Council. When the Council determines that an applicant has met all the qualifications for certification, and has submitted the required fee, the Council shall issue a certificate to the applicant, showing thereon the appropriate specialty.

"**§ 90-419. Reexamination.**

Any applicant who fails to pass the first certificate examination may take additional examinations in accordance with rules recommended by the Council and adopted by the Commission.

"**§ 90-420. Certificate renewal.**

Every certificate issued under this Article shall be renewed during the month of January of each year. On or before the date the current certificate expires, every individual who wishes to continue to practice shall apply for a certificate renewal and submit the required fee. Certificates that are not so renewed shall automatically lapse. A certificate that has lapsed may be reissued in the same manner as for renewal within five years from the date of lapse. A certificate that has been expired for more

than five years may be reissued only in a manner prescribed by the Council.

"**§ 90-421. Continuing education.**

(a) The Council shall require evidence of successful completion of a continuing educational program as a condition of certificate renewal. The Council shall determine the number of hours and subject matter of continuing education for each specialty in accordance with the requirements of the American Registry of Radiologic Technologists, and shall recommend those requirements for adoption by the Commission.

(b) The Council shall grant approval to a continuing education program or course upon finding that the program or course offers an educational experience designed to enhance the practice of radiation technology.

(c) If the program offers to teach certificate holders to perform advanced skills, the Council may grant approval for the program and the performance of the advanced skills by those successfully completing the program when it finds that the nature of the procedures taught in the program and the program facilities and faculty are such that a certificate holder fully completing the program can reasonably be expected to carry out those procedures safely and properly. Nothing in this section or in any other part of this Article may be construed to imply, encourage, or authorize site visits to schools, colleges, or college-used facilities as a part of or as being prerequisite to approval of a program.

"**§ 90-422. Inactive list.**

(a) When a certificate holder submits a request for inactive status, the Council shall issue to the certificate holder a statement of inactive status and shall place the certificate holder's name on the inactive list. While on the inactive list, the person shall not be subjected to renewal requirements and shall not practice radiation technology in North Carolina.

(b) When such person desires to be removed from the inactive list and returned to the active list, the person shall submit an application to the Council on a form furnished by the Council and shall pay the fee for certificate renewal. The Council shall require evidence of competency to resume the practice of radiation technology before returning the applicant to active status.

"**§ 90-423. Exemptions from certification.**

The following individuals shall be permitted to practice radiologic technology, radiation therapy, or nuclear medicine technology without a certificate:

(1) Students enrolled in an educational program, when engaged in completing a clinical education requirement for graduation and performing under the direction of a technologist certified under G.S. 90-414 or G.S. 90-417 who is a member of the faculty of the educational program;

(2) Individuals who engage in the practice of radiation technology while seeking certification pursuant to G.S. 90-415 until Council action on their application or January 1, 1994, whichever is sooner;

(3) A licensed practitioner.

(4) Licensed dental hygienists and dental assistants who operate dental X-ray equipment for the sole purpose of oral radiography under rules of the Board of Dental Examiners.

(5) Individuals who perform radiation technology on the foot and ankle while under the supervision of a North Carolina licensed podiatrist when such individuals have received a certificate of registration from the North Carolina Board of Podiatry Examiners and when such individuals have successfully completed the course of study approved by the North Carolina board of Podiatry Examiners testing knowledge of radiography of the foot and ankle. Such individuals shall not use contrast media, radioactive materials, or radiation therapy. Such individuals shall perform radiography of the foot and ankle only under the orders of a licensed podiatrist.

(6) Individuals who perform radiography while employed by or contracted to, and under the supervision of, a North Carolina licensed chiropractor, in a manner and under circumstances satisfactory to the North Carolina Board of Chiropractic Examiners. Such individuals shall not use contrast media, radioactive materials, or radiation therapy.

(7) Individuals working under the supervision of a physician licensed to practice medicine in North Carolina when such individuals are working in the physician's private office and are performing routine diagnostic radiographic examinations of the chest, upper and lower extremities, sinus, abdomen

(anterior/posterior) and lumbar spine (anterior/posterior and lateral).

"§ 90-424. Unlawful practice.

