Healthcare and Regulatory Subcommittee Meeting

Thursday, August 30, 2018

Contents

AGENDA

South Carolina House of Representatives

Legislative Oversight Committee

HEALTHCARE AND REGULATORY SUBCOMMITTEE
Chairman Phyllis J. Henderson
The Honorable William K. Bowers
The Honorable MaryGail K. Douglas
The Honorable Bill Taylor

Monday July 30, 2018
11:00 a.m.
Room 321 - Blatt Building

Pursuant to Committee Rule 6.8, S.C. ETV shall be allowed access for internet streaming whenever technologically feasible.

AGENDA

I. Approval of Minutes

II. Discussion of study of the Department of Disabilities and Special Needs

III. Adjournment

MEETING MINUTES

Healthcare and Regulatory Subcommittee Meeting
Monday, July 30, 2018, at 11:00 am
Blatt Building Room 317

Archived Video Available

I. Pursuant to House Legislative Oversight Committee Rule 6.8, South Carolina ETV was allowed access for streaming the meeting. You may access an archived video of this meeting by visiting the South Carolina General Assembly's website (http://www.scstatehouse.gov) and clicking on *Committee Postings and Reports*, then under *House Standing Committees* click on *Legislative Oversight*. Then, click on *Video Archives* for a listing of archived videos for the Committee.

Attendance

I. The Healthcare and Regulatory Subcommittee is called to order by Chair Phyllis J. Henderson on Monday, July 30, 2018, in Room 317 of the Blatt Building. All members of the Subcommittee are present for all or a portion of the meeting, with the exception of Representative Bill Bowers.

Minutes

I. House Rule 4.5 requires standing committees to prepare and make available to the public the minutes of committee meetings, but the minutes do not have to be verbatim accounts of meetings. It is the practice of the Legislative Oversight Committee to provide minutes for its subcommittee meetings.

II. Representative Douglas moves to approve the meeting minutes from the February 1, 2018 meeting.

Representative Douglas moves to approve the meeting minutes from the February 1, 2018 meeting.	Yea	Nay	Not Voting (Absent)	Not Voting (Present)
Rep. William K. Bowers			✓	
Rep. MaryGail Douglas	✓			
Rep. Henderson	✓			
Rep. Taylor	✓			

Meeting

I. Chair Henderson explains that this is the Subcommittee's seventh meeting with the Department of Disabilities and Special Need (DDSN).

II. Chair Henderson explains that the purpose of the meeting is to hear testimony about the agency's performance measurement.

III. Chair Henderson explains that all testimony given to this subcommittee, which is an investigating committee, must be under oath. She reminds those sworn in during prior meetings that they remain under oath.

IV. Pat Maley, Interim DDSN Director, provides testimony on the agency's recently implemented Enterprise Performance Management system, including annual results, tactical project progress, and quarterly reporting. He also provided the agency's analysis of the increase in abuse and neglect allegations. Lastly, he provided an overview of the agency's major initiatives.

V. Subcommittee members ask questions regarding agency performance, which Interim Director Maley answers.

VI. There being no further business, the meeting is adjourned.

STUDY TIMELINE

Study Update - Department of Disabilities and Special Needs

- March 2015 - Agency submits its **Annual Restructuring and Seven-Year Plan Report**, which is available online.

- January 11, 2016 - Agency submits its **2016 Annual Restructuring Report**, which is available online.

- January 10, 2017 - **Full committee votes to schedule the Department of Disabilities and Special Needs for study**. Video of the meeting is available online.

- February 9, 2017-March 13, 2017 - Committee solicits input from the public about the agency in the form of an **online public survey.** The results of the public survey are available online.

- March 2, 2017 - Committee holds **public input meeting** (Meeting #1) about Department of Archives and History; DDSN; and John de la Howe School. Video of the meeting is available online.

- May 1, 2017 - Agency submits its **Program Evaluation Report**, which is available online.

- September 18, 2017 - Subcommittee holds meeting #2 to discuss agency **history, governance, services, and customers**.

- October 10, 2017 - Subcommittee holds meeting #3 to discuss **agency finances and responses to questions** from September 18, 2017 meeting.

- October 24, 2017 - Subcommittee holds meeting #4 to continue to discuss **agency finances and responses to questions** from the September 18, 2017, and October 10, 2017 meetings.

- Novermber 6, 2017 - Subcommittee holds meeting #5 to discuss **human resources and responses to questions** from the October 24, 2017 meeting.

- November 30, 2017 - Subcommittee holds meeting #6 to receive testimony from the **Department of Health and Human Services, Vocational Rehabilitation Department, and directors of Disabilities and Special Needs Boards and other providers**.

- February 1, 2018 - Subcommittee holds meeting #7 to receive testimony about an **internal review of the provider payment system.**

- July 30, 2018 - Subcommittee holds meeting #8 to receive testimony about the agency's **performance management**.

- Ongoing - Public may submit written comments on the Oversight Committee's webpage on the General Assembly's website (www.scstatehouse.gov).

