NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

The North Carolina Medical Care Commission
701 Barbour Drive
Raleigh, North Carolina

MINUTES

CALLED MEETING OF THE EXECUTIVE COMMITTEE
CONFERENCE TELEPHONE MEETING ORIGINATING
FROM THE COMMISSION'S OFFICE
May 12, 2010
11:00 A.M.

Members of the Executive Committee Present:

Joseph D. Crocker, Vice-Chairman
George H.V. Cecil
Gerald P. Cox
Charles T. Frock
Mary L. Piepenbring

Members of the Executive Committee Absent:

Lucy Hancock Bode, Chairman
Dr. Robert Schaaf

Members of Staff Present:

Jeff Horton, DHSR Acting Director/MCC Acting Secretary
Christopher B. Taylor, CPA, Assistant Secretary
Drexdal Pratt, Chief, Office of Emergency Medical Services
Nadine Pfeiffer, Assistant Chief, Office of Emergency Medical Services/ DHSR Rule Making Coordinator
Azzie Conley, Chief, Acute and Home Care Section
Gloria Hale, EMSC Program Manager/DHSR Rule Making Coordinator in Training
Donnie Sides, Operations Manager, Office of Emergency Medical Services
Alice S. Creech, Bond Program Assistant

Others Present:

None

1. Purpose of Meeting

To consider for discussion and approval bids that were taken from three law firms to serve as bond counsel to refund or convert all or part of the Series 2008 Bonds for CaroMont Health. To consider a resolution to initiate the rulemaking process for the adoption of Office of Emergency Services' Rules and a resolution to initiate the rulemaking process for the adoption of 10A NCAC 13B.3302 Minimum Provisions of Patient's Bill Rights.

2. Bond Counsel-CaroMont Health- Chris Taylor

Results of Request for Proposal for firms to serve as bond counsel on CaroMont Health Refunding/Conversion Bond Issue set forth in Exhibit A.

Exhibit A

CaroMont Health
Results of RFPs to Serve as Bond Counsel

Firm	Refund All of Series 2008 Bonds	Refund Part of Series 2008 Bonds	Conversion of All of Series 2008 Bonds to Fixed Rate Bonds	Conversion of a Part of Series 2008 Bonds to Fixed Rate Bonds (A)
Hunton & Williams	$50,000	$50,000	NP	NP
McGuire Woods	NP	$70,000	$60,000	$78,500
Womble Carlyle Sandridge & Rice	$60,000	$60,000	NP	$75,000

Notes:
NP = Did not propose fee for this.
(A) Conversion of a portion of Series 2008 Bonds is not permitted under Trust Agreement and would require amendments to do so.

Executive Committee Action: A motion was made by Mr. George Cecil, seconded by Mr. Gerald Cox to approve request from CaroMont to use Womble Carlyle Sandridge and Rice, PLLC to serve as bond counsel in accordance with fee proposal set forth in Exhibit A.

3. The North Carolina Medical Care Commission initiation of the rulemaking process for the following rules:-Remarks were made by Drexdal Pratt, Nadine Pfeiffer and Gloria Hale.

10A NCAC 13P .0217 Medical Ambulance/Evacuation Bus: Vehicle and Equipment Requirements
10A NCAC 13P .0218 Pediatric Specialty Care Ground Ambulance: Vehicle and Equipment Requirements
10A NCAC 13P .0219 Staffing for Medical Ambulance/Evacuation Bus Vehicles
10A NCAC 13P .0220 Staffing for Pediatric Specialty Care Ground Ambulances

Executive Committee Action: No vote was taken on rules **10A NCAC 13P.0217, 10A NCAC 13P.0218, 10A NCAC 13P.0219 and 10A NCAC 13P.0220** and Office of Emergency Medical Services' Staff were instructed to incorporate additional rule changes to address concerns raised by Members of the Executive Committee and bring back to the Executive Committee on Friday, May 14, 2010 at 1:00 p.m.