(a) Subject to the provisions of G.S. 90-423, G.S. 90-414, G.S. 90-415, and G.S. 90-417 it shall be a violation of this Article for a person to:

(1) Practice radiation therapy technology, radiologic technology, or nuclear medicine technology without the certificate required under this Article;

(2) Employ or solicit uncertified individuals to practice radiologic technology, radiation therapy technology, or nuclear medicine technology;

(3) Use in connection with the person's name any letters, words, or insignia implying the person is a certified radiologic technologist, radiation therapy technologist, or nuclear medicine technologist unless the person is certified in accordance with this Article;

(4) Sell, fraudulently obtain, or fraudulently furnish any certificate of graduation from an educational program;

(5) Practice radiologic technology, radiation therapy, technology, or nuclear medicine technology, under cover of any fraudulently obtained certificate; or

(6) Conduct an educational program that is not approved by the Council.

(b) Violation of this Article is a misdemeanor punishable in the discretion of the court.

"§ 90-425. Disciplinary authority of the Council.

(a) Grounds for disciplinary action include the following:

(1) Giving false information to or withholding material information from the Council in procuring or attempting to procure a certificate to practice as a radiation technologist;

(2) Having been convicted of or pled guilty or no contest to any crime that indicates that the person is unfit or incompetent to practice as a radiation technologist or that indicates that the person has deceived or defrauded the public;

(3) Having a mental or physical disability or using any drug to a degree that interferes with the person's fitness to practice radiation technology;

(4) Engaging in professional conduct that endangers the public health;

(5) Being unfit or incompetent to practice radiation technology by reason of deliberate or negligent acts or omissions regardless of whether actual injury to a patient is established;

(6) Conducting an educational program in radiation technology other than as defined in this act;

(7) Willfully violating any provision of this Article or of rules adopted by the Commission;

(8) Having pled guilty or no contest to an offense under State or federal narcotic or controlled substance laws or having been found guilty of same.

(b) In accordance with the provisions of Chapter 150B of the General Statutes, the Council may require remedial education, issue a letter of reprimand, restrict, revoke, or suspend any certificate to practice as a radiation technologist in North Carolina or deny any application of certification if the Council determines that the applicant or certificate holder has committed any of the above acts. The Council may reinstate a revoked certificate or remove certification restrictions when it finds that the reasons for revocation or restriction no longer exist and that the person can reasonably be expected to practice radiation technology safely and properly.

"**§ 90-426. Enjoining illegal practices.**

If the Council or the Commission finds that any person is violating any of the provisions in this Article, it may apply in its own name to the superior court for a temporary or permanent restraining order or injunction to prevent such person from continuing such illegal practices. The court is empowered to grant such injunctions regardless of whether criminal prosecution or other action has been or may be instituted as a result of such violation. All actions by the Council or Commission shall be governed by the Rules of Civil Procedure and Article 37 of Chapter 1 of the General Statutes.

The venue for actions brought under this Article shall be the Superior Court of Wake County, North Carolina.

"**§ 90-427. Reports; immunity from suit.**

Any person who has reasonable cause to suspect misconduct or incapacity of a certificate holder, or who has reasonable cause to suspect that any person is in violation of this Article, shall report the relevant facts to the Council. Upon receipt of such charge, or upon its own initiative, the Council may give notice of an administrative hearing or may, after diligent investigation, dismiss unfounded charges. Any person making a

report pursuant to this section shall be immune from any criminal prosecution or civil liability resulting therefrom."

Sec. 2. G.S. 143B-165 reads as rewritten:

"§ 143B-165. North Carolina Medical Care Commission -- creation, powers and duties.

There is hereby created the North Carolina Medical Care Commission of the Department of Human Resources with the power and duty to ~~promulgate~~ adopt rules ~~and regulations~~ to be followed in the construction and maintenance of public and private hospitals, medical centers, and related facilities with the power and duty to adopt, amend and rescind rules ~~and regulations~~ under and not inconsistent with the laws of the State necessary to carry out the provisions and purposes of this Article.

(1) The North Carolina Medical Care Commission has the duty to adopt statewide plans for the construction and maintenance of hospitals, medical centers, and related facilities, or such other as may be found desirable and necessary in order to meet the requirements and receive the benefits of any federal legislation with regard thereto.

(2) The Commission is authorized to adopt such rules ~~and regulations~~ as may be necessary to carry out the intent and purposes of Article 13 of Chapter 131 of the General Statutes of North Carolina.

(3) The Commission may adopt such reasonable and necessary standards with reference thereto as may be proper to cooperate fully with the Surgeon General or other agencies or departments of the United States and the use of funds provided by the federal government as contained and referenced in Article 13 of Chapter 131 of the General Statutes of North Carolina.