AGENCY OVERVIEW

Snapshot

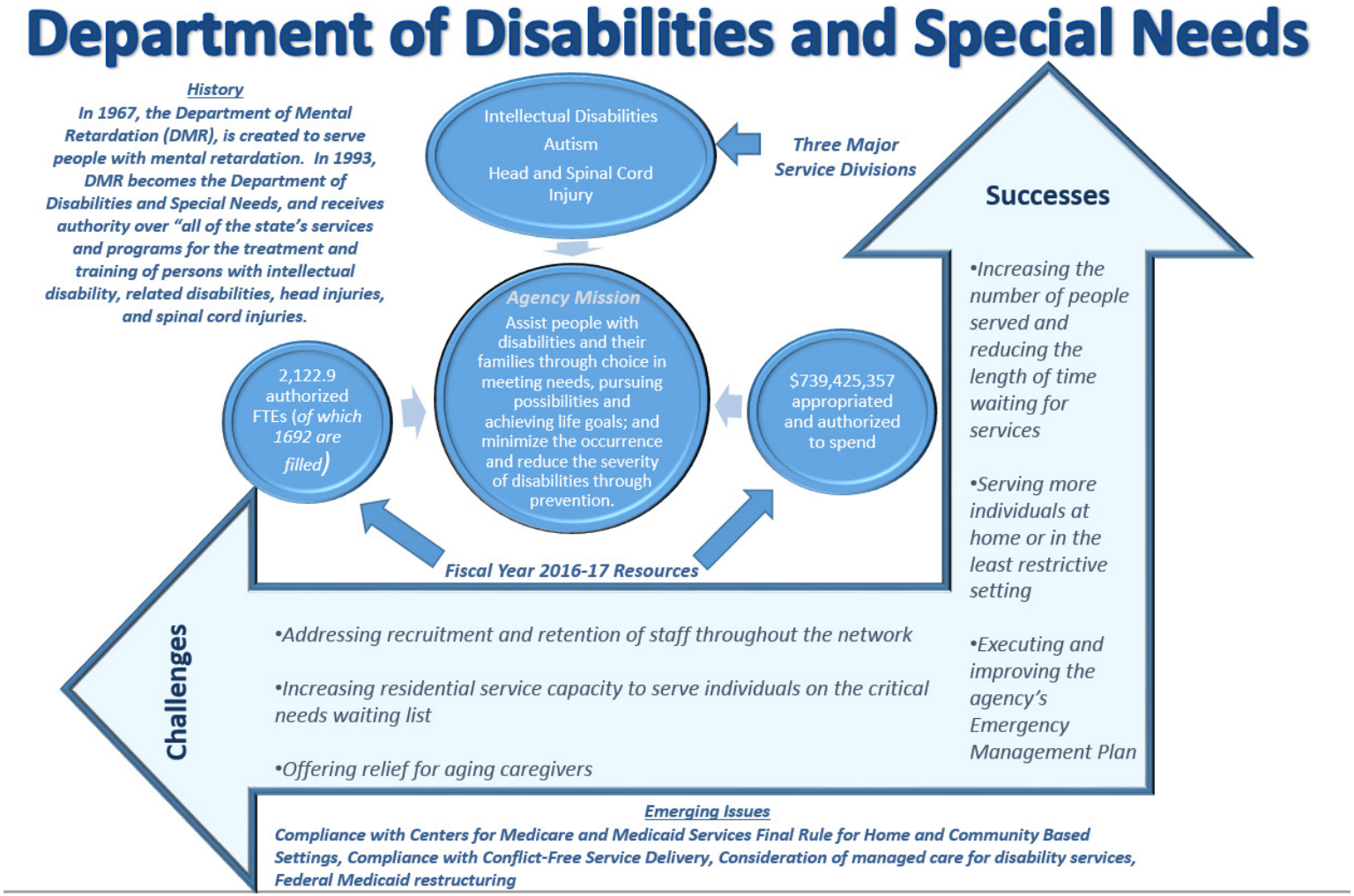

Figure 1. Snapshot of agency that includes its history, mission, resources, successes, challenges, and emerging issues. Source: Agency PER

AGENCY RECOMMENDATIONS

Recommendations for Internal Changes (May 2017 Program Evaluation Report)

1. Internal Change: *Evaluation of Abuse, Neglect, and Exploitation (ANE) reporting and follow up system.*

- The Legislative Audit Council (LAC) reviewed DDSN in 2014 and made several recommendations related to the ANE system. Last year DDSN asked the South Carolina Inspector General (SIG) to conduct a review of one of the private providers, SC Mentor. In this review the SIG made several recommendations about the South Carolina statewide ANE system. Most of the recommendations related to ANE centered around improving timely investigation and ensuring appropriate follow through of ANE allegations by the individual service provider and DDSN.
- DDSN hosted meetings with state agencies involved in the statewide ANE reporting and investigation process to discuss the potential implementation of the recommendations. DDSN does not have authority to unilaterally change this statewide process; it requires the cooperation of multiple agencies. This multi-agency group has referred several recommendations to the Adult Protection Coordinating Council as the entity best suited for further discussion and possible decision making on some of the recommendations. A specific recommendation of South Carolina having a single point of entry for all reports of potential ANE, regardless of the location or age of the vulnerable individual is being specifically discussed in multiple agency work groups.

    - DDSN staff are currently participating in meeting with the Institute of Medicine and Public Health to establish an Adult Abuse Registry. The need for an Adult Abuse Registry has been noted in several prior reviews of DDSN and other agencies supporting vulnerable adults. DDSN also continues representation on the Adult Protection Coordinating Council where a sub-group is working on the need for a single contact point for all allegations of abuse, neglect or exploitation towards vulnerable adults. The current system is complex and requires different entities to receive reports, depending on the age of the person affected or where the person lives.

    - DDSN staff are currently reviewing Standard of Care related data from the State Long-Term Care Ombudsman's office to improve transparency in the data shared with the public. Based on Federal guidelines, the SLTCOP uses 101 classifications for Standard for Care violations. DDSN is organizing similar complaint types into 7 distinct categories for internal reporting purposes. This information can them be used to target specific agency training aimed at improving consumer satisfaction and the overall quality of care.