3A. 10A NCAC 13P .0217 is proposed for adoption as follows:

10A NCAC 13P .0217-MEDICAL AMBULANCE/EVACUATION BUS: VEHICLE AND EQUIPMENT REQUIREMENTS

(a) A Medical Ambulance/Evacuation bus is a multiple passenger vehicle configured and medically equipped for emergency and non-emergency transport of at least three stretcher bound patients with traumatic or medical conditions.

(b) To be permitted as a Medical Ambulance/Evacuation Bus, a vehicle shall have:

(1) a non-light penetrating sliding curtain installed behind the driver from floor-to-ceiling and from side-to-side to keep all light from reaching the driver's area during vehicle operation at night;

(2) patient care equipment and supplies as defined in the "North Carolina College of Emergency Physicians: Standards for Medical Oversight and Data Collection," which is incorporated by reference, including subsequent amendments and editions. This document is available from the OEMS, 2707 Mail Service Center, Raleigh, North Carolina 27699-2707, at no cost. The equipment and supplies shall be clean, in working order, and secured in the vehicle;

(3) five pound fire extinguishers mounted in a quick release bracket located inside the patient compartment at the front and rear of the vehicle that are either a dry chemical or all-purpose type and has a pressure gauge; and

(4) monitor alarms installed inside the patient compartment at the front and rear of the vehicle to warn of unsafe buildup of carbon monoxide.

(5) the name of the EMS Provider permanently displayed on each side of the vehicle;

(6) reflective tape affixed to the vehicle such that there is reflectivity on all sides of the vehicle;

(7) emergency warning lights and audible warning devices mounted on the vehicle as required by G.S. 20-125 in addition to those required by Federal Motor Vehicle Safety Standards. All warning devices shall function properly;

(8) no structural or functional defects that may adversely affect the patient, the EMS personnel, or the safe operation of the vehicle;

(9) an operational two-way radio that:

(A) is mounted to the ambulance and installed for safe operation and controlled by the ambulance driver;

(B) has sufficient range, radio frequencies, and capabilities to establish and maintain two-way voice radio communication from within the defined service area of the EMS System to the emergency communications center or PSAP designated to direct or dispatch the deployment of the ambulance;

(C) is capable of establishing two-way voice radio communication from within the defined service area to the emergency department of the hospital(s) where patients are routinely transported and to facilities that provide on-line medical direction to EMS personnel;

(D) is equipped with a radio control device mounted in the patient compartment capable of operation by the patient attendant to receive on-line medical direction; and

(E) is licensed or authorized by the FCC;

(10) permanently installed heating and air conditioning systems; and

(11) a copy of the EMS System patient care treatment protocols.

(c) A Medical Ambulance/Evacuation Bus shall not use a radiotelephone device such as a cellular telephone as the only source of two-way radio voice communication.

(d) Communication instruments or devices such as data radio, facsimile, computer, or telemetry radio shall be in addition to the mission dedicated dispatch radio and shall function independently from the mission dedicated radio.

(e) The EMS System medical director shall designate the combination of medical equipment as required in Subparagraph (b)(2) of this Rule that is carried on a mission based on anticipated patient care needs.

History Note: *Authority G.S. 131E-157(a); 143-508(d)(8);*
Eff. January 1, 2011.

3B. 10A NCAC 13P .0218 is proposed for adoption as follows:

10A NCAC 13P .0218-PEDIATRIC SPECIALTY CARE GROUND AMBULANCE: VEHICLE AND EQUIPMENT REQUIREMENTS

(a) A Pediatric Specialty Care Ground Ambulance is an ambulance used solely to transport patients 18 years old or younger with traumatic or medical conditions or for whom the need for specialty care or emergency or non-emergency medical care is anticipated during an inter-facility transport.

(b) To be permitted as a Pediatric Specialty Care Ground Ambulance, a vehicle shall have:

(1) a patient compartment that meets the following interior dimensions:

(A) the length, measured on the floor from the back of the driver's compartment, driver's seat or partition to the inside edge of the rear loading doors, is at least 102 inches; and

(B) the height is at least 48 inches over the patient area, measured from the approximate center of the floor, exclusive of cabinets or equipment.