(4) The Commission shall have the power and duty to approve projects in the amounts of grants-in-aid from funds supplied by the federal and State governments for the planning and construction of hospitals and other related medical facilities according to the provisions of Article 13 of Chapter 131 of the General Statutes of North Carolina.

(5) Repealed by Session Laws 1981 (Regular Session, 1982), c. 1388, s. 3.

(6) The Commission has the duty to adopt rules ~~and regulations~~ and standards with respect to the

different types of hospitals to be licensed under the provisions of Article 13A of Chapter 131 of the General Statutes of North Carolina.

(7) The Commission is authorized and empowered to adopt such ~~rules~~ rules, ~~and regulations,~~ not inconsistent with the laws of this State, as may be required by the federal government for grants-in-aid for medical facility services and licensure which may be made available to the State by the federal government. This section is to be liberally construed in order that the State and its citizens may benefit from such grants-in-aid.

(8) The Commission shall adopt such rules ~~and regulations,~~ consistent with the provisions of this Chapter. All rules ~~and regulations~~ not inconsistent with the provisions of this Chapter heretofore adopted by the North Carolina Medical Care Commission shall remain in full force and effect unless and until repealed or superseded by action of the North Carolina Medical Care Commission. All rules ~~and regulations~~ adopted by the Commission shall be enforced by the Department of Human ~~Resources.~~ Resources, except that rules adopted under subdivision (12) of this section shall be enforced by the Council on Radiation Technology.

(9) The Commission shall have the power and duty to adopt rules ~~and regulations~~ with regard to emergency medical services in accordance with the provisions of Article 26 of Chapter 130 and Article 56 of Chapter 143 of the General Statutes of North Carolina.

(10) The Commission shall have the power and duty to ~~promulgate~~ adopt rules ~~and regulations~~ for the operation of nursing homes, as defined by G.S. 130-9(e).

(11) The Commission is authorized to adopt such rules as may be necessary to carry out the provisions of Part C of Article 6, and Article 10, of Chapter 131E of the General Statutes of North Carolina.

(12) The Commission may adopt rules in accordance with Chapter 150B of the General Statutes, and upon recommendation by the Council on Radiation Technology, as necessary for the purpose of

carrying out the intent and purposes of Article 28 of Chapter 90 of the General Statutes."

Sec. 3. G.S. 143B-166 reads as rewritten:

"**§ 143B-166. North Carolina Medical Care Commission -- members; selection; quorum; compensation.**

The North Carolina Medical Care Commission of the Department of Human Resources shall consist of ~~17~~ 18 members appointed by the Governor. Three of the members appointed by the Governor shall be nominated by the North Carolina Medical Society, one member shall be nominated by the North Carolina Nurses Association, one member shall be nominated by the North Carolina Pharmaceutical Association, one member nominated by the Society of Radiological Technologists, one member nominated by the Duke Foundation and one member nominated by the North Carolina Hospital Association. The remaining 10 members of the North Carolina Medical Care Commission shall be appointed by the Governor and selected so as to fairly represent agriculture, industry, labor, and other interest groups in North Carolina. One such member appointed by the Governor shall be a dentist licensed to practice in North Carolina. The initial members of the Commission shall be 18 members of the North Carolina Medical Care Commission who shall serve for a period equal to the remainder of their current terms on the North Carolina Medical Care Commission, six of whose appointments expire June 30, 1973, four of whose appointments expire June 30, 1974, four of whose appointments expire June 30, 1975, and four of whose appointments expire June 30, 1976. To achieve the required 17 members the Governor shall appoint three members to the Commission upon the expiration of four members' initial terms on June 30, 1973. At the end of the respective terms of office of the initial members of the Commission, their successors shall be appointed for terms of four years and until their successors are appointed and qualify. Any appointment to fill a vacancy on the Commission created by the resignation, dismissal, death, or disability of a member shall be for the balance of the unexpired term.

The Governor shall have the power to remove any member of the Commission from office for misfeasance, malfeasance or nonfeasance in accordance with the provisions of G.S. 143B-13 of the Executive Organization Act of 1973.

Vacancies on said Commission among the membership nominated by a society, association, or foundation as hereinabove provided shall be filled by the Executive Committee or other authorized agent of said society, association or foundation until the next meeting of the society, association or foundation at which time

the society, association or foundation shall nominate a member to fill the vacancy for the unexpired term.

The members of the Commission shall receive per diem and necessary travel and subsistence expenses in accordance with the provisions of G.S. 138-5.