- DDSN has modified some of the agency process to implement other aspects of the recommendations of the SIG or LAC and others are still under consideration.

    a) Stage of analysis; Recommendations are complete; some internal changes have been implemented; some are still under consideration; and others require discussion, approval and implementation by multiple entities, including state agencies or local law enforcement.

    b) Objectives and Associated Performance measures impacted and predicted impact;

        - Annual Rate of Substantiated Allegations of Abuse/Neglect/Exploitation Per 100 Served in Community Residential Settings: The recommendations center around ways to improve the existing statewide ANE system, which included better program review and enhanced resources improve timeliness of investigative closures and follow through from the provider and DDSN. These have the potential to improve the overall reporting and investigation of ANE allegations. If recommendations result in improved response and follow through and remediation of the circumstances surrounding allegations of ANE, potentially, the likelihood of repeated situations resulting in allegations of ANE will be lessened.

        - Annual Rate of Substantiated Allegations of Abuse/Neglect/Exploitation Per 100 Served in Regional Centers: Many of the recommendations centered around those allegations that result in referrals to Local Law Enforcement (LLE). Most allegations of ANE at the regional centers are investigated by the South Carolina Law Enforcement Division (SLED) unless the allegation involves a minor, in which case the investigation will be referred to the South Carolina Department of Social Services (DSS). The response time for these investigations are generally quicker than LLE. However, other changes in the overall statewide system could affect the Regional Centers as well.

    c) Costs of the objectives that will be impacted and the anticipated impact;

        - Objective 3.1.8: The annual rate of substantiated ANE per 100 served will be less than 0.07% in community residential settings and 0.25% in Regional Centers. Changes internal to DDSN or to the statewide system of reporting and investigation of ANE have potential to impact the reporting and tracking of the allegations as well as the quality of care resulting in the number of allegations.

    d) On which objective(s) the agency plans to utilize additional available funds if the change saves costs, or obtain funds if the change requires additional funds, and how the objective(s) receiving or releasing the funds will be impacted;

- The cost of implementation is not yet known.

e) **Anticipated implementation date:** Still under consideration and review; unknown.

*2. **Internal Change:** Changes to the Tracking and Reporting of Critical Incidents*

- DDSN tracked medically-oriented "critical incidents" and determined that they account for about 60% of all Critical Incident Reports submitted through the agency's web-based reporting system. Based on the fact that DDSN serves a population that is aging in place and some are receiving end of life care in their residential settings, DDSN will transition the medically-oriented events to Therap General Event Reporting (GER). The events that will be transitioned to Therap include hospitalizations, emergency room visits, illnesses such as flu or pneumonia, and major medical events (cardiac events, stroke, uncontrolled seizures, and admission to ICU or CCU). These events are medical in nature and are not the result of any action or inaction by staff supporting the DDSN service recipient.

- Falls, choking incidents, and any accidents involving serious injury will continue to be reported as "Critical Incidents." This will allow for better reporting of true "critical incidents" and better assist DDSN in supporting provider agencies with training and technical assistance with prevention efforts.

a) **Stage of analysis:** DDSN has already changed how these critical incidents are reported to the DSN Commission and other stakeholders. The change the data collection utilizing Therap will occur in summer 2017.

b) **Objectives and Associated Performance measures impacted and predicted impact:**

- Annual Rate of Critical Incidents Per 100 Served in Community Residential Settings: Shifting reporting and tracking of more routine medical incidents will allow the agency and providers to more appropriately focus on true critical incidents. This will likely afford more opportunity to engage in prevention efforts and remediation after an incident and therefore reduce the overall number of incidents.
- Annual Rate of Critical Incidents Per 100 Served in Regional Centers: Shifting reporting and tracking of more routine medical incidents will allow the agency and providers to more appropriately focus on true critical incidents. This will likely afford more time and opportunity to engage in prevention efforts and remediation after an incident and therefore reduce the overall number of incidents.
- Annual Rate of Fall Related Critical Incidents Per 100 Served in Community Residential Settings: This measure will continue to be measured through the Critical Incident Management System, but shifting the reporting and tracking of less critical, routine medical incidents will allow the agency and providers to more appropriately focus more severe incidents.
- Annual Rate of Fall Related Critical Incidents Per 100 Served in Regional Centers: This measure will continue to be measured through the Critical Incident Management

System, but shifting the reporting and tracking of less critical, routine medical incidents will allow the agency and providers to more appropriately focus more severe incidents.

c) Costs of the objectives that will be impacted and the anticipated impact:
   - Objective 3.1.6: Annual rate of falls leading to injury per 100 consumers served in community residential and Regional Centers will be less than 1.12. This data will continue to be measured through the Critical Incident Management System, but shifting the reporting and tracking of less critical, routine medical incidents will allow the agency and providers to more appropriately focus more severe incidents.
   - Objective 3.1.7: Annual rate of critical incident report per 100 consumers should not exceed 19 in residential settings and 39 in Regional Centers. Shifting reporting and tracking of more routine medical incidents will allow the agency and providers to more appropriately focus on true critical incidents. This will likely afford more opportunity to engage in prevention efforts and remediation after an incident and therefore reduce the overall number of incidents.
   - Objective 3.1.8: Modify the critical incident reporting program to focus collection on relevant incidents and eliminate benign incidents; establish criteria for proactive inquiry; and establish criteria for proactive inquiry; and establish performance benchmarks within 90 days after initiating modified process. Performance measure for this new initiative.

d) On which objective(s) the agency plans to utilize additional available funds if the change saves costs, or obtain funds if the change requires additional funds, and how the objective(s) receiving or releasing the funds will be impacted: There is no anticipated cost to the agency. This is a shift in how data is tracked and reported utilizing functions in the new electronic record system DDSN is implementing statewide.

e) Anticipated implementation date: Late summer 2017

3. Internal Change: Direct Service Operations – DDSN to develop and directly operate six small community based group homes for eighteen individuals with significant behavioral challenges.