(2) patient care equipment and supplies as defined in the "North Carolina College of Emergency Physicians: Standards for Medical Oversight and Data Collection," which is incorporated by reference, including subsequent amendments and editions. This document is available from the OEMS, 2707 Mail Service Center, Raleigh, North Carolina 27699-2707, at no cost. The equipment and supplies shall be clean, in working order, and secured in the vehicle;

(3) one fire extinguisher mounted in a quick release bracket that is either a dry chemical or all-purpose type and has a pressure gauge;

(4) the name of the EMS Provider permanently displayed on each side of the vehicle;

(5) reflective tape affixed to the vehicle such that there is reflectivity on all sides of the vehicle;

(6) emergency warning lights and audible warning devices mounted on the vehicle as required by G.S. 20-125 in addition to those required by Federal Motor Vehicle Safety Standards. All warning devices shall function properly;

(7) no structural or functional defects that may adversely affect the patient, the EMS personnel, or the safe operation of the vehicle;

(8) an operational two-way radio that:

(A) is mounted to the ambulance and installed for safe operation and controlled by the ambulance driver;

(B) has sufficient range, radio frequencies, and capabilities to establish and maintain two-way voice radio communication from within the defined service area of the EMS System to the emergency communications center or PSAP designated to direct or dispatch the deployment of the ambulance;

(C) is capable of establishing two-way voice radio communication from within the defined service area to the emergency department of the hospital(s) where patients are routinely transported and to facilities that provide on-line medical direction to EMS personnel;

(D) is equipped with a radio control device mounted in the patient compartment capable of operation by the patient attendant to receive on-line medical direction; and

(E) is licensed or authorized by the FCC;

(9) permanently installed heating and air conditioning systems; and

(10) a copy of the EMS System patient care treatment protocols.

(c) Pediatric Specialty Care Ground ambulances shall not use a radiotelephone device such as a cellular telephone as the only source of two-way radio voice communication.

(d) Communication instruments or devices such as data radio, facsimile, computer, or telemetry radio shall be in addition to the mission dedicated dispatch radio and shall function independently from the mission dedicated radio.

(e) The Specialty Care Transport Program medical director shall designate the combination of medical equipment as required in Subparagraph (b)(2) of this Rule that is carried on a mission based on anticipated patient care needs.

History Note: *Authority G.S. 131E-157(a); 143-508(d)(8);*
Eff. January 1, 2011.

3C. 10A NCAC 13P .0219 is proposed for adoption as follows:

10A NCAC 13P .0219-STAFFING FOR MEDICAL AMBULANCE/EVACUATION BUS VEHICLES

Medical Ambulance/Evacuation Bus vehicles are exempt from the requirements of G.S. 131E-158(a). The EMS System Medical Director shall determine the combination and number of EMT, EMT-Intermediate, and EMT-Paramedic personnel required for the staffing of Medical Ambulance/Evacuation Bus vehicles.

History Note: Authority G.S. 131E-158(b);
Eff. January 1, 2011.

3D. 10A NCAC 13P .0220 is proposed for adoption as follows:

10A NCAC 13P .0220-STAFFING FOR PEDIATRIC SPECIALTY CARE GROUND AMBULANCES

Pediatric Specialty Care Ground ambulances operated within the approved Specialty Care Transport Program dedicated solely for the inter-facility transport of non-emergent, emergent, and critically ill or injured Neonatal and Pediatric patients are exempt from the requirements of G.S. 131E-158(a).

History Note: Authority G.S. 131E-158(b);
Eff. January 1, 2011.

4. Resolution: The North Carolina Medical Care Commission does hereby initiate the rulemaking process for the following rule in response to request set forth on Exhibit 4B.- Remarks were made by Jeff Horton and Gloria Hale

Executive Committee Action: A motion was made by Mr. Charles Frock, seconded by Ms. Mary Piepenbring and unanimously approved.

10A NCAC 13B .3302 Minimum Provisions of Patient's Bill of Rights

4A. 10A NCAC 13B .3302 is proposed to be amended as follows:

10A NCAC 13B .3302-MINIMUM PROVISIONS OF PATIENT'S BILL OF RIGHTS-

(a) A patient has the right to respectful care given by competent personnel.