A majority of the Commission shall constitute a quorum for the transaction of business.

All clerical and other services required by the Commission shall be supplied by the Secretary of Human Resources."

Sec. 4. The additional member of the Medical Care Commission provided for in Section 3 of this act shall be appointed no later than August 1, 1993, and shall serve for a term ending June 30, 1997 and until a successor is appointed and qualified. Successors to this member shall serve terms of four years and until their successors are appointed and qualified.

Sec. 5. Severability. If any provision of this Article or the application thereof to any person or circumstances is held invalid, the validity of the remainder of the act and of the application of such provision to other persons and circumstances shall not be affected thereby.

Sec. 6. This act is effective upon ratification.

SUMMARY
PROPOSED LEGISLATION FOR
CERTIFICATION OF RADIATION TECHNOLOGISTS
(93-LN-006)

This legislation establishes the Radiation Technology Practice Act, sets forth the Act's purpose and the policy behind it, requires certification for specified persons who perform radiation technology, establishes a council to implement the certification requirements under the authority of the Medical Care Commission, indicates who is required to be certified and who is exempt from certification, provides that the council shall support its activities through authorized fees and receipt of contributions and prohibits the use of State funds for this purpose, and authorizes the Medical Care Commission to adopt rules to implement the Act. Following is a section-by-section analysis of the proposed legislation.

Section 1 codifies the Act in Chapter 90 of the General Statutes:

Section #	
§§90-405/406	Legislation entitled "Radiation Technology Practice Act; policy is to protect public health by reducing harmful effects of excessive and improper exposure to ionizing radiation; purpose is to require certification of persons performing radiation technology.
§90-407	Defines terms used in the Act.
§90-408	Creates the North Carolina Council on Radiation Technology. Provides for appointment of eight members with expertise in radiation technology, administration, and education. Speaker appoints four members, President Pro Tempore appoints four members. Sets forth qualifications for members, appointments to vacant positions, removal from council, compensation of council members, council officers, members' immunity from suit, and council meetings.
§90-409	Sets out council's powers and duties to: administer the Act, recommend rules to the Medical Care Commission, employ council staff, provide for examination and qualification for certification, issue and renew certificates, carry out disciplinary authority, recommend educational programs for accreditation, conduct specified investigations, maintain records, set fees as authorized, and adopt a seal.
§90-410	Specifies duties of Executive Director of Council.
§90-411-413	Authorizes use of funds and acceptance of contributions, establishes fee limits.
§90-414	Authorizes immediate certification for persons who: prove employment as a specified technologist, and prove certification by specified professional association, and apply for certification under this section within one year of effective date of the Act.
§90-415	Makes eligible for certification without examination those persons who: have been engaged in the technology under specified

supervision for four years prior to January 1, 1993, and who continue to practice as such at time of application, and prove good moral character, and prove practice in North Carolina for two years immediately preceding effective date of the Act, and file application under this section prior to January 1, 1994.

§90-416 Provides for certification by reciprocity to persons who Council deems to be competent to practice and who are licensed or certified under the laws of another state when that state's laws are substantially equivalent to the requirements for certification under the Act.

§90-417 Effective January 1, 1994, any person who practices radiation technology and is not covered under §§415 through 417, or is not exempt, to become certified in accordance with requirements of this section (apply and pay fee, good moral character, graduation from accredited program, pass exam given by the Council).

§90-418-421 Requires exam to be given three times each year, and provides for re-examination, certificate renewal, and continuing education.

§90-422 Sets out circumstances whereupon certificate holder may be placed on inactive list, and subsequently restored to active status.

§90-423 Provides for exemptions from certification under certain circumstances: students, persons grandfathered in under the Act, licensed practitioners (doctors, dentists, chiropractors, podiatrists, osteopaths), dental hygienists, persons under supervision of podiatrists and chiropractors, persons in physician's private office.

§90-424-27 Establishes conduct that is a violation of the Act, and provides for disciplinary authority of Council, enables Council to apply for injunction against violations, and grants immunity from suit to persons who report violations.

Sections 2 & 3 authorize Medical Care Commission to adopt rules to implement the Act, and provide for the appointment of a radiological technologist to the Commission.

Section 4 Requires that the new member of the Commission be appointed not later than August 1, 1993 and shall serve for four years thereafter.

Section 5 Provides that if any portion of the Act is deemed invalid, that the remainder of the Act shall not be affected by that action.

Section 6 Act is effective upon ratification.