- Historically DDSN has utilized the community network of local Disabilities and Special Needs Boards and Qualified residential providers to develop and operate community services. This service network currently provides a wide array of community residential services to approximately 4,725 individuals.
- This action is being taken due to the growing number of individuals on the DDSN Critical Needs List and the increase in the average time that an individual placed on the Critical Needs List has to wait to access residential services. The individuals placed on the Critical Needs List typically require out-of-home residential services to address their needs. The growth in the Critical Needs List and increased wait time to access residential services is attributable to a

growth in the number of individuals with significant behavioral needs and a limited interest by the existing community service network to serve individuals with significant behavioral needs.

- DDSN approached residential service providers specializing in supporting individuals with significant behavioral needs operating in other states but was unsuccessful in getting additional providers to come to South Carolina. While DDSN could opt to serve some of these individuals with significant behavioral needs in the DDSN operated regional centers, this would be contrary to the federal and state requirement to serve people with disabilities in the least restrictive community setting possible. To ensure availability of appropriate residential settings for individuals with significant behavioral needs DDSN will open and directly operate a small quantity of homes in the community.

a) **Stage of analysis:** Change is in the beginning stages and is projected to be completed late summer 2018.

b) **Objectives and Associated Performance measures impacted and predicted impact:** This initiative will create more community based residential options for individuals with significant behavioral needs.

- Ratio of Persons Served in HCB Waivers Versus ICF/IID will be at least 9.6 to 1 – By serving individuals with significant behavioral challenges in community waiver funded homes instead of regional centers, the ratio of persons served in HCB Waivers versus ICFs/IID will be strengthened.
- Number of Persons Served Per 100,000 General Population in 16 + Bed Facilities will be lower than the National Average – By serving individuals with significant behavioral challenges in community waiver funded homes instead of regional centers, the number of persons served in 16 + bed facilities will be prevented from increasing.
- Average Length of Wait for Individuals Place on Critical Needs List will be less than 60 Days - As additional community residential services for persons with significant behavioral challenges are developed, this will allow those individuals with significant behavioral challenges to be served from the Critical Needs List more quickly.
- Develop 6 DDSN directly operated community homes – this initiative is this performance objective.

c) **Costs of the objectives that will be impacted and the anticipated impact:**

- Strategy 2.2: Community Residential Services (residential habilitation services while still in the community)– Directly operating community residential services for persons with significant behavioral needs will avoid the higher costs associated the more restrictive ICF/IID facilities. DDSN will operate these homes at the same rate paid to community providers for this population, therefore the incurred cost is the same to the agency. This avoids placement of individuals into more restrictive and therefore more

costly settings; generating savings which may be utilized by the agency and community provider network to serve more individuals.

d) On which objective(s) the agency plans to utilize additional available funds if the change saves costs, or obtain funds if the change requires additional funds, and how the objective(s) receiving or releasing the funds will be impacted: DDSN will operate these homes at the same rate paid to community providers for this population, therefore the incurred cost is the same to the agency for Community residential services expansion for this population. This does avoid placement of individuals into more restrictive and therefore more costly settings. In doing so, this generates cost reductions which may be redirected by the agency and community provider network to serve more individuals.

e) Anticipated implementation date: August 2018

4. Internal Change: *Plan Review and Service Authorization* - *Move the approval of the Case Management Annual Support Plan and Medicaid Waiver Service Requests away from Case Management providers and to the DDSN Central Office.*

- Currently, each waiver participant's case manager is responsible for assessing, planning and authorizing waiver services for the participant. For most waiver services, the authority to approve the plan of care, including the amount of service a participant may receive, lies with the case manager. The State (DDSN and DHHS) conducts reviews of plans but do not approve plans prior to implementation.
- Bestowing this authority on the case manager, is not consistent with 42 CFR§441.301(b)(1)(i) and creates potential inconsistency and a conflict of interest in that case managers and/or Medicaid Targeted Case Management (MTCM) providers may, to address the same need, determine that differing amounts of waiver services are required to address the need. While some variances are to be expected, having this authority could be used by an MTCM provider to attract or maintain clientele. The current waiver documents also include the service of Waiver Case Management which, when implemented by DHHS, would put the Case Managers in a position to be authorizing the delivery of the service which they are being paid to provide.
- DDSN is in the process of developing policies and procedures for a system in which the Annual Plan and any changes throughout the year must be approved by DDSN Staff. This system change will benefit Case Management providers through increased system efficiencies and less opportunity for errors that result in recoupment of Medicaid funds. It will also benefit the individuals served through creating an approval environment that is consistent in its approval methodology and free of any potential operational conflict including the authorization of Waiver Case Management.

a) Stage of analysis: Change is in the final stages and will be implemented late summer 2017.

b) Objectives and Associated Performance measures impacted and predicted impact: This change will create a more consistent approval process for individuals served across the state while also minimizing the errors in the Support Plan that cause recoupment of funds. This also removes some

of the inherent conflict of interest present in the case of a Case Manager approving their own level of service and authorizing themselves to provide that service as required by CMS.