(b) A patient has the right, upon request, to be given the name of his attending physician, the names of all other physicians directly participating in his care, and the names and functions of other health care persons having direct contact with the patient.

(c) A patient has the right to privacy concerning his own medical care program. Case discussion, consultation, examination, and treatment are considered confidential and shall be conducted discreetly.

(d) A patient has the right to have all records pertaining to his medical care treated as confidential except as otherwise provided by law or third party contractual arrangements.

(e) A patient has the right to know what facility rules and regulations apply to his conduct as a patient.

(f) A patient has the right to expect emergency procedures to be implemented without unnecessary delay.

(g) A patient has the right to good quality care and high professional standards that are continually maintained and reviewed.

(h) A patient has the right to full information in laymen's terms, concerning his diagnosis, treatment and prognosis, including information about alternative treatments and possible complications. When it is not possible or medically advisable to give such information to the patient, the information shall be given on his behalf to the patient's designee.

(i) Except for emergencies, a physician must obtain necessary informed consent prior to the start of any procedure or treatment, or both.

(j) A patient has the right to be advised when a physician is considering the patient as a part of a medical care research program or donor program. Informed consent must be obtained prior to actual participation in such a program and the patient or legally responsible party, may, at any time, refuse to continue in any such program to which he has previously given informed consent. An Institutional Review Board (IRB) may waive or alter the informed consent requirement if it reviews and approves a research study in accord with federal regulations for the protection of human research subjects including U.S. Department of Health and Human Services (HHS) regulations under 45 CFR Part 46 and U.S. Food and Drug Administration (FDA) regulations

under 21 CFR Parts 50 and 56. For any research study proposed for conduct under an FDA "Exception from Informed Consent Requirements for Emergency Research" or an HHS "Emergency Research Consent Waiver" in which informed consent is waived but community consultation and public disclosure about the research are required, any facility proposing to be engaged in the research study also must verify that the proposed research study has been registered with the North Carolina Medical Care Commission. When the IRB reviewing the research study has authorized the start of the community consultation process required by the federal regulations for emergency research, but before the beginning of that process, notice of the proposed research study by the facility shall be provided to the North Carolina Medical Care Commission. The notice shall include:

(1) the title of the research study;

(2) a description of the research study, including a description of the population to be enrolled;

(3) a description of the planned community consultation process, including currently proposed meeting dates and times;

(4) an explanation of the way that people choosing not to participate in the research study may opt out; and

(5) contact information including mailing address and phone number for the IRB and the principal investigator.

The Medical Care Commission may publish all or part of the above information in the North Carolina Register, and may require the institution proposing to conduct the research study to attend a public meeting convened by a Medical Care Commission member in the community where the proposed research study is to take place to present and discuss the study or the community consultation process proposed.

(k) A patient has the right to refuse any drugs, treatment or procedure offered by the facility, to the extent permitted by law, and a physician shall inform the patient of his right to refuse any drugs, treatment or procedures and of the medical consequences of the patient's refusal of any drugs, treatment or procedure.

(l) A patient has the right to assistance in obtaining consultation with another physician at the patient's request and expense.

(m) A patient has the right to medical and nursing services without discrimination based upon race, color, religion, sex, sexual ~~preference,~~ orientation, gender identity, national origin or source of payment.

(n) A patient who does not speak English shall have access, when possible, to an interpreter.

(o) A facility shall provide a patient, or patient designee, upon request, access to all information contained in the patient's medical records. A patient's access to medical records may be restricted by the patient's attending physician. If the physician restricts the patient's access to information in the patient's medical record, the physician shall record the reasons on the patient's medical record. Access shall be restricted only for sound medical reason. A patient's designee may have access to the information in the patient's medical records even if the attending physician restricts the patient's access to those records.

(p) A patient has the right not to be awakened by hospital staff unless it is medically necessary.

(q) The patient has the right to be free from duplication of medical and nursing procedures as determined by the attending physician.

(r) The patient has the right to medical and nursing treatment that avoids unnecessary physical and mental discomfort.