- Percent of Total Served Supported in Home and Compare to National Benchmark - As services are approved more consistently, the Measure of Average Annual Per Person HCB Waiver Cost may change as a more consistent approval process is utilized. The agency ensures that people are served at the most appropriate level and service dollars are used to support individuals appropriately in their homes avoiding more expensive residential placement whenever possible.
- Number of Persons Served Per 100,000 General Population and Compare to National Benchmark - As services are approved more consistently, the Measure of Average Annual Per Person HCB Waiver Cost may change as a more consistent approval process is utilized and therefore more individuals may be served with the same amount of funds.
- Average Annual Per Person HCB Waiver Costs and Compare to National Benchmark - As services are approved more consistently, the Measure of Average Annual Per Person HCB Waiver Cost may change as a more consistent approval process is utilized and therefore more individuals may be served with the same amount of funds.
- Number of Individuals on DDSN Managed HCB Waiver Waiting Lists - As services are approved more consistently, the Measure of Average Annual Per Person HCB Waiver Cost may change as a more consistent approval process is utilized and therefore more individuals may be served with the same amount of funds.
- Begin Centralization of Annual Service Authorizations by DDSN – this initiative is this performance objective.

c) Costs of the objectives that will be impacted and the anticipated impact:

- Strategy 2.1: In-Home Family Support Services (least restrictive community setting)– Approving waiver services at the central level will insure that services are utilized as intended, help prevent abuse and allow for more equitable distribution of funds/services.
- Strategy 4.1: Monitor organizational effectiveness through benchmarks – This will help ensure the in-home supports are appropriate and therefore help increase maximum utilization.

d) On which objective(s) the agency plans to utilize additional available funds if the change saves costs, or obtain funds if the change requires additional funds, and how the objective(s) receiving or releasing the funds will be impacted: Savings generated from this initiative will be utilized by the DDSN community provider network to maintain financial solvency and assure consumers are receiving the appropriate services commiserate with identified needs.

e) **Anticipated implementation date:** August 2017

5. Internal Change: DDSN Outcome-based Provider Evaluation

- DDSN is committed to understanding and responding to strategies that help improve organizational performance. Activities in this area are based on the work of the Council on Quality and Leadership (CQL). The strategies are based upon the organization, assessment and synthesis of reliable and valid data from multiple sources and have at their core common values and principles. The logic of the organizing principles is to help us understand, implement and produce results for our primary customers and their families
- The application of the Basic Assurances® involves two broad evaluation strategies – evaluation of both the system and the organizational practice. The modified system will comprise three components: (1) Periodic Review-Each residential and day service provider will be reviewed on a three year rotation, beginning with residential providers scoring below 85% on the Contract Compliance Review; (2) Development of Quality Enhancement Plan- After the Basic Assurances ® Review, the Contractor will review the provider's Quality Enhancement Plan, designed to move the provider towards person-centered services; and (3) Intermittent Review-after each provider has their initial review, the Contractor will monitor the provider's Quality Enhancement Plan that develops for the Basic Assurance findings.

a) **Stage of analysis:** DDSN has completed the changes necessary to issue the 5 year RFP for the contract with a Quality Improvement Organization (QIO) and will be submitting to the State Procurement Office of the State Fiscal Accountability Authority in early May 2017. The State Procurement Office should post the RFP for bidding in the summer of 2017.

b) **Objectives and Associated Performance measures impacted and predicted impact:**
   - Average overall contract compliance review score - While the actual percentage of the scores may not change, the review process will be increasingly focused on meaningful outcome measures of provider performance and less so on administrative compliance.
   - Annual number of community service providers with less than 70 % contract compliance review key indicator in one review area (total six possible review areas) – the increased focus on outcome and process measurements are expected to increase the overall level of compliance across multiple areas measured.

c) **Costs of the objectives that will be impacted and the anticipated impact:** DDSN anticipates the overall cost of the contract with the QIO to increase due to the increased requirement of using Basic Assurances® as part of the quality review process.
   - Strategy 2.2: Community residential Services (residential habilitation service while still in the community) – this initiative is expected to increase focus on process and consumer outcomes and therefore increase the overall provision of services statewide.

- Strategy 3.1: Quality assurance monitoring of providers' compliance with contract operational performance; consumer health, safety and welfare, and facility licensing standards- this initiative is expected to increase focus on process and consumer outcomes and therefore increase the overall provision of services statewide.
- Strategy 4.1: Monitor organizational effectiveness through benchmarks- this initiative is expected to increase focus on process and consumer outcomes and therefore increase the overall provision of services statewide.

d) On which objective(s) the agency plans to utilize additional available funds if the change saves costs, or obtain funds if the change requires additional funds, and how the objective(s) receiving or releasing the funds will be impacted: DDSN anticipates the overall cost of the contract with the QIO to increase due to the increased requirement of using Basic Assurances® as part of the quality review process. This increase in cost will be absorbed in the basic operating costs of the agency.

e) Anticipated implementation date: Fall of 2017

Agency Recommendations for Statutory Changes (PER Addendum, October 8, 2017)

1. Notification of applicant qualifying for services

Impacted Section	SC Code §44-20-370 (A)
Rationale	Should be amended to reflect that services are offered through private qualified providers as well as the county DSN boards.
Recommendation	(A) The department shall: (1) Notify applicants when they have qualified under the provisions of this chapter; (2) Establish standards of operation and service for private qualified providers and county disabilities and special needs programs funded in part or in whole by state appropriations to the department or through other fiscal resources under its control; (3) Review service plans submitted by private qualified providers and county boards of disabilities and special needs and determine priorities for funding plans or portions of the plans subject to available funds; (4) Review private qualified providers and county programs covered in this chapter; (5) Offer consultation and direction to private qualified providers and county boards; (B) The department shall seek to develop and utilize the most current and promising methods for the training of persons with intellectual disability, related disabilities, head injuries, and spinal cord injuries. It shall utilize the assistance, services, and findings of other state and federal agencies. The department shall disseminate these methods to private qualified providers and the county boards and programs providing related services.
Other Impacted Entities	Private qualified providers.

2. Establishes Self-Sufficiency Fund

Impacted Section	SC Code §44-28-10 thru 44-28-80
Rationale	Should be repealed because it was never established and the ABLE act is now in effect.
Recommendation	~~SECTION 44-28-10. Establishment of fund; purpose.~~ ~~There is established the Self-Sufficiency Trust Fund, separate and distinct from the general fund, in the State Treasury. The purpose of the Self-Sufficiency Trust Fund is to provide a life-care planning option to meet the supplemental service needs of individuals with disabilities in order to enable parents and families to plan a more secure future for their disabled dependents without fear of loss of benefits or invasion of trust principal.~~ ~~SECTION 44-28-20. Definition of "self-sufficiency trust."~~

~~For the purpose of this chapter "a self-sufficiency trust" means a trust created by a nonprofit corporation exempt from federal income taxes pursuant to Section 501(c)(3) of the Internal Revenue Code of 1986 and organized for purposes of providing care or treatment of one or more developmentally disabled, mentally ill, or physically handicapped persons eligible for services of the South Carolina Department of Disabilities and Special Needs, State Department of Mental Health, or the State Agency of Vocational Rehabilitation.~~

~~SECTION 44-28-30. State Treasurer custodian of trust fund; agreement to specify supplemental care or treatment for each beneficiary.~~

~~(A) The State Treasurer is the custodian of the Self-Sufficiency Trust Fund and pursuant to an agreement with the trustee of a self-sufficiency trust may accept money from a self-sufficiency trust in the name of a beneficiary for deposit in the Self-Sufficiency Trust Fund. The treasurer shall maintain a separate account in the Self-Sufficiency Trust Fund for each named beneficiary and shall promptly credit the account of a beneficiary with money received from a self-sufficiency trust on behalf of that beneficiary.~~

~~(B) The agreement, naming one or more beneficiaries residing in this State who are developmentally disabled, mentally ill, or physically handicapped, must specify the supplemental care or treatment to be provided for each named beneficiary with the money deposited in the Self-Sufficiency Trust Fund.~~

~~SECTION 44-28-40. Departments and Agency required to provide care or treatment using monies in fund account; vouchers.~~

~~(A) The South Carolina Department of Disabilities and Special Needs, State Department of Mental Health, or the State Agency of Vocational Rehabilitation must provide care or treatment for a beneficiary from monies available from the beneficiary's account maintained in the Self-Sufficiency Trust Fund.~~

~~(B) Upon proper certification by the South Carolina Department of Disabilities and Special Needs, the State Department of Mental Health, or the State Agency of Vocational Rehabilitation, the State Treasurer shall process vouchers from the Self-Sufficiency Trust Fund accounts for services provided pursuant to this section.~~

~~SECTION 44-28-50. Receipt of monies from fund not to reduce, impair, or diminish other benefits.~~

~~The receipt by a beneficiary of money from the Self-Sufficiency Trust Fund or of supplemental care or treatment provided with money from the fund may in no way reduce, impair, or diminish the benefits to which the beneficiary is otherwise entitled by law.~~

~~SECTION 44-28-60. Money not usable for supplemental care and treatment to be returned to depositing trust; interest.~~

~~If the State Treasurer after consultation with the South Carolina Department of Disabilities and Special Needs, the State Department of Mental Health, or the State Agency of Vocational Rehabilitation determines that the money in the account of a named beneficiary cannot be used for supplemental care or treatment of the beneficiary in a manner consistent with the~~

	~~agreement or upon request of the trustee of the self-sufficiency trust, the remaining money in the account and any accumulated interest promptly must be returned to the self-sufficiency trust which deposited the money in the Self-Sufficiency Trust Fund.~~ ~~**SECTION 44-28-70.** Crediting and allocation of interest.~~ ~~The State Treasurer shall credit interest earned on the Self-Sufficiency Trust Fund to the fund and shall allocate the interest pro rata to the accounts of the named beneficiaries of the fund.~~ ~~**SECTION 44-28-80.** Departments and Agency to promulgate regulations for implementation and administration of fund.~~ ~~The South Carolina Department of Disabilities and Special Needs, the State Department of Mental Health, and the State Agency of Vocational Rehabilitation shall promulgate regulations necessary for the implementation and administration of the Self-Sufficiency Trust Fund.~~
Other Impacted Entities	Department of Mental Health, Vocational Rehabilitation and State Treasurer's Office. Note: Service recipients of the Department of Mental Health and Vocational Rehabilitation use ABLE accounts. The ABLE accounts are administered by the State Treasurer's Office.

3. Establishes Disability Trust Fund

Impacted Section	SC Code §44-28-310 through 44-28-370
Rationale	Should be repealed because it was never established and the ABLE act is now in effect.
Recommendation	~~**SECTION 44-28-310.** Establishment of fund; purpose.~~ ~~There is established the Disability Trust Fund, separate and distinct from the general fund, in the State Treasury. The purpose of the Disability Trust Fund is to provide supplemental services to meet the needs of low-income and indigent individuals with disabilities.~~ ~~**SECTION 44-28-320.** Source of monies for fund.~~ ~~The State Treasurer may accept for deposit in the Disability Trust Fund:~~ ~~(1) monies left to the Disability Trust Fund by donors of a self-sufficiency trust defined in Article 1 of this chapter at the death of the disabled beneficiary; and~~ ~~(2) bequests and contributions from private donors, corporations, or foundations.~~ ~~**SECTION 44-28-330.** Use of monies in fund.~~ ~~Monies in the Disability Trust Fund must be expended solely to provide supplemental services to meet the need for care or treatment for low-income or indigent individuals with developmental disabilities, mental illness, or physical handicaps.~~