(s) When medically permissible, a patient may be transferred to another facility only after he or his next of kin or other legally responsible representative has received complete information and an explanation concerning the needs for and alternatives to such a transfer. The facility to which the patient is to be transferred must first have accepted the patient for transfer.

(t) The patient has the right to examine and receive a detailed explanation of his bill.

(u) The patient has a right to full information and counseling on the availability of known financial resources for his health care.

(v) A patient has the right to be informed upon discharge of his continuing health care requirements following discharge and the means for meeting them.

(w) A patient shall not be denied the right of access to an individual or agency who is authorized to act on his behalf to assert or protect the rights set out in this Section.

(x) A patient has the right to be informed of his rights at the earliest possible time in the course of his hospitalization.

(y) A patient has the right to designate visitors who shall receive the same visitation privileges as the patient's immediate family members, regardless of whether the visitors are legally related to the patient.

History Note: *Authority G.S. 131E-75; 131E-79; 131E-117; 143B-165;*
RRC Objection due to ambiguity Eff. July 13, 1995;
Eff. January 1, 1996;
Temporary Amendment Eff. April 1, 2005;
Amended Eff. January 1, 2011; May 1, 2008; November 1, 2005;

Exhibit 4B- Request for amendment to 10NCAC 13 .3302-Minimum Provisions of Patient's Bill of Rights

EQUALITY
NORTH CAROLINA

April 29, 2010

Mr. Jeff Horton
Office of the Director
Division of Health Service Regulation
2701 Mail Service Center
Raleigh, NC 27699-2701

Dear Mr. Horton:

I am writing to petition the Medical Care Commission for a rules change. We request that 10A NCAC 13B .3302, Minimum Provisions of Patient's Bill of Rights, be updated by amending section (m) as follows:

> (m) A patient has the right to medical and nursing services without discrimination based upon race, color, religion, sex, ~~sexual preference,~~ sexual orientation, gender identity, national origin or source of payment.

This amendment would make two changes to the rule.

First, it would replace the outdated term "sexual preference" with "sexual orientation." The latter term has emerged as the standard legal class that describes an individual's heterosexuality, homosexuality or bisexuality. "Sexual orientation" is the term used in the North Carolina General Statutes, the laws of other states, and in the US Code.

This change would not substantively change the protections offered by the provision, but would conform it to what is now the standard language.

Second, the amendment would add the category "gender identity." This term, also used in North Carolina and federal law, provides protection for individuals whose gender presentation may or may not reflect their assigned sex at birth.

This change is critically important to ensuring the health, wellbeing, and fair treatment of transgender North Carolinians.

Although we recognize that North Carolina hospitals strive to treat all patients fairly, we also know that clear policies like the Patient's Bill of Rights are needed to ensure that every hospital employee understands and meets this expectation.

Securing equal rights and justice for lesbian, gay, bisexual, and transgender North Carolinians

PO Box 28768 ○ Raleigh, NC 27611 ○ tel (919) 829-0343 ○ fax (919) 827-4573 ○ enc@equalitync.org ○ equalitync.org

There have been incidents where transgender patients have been denied care or had their access to care delayed because of their gender identity, both here in North Carolina and across the country. Indeed, a recent national survey conduced by Lambda Legal found that 27 percent of transgender respondents reported being refused care, and many were subjected to harsh language or experienced physically rough or abusive treatment when seeking health care.

When faced with hospitalization, every patient deserves the best possible care, regardless of his or her sexual orientation or gender identity. Adopting these simple changes will help ensure that all North Carolinians are able to access health care without fear of discrimination.

If I can provide any additional information to assist you in considering this matter, please don't hesitate to contact me.

Sincerely,

Ian Palmquist
Executive Director
Equality NC Foundation

CC: Nadine Pfeiffer, Rule-Making Coordinator, Division of Health Service Regulation
John Dervin, Policy Advisor, Office of the Governor
Jamal Jones, Director of Government Relations, North Carolina Hospital Association

5. Adjournment

There being no further business, the meeting was adjourned at 11:45 a.m.

Respectfully submitted,

_____

Christopher B. Taylor, CPA, Assistant Secretary