	~~SECTION 44-28-340. Interest earned to be credited to fund.~~ ~~The State Treasurer shall credit earned interest on the Disability Trust Fund to the fund.~~ ~~SECTION 44-28-350. Receipt of monies from fund not to reduce, impair, or diminish other benefits.~~ ~~The receipt by a beneficiary of money from the trust fund or of supplemental care or treatment provided with money from the trust fund does not in any way reduce, impair, or diminish the benefits to which the beneficiary is otherwise entitled by law.~~ ~~SECTION 44-28-360. Departments and Agency required to provide care or treatment to eligible beneficiaries using monies from fund.~~ ~~The South Carolina Department of Disabilities and Special Needs, State Department of Mental Health, or State Agency of Vocational Rehabilitation must provide care or treatment for the beneficiary from monies available from the Disability Trust Fund. These agencies are responsible only for the beneficiaries that meet their individual eligibility criteria.~~ ~~SECTION 44-28-370. Departments and Agency to promulgate regulations for implementation and administration of fund.~~ ~~The South Carolina Department of Disabilities and Special Needs, the State Department of Mental Health, and the State Department of Vocational Rehabilitation shall promulgate regulations necessary for the implementation and administration of the Disability Trust Fund.~~
Other Impacted Entities	Department of Mental Health, Vocational Rehabilitation and State Treasurer's Office. Note: Service recipients of the Department of Mental Health and Vocational Rehabilitation use ABLE accounts. The ABLE accounts are administered by the State Treasurer's Office.

4. Defines person with intellectual disability

Impacted Section	SC Code § 44-23-10 (22)
Rationale	Should be amended to have the same definition as the statute for DDSN at 44-20-30 (12)
Recommendation	~~(22) "Person with intellectual disability" means a person, other than a person with a mental illness primarily in need of mental health services, whose inadequately developed or impaired intelligence and adaptive level of behavior require for the person's benefit, or that of the public, special training, education, supervision, treatment, care, or control in the person's home or community or in a service facility or program under the control and management of the Department of Disabilities and Special Needs.~~ "Intellectual disability" means significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period.

Other Impacted Entities	None

5. Defines person with mental deficiency

Impacted Section	SC Code § 44-25-20g
Rationale	Should be amended to have the same definition as the statute for DDSN at 44-20-30 (12)
Recommendation	~~(g) "Mental deficiency" shall mean mental deficiency as defined by appropriate clinical authorities to such extent that a person so afflicted is incapable of managing himself and his affairs, but shall not include mental illness as defined herein.~~ "Intellectual disability" means significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period.
Other Impacted Entities	None

6. Governmental entities subject to zoning ordinances

Impacted Section	SC Code §6-29-770
Rationale	The notice provision Subsection (E) needs to be amended to remove requirement that notice must be given for a home for persons with disabilities as it violates the Federal Fair Housing Law.
Recommendation	(E) The provisions of this section do not apply to a home serving nine or fewer mentally or physically handicapped persons provided the home provides care on a twenty-four hour basis and is approved or licensed by a state agency or department or under contract with the agency or department for that purpose. A home is construed to be a natural family or such similar term as may be utilized by any county or municipal zoning ordinance to refer to persons related by blood or marriage. ~~Prior to locating the home for the handicapped persons, the appropriate state agency or department or the private entity operating the home under contract must first give prior notice to the local governing body administering the pertinent zoning laws, advising of the exact site of any proposed home. The notice must also identify the individual representing the agency, department, or private entity for site selection purposes. If the local governing body objects to the selected site, the governing body must notify the site selection representative of the entity seeking to establish the home within fifteen days of receiving notice and must appoint a representative to assist the entity in selection of a comparable alternate site or structure, or both. The site selection representative of the entity seeking to establish the home and the representative of the local governing body shall select a third mutually agreeable person. The three persons have forty-five days to make a final selection of the site by majority vote. This final selection is binding on the entity and the governing body. In the event no selection has been made by the end of the forty five day period, the entity establishing the home shall select the site without further~~

	~~proceedings~~. An application for variance or special exception is not required. No person may intervene to prevent the establishment of a community residence without reasonable justification.
Other Impacted Entities	Local County Governments. Note: As County Zoning Ordinances should already be compliant with federal statutes, there should be no negative impact to county government operations.

7. Priority list of persons who can make healthcare decisions (modified July 16, 2018 via letter (Appendix A))

Impacted Section	SC Code §44-66-30(A); 44-26-40; 44-26-50; and 44-26-60(C)
Rationale	Amend to replace section previously removed with an amendment
Recommendation	SECTION 44-66-30. Persons who may make health care decisions for patient who is unable to consent; order of priority; exceptions. (A) Where a patient is unable to consent, decisions concerning his health care may be made by the following persons in the following order of priority: (1) a guardian appointed by the court pursuant to Article 5, Part 3 of the South Carolina Probate Code, if the decision is within the scope of the guardianship; (2) an attorney-in-fact appointed by the patient in a durable power of attorney executed pursuant to Section 62-5-501, if the decision is within the scope of his authority; (3) a person given priority to make health care decisions for the patient <u>when the agency has taken custody of the patient</u> by another statutory provision; (4) a spouse of the patient unless the spouse and the patient are separated pursuant to one of the following: (a) entry of a pendente lite order in a divorce or separate maintenance action; (b) formal signing of a written property or marital settlement agreement; or (c) entry of a permanent order of separate maintenance and support or of a permanent order approving a property or marital settlement agreement between the parties; (5) an adult child of the patient, or if the patient has more than one adult child, a majority of the adult children who are reasonably available for consultation; (6) a parent of the patient; (7) an adult sibling of the patient, or if the patient has more than one adult sibling, a majority of the adult siblings who are reasonably available for consultation; (8) a grandparent of the patient, or if the patient has more than one grandparent, a majority of the grandparents who are reasonably available for consultation;

(9) any other adult relative by blood or marriage who reasonably is believed by the health care professional to have a close personal relationship with the patient, or if the patient has more than one other adult relative, a majority of those other adult relatives who are reasonably available for consultation;

(10) a person given authority to make health care decisions for the patient by another statutory provision.

SECTION 44-26-40. Determination of competency to consent to or refuse major medical treatment.

If a client resides in a facility operated by or contracted to by the department, the determination of that client's competency to consent to or refuse major medical treatment must be made pursuant to Section ~~44-66-20(6)~~ 44-66-20(8) of the Adult Health Care Consent Act. The department shall abide by the decision of a client found competent to consent.

SECTION 44-26-50. Health care decisions of client found incompetent to consent to or refuse major medical treatment.

If the client is found incompetent to consent to or refuse major medical treatment, the decisions concerning his health care must be made pursuant to Section 44-66-30 of the Adult Health Care Consent Act. An authorized designee of the department may make a health care decision pursuant to Section ~~44-66-30(8)~~ 44-66-30(10) of the Adult Health Care Consent Act. The person making the decision must be informed of the need for major medical treatment, alternative treatments, and the nature and implications of the proposed health care and shall consult the attending physician before making decisions. When feasible, the person making the decision shall observe or consult with the client found to be incompetent.

SECTION 44-26-60. Health care decisions of minor clients.

(A) If the client is a minor, the decisions concerning his health care must be made by the following persons in the following order of priority:

(1) legal guardian;

(2) parent;

(3) grandparent or adult sibling;

(4) other relative by blood or marriage who reasonably is believed by the health care professional to have a close personal relationship with the client;

(5) other person who reasonably is believed by the health care professional to have a close personal relationship with the client;

(6) authorized designee of the department.

(B) If persons of equal priority disagree on whether certain health care must be provided to a client who is a minor, a person authorized in subsection (A), a health care provider involved in the care of the client, or another person interested in the welfare of the client may petition the probate court for an order determining what care is to be provided or for appointment of a temporary or permanent guardian.

	(C) Priority under this section must not be given to a person if a health care provider, responsible for the care of a client who is unable to consent, determines that the person is not reasonably available, is not willing to make health care decisions for the client, or is unable to consent as defined in Section ~~44-66-20(6)~~ 44-66-20(8) of the Adult Health Care Consent Act. (D) In an emergency health care may be provided without consent pursuant to Section 44-66-40 of the Adult Health Care Consent Act to a person found incompetent to consent to or refuse major medical treatment or who is incapacitated solely by virtue of minority.
Other Impacted Entities	

8. Definition of facility in Omnibus Adult Protection Act (OAPA)

Impacted Section	SC Code § 43-35-10(4)
Rationale	To add day programs to the definition of facility type.
Recommendation	4) "Facility" means a nursing care facility, community residential care facility, a psychiatric hospital, day program or any residential program operated or contracted for operation by the Department of Mental Health or the Department of Disabilities and Special Needs.
Other Impacted Entities	Department of Mental Health

9. Sharing of information related to investigations under the Adult Protection Act (OAPA)

Impacted Section	SC Code § 43-35-60
Rationale	Require agencies to share the case disposition with the relevant facility.
Recommendation	Unless otherwise prohibited by law, a state agency, an investigative entity, and law enforcement may share information related to an investigation conducted as a result of a report made under this chapter. An investigative entity and law enforcement shall share specific case dispositions with the relevant facility. Information in these investigative records must not be disclosed publicly.
Other Impacted Entities	SLED, Long term Care Ombudsman, DSS, DMH, local law enforcement agencies and Office of the Attorney General.

Agency Recommendations for Regulatory Changes (PER Addendum, October 8, 2017)

1. License requirement for facilities and programs

Impacted Section	SC Code of Regulations 88-105 thru 88-920 et seq.
Rationale	The former Department of Mental Retardation is now the Department of Disabilities and Special Needs.
Recommendation	Should be amended to change the name of the agency from the South Carolina Department of Mental Retardation to the Department of Disabilities and Special Needs throughout the regulations.
Other Impacted Entities	None

2. Scope

Impacted Section	SC Code of Regulation 88-105A
Rationale	Should be amended to denote programs receiving funds through DDSN and to rename the Department.
Recommendation	A. No program receiving funds through DDSN shall be operated in part or in full for the care, maintenance, education, training or treatment of ~~more than two~~ persons with intellectual disability unless a license is first obtained from the South Carolina ~~Department of Mental Retardation~~ Department of Disabilities and Special Needs. "In part" shall mean a program operating for at least ten (10) hours a week.
Other Impacted Entities	None

3. Recreational Camp

Impacted Section	SC Code of Regulations 88-110 D(1)
Rationale	Should be repealed as DDSN no longer licenses recreational camps or Sheltered Workshops.
Recommendation	D. The license will specify the name of the licensee, the maximum number of participants to be present at the facility at one time and the type of program it is determined to be. The program type is designated as follows: ~~(1) Recreation Camp;~~ ~~(a) Residential;~~ ~~(b) Day.~~ ~~(5) Sheltered Workshop;~~
Other Impacted Entities	None

4. Applications for License

Impacted Section	SC Code of Regulations 88-120 A and B
Rationale	Should be amended to have applications going to the Department of Disabilities and Special Needs.
Recommendation	A. Applications for license shall be made to the Department. ~~appropriate regional office of the South Carolina Department of Mental Retardation, Community Program Division:~~ ~~(1) Coastal Region~~ ~~Suite 907—Summerall Center~~ ~~19 Hagood Street~~ ~~Charleston, South Carolina 29403~~ ~~(2) Midlands Center~~ ~~8301 Farrow Road.~~ ~~Columbia, South Carolina 29203~~ ~~(3) Pee Dee Center~~ ~~Post Office Box 3209~~ ~~Florence, South Carolina 29502~~ ~~(4) Whitten Center~~ ~~Post Office Drawer 239~~ ~~Clinton, South Carolina 29325~~ B. Applicants will be provided the appropriate forms for licensing upon request from ~~one of the above locations~~ the Department.
Other Impacted Entities	None

5. Waivers

Impacted Section	SC Code of Regulations 88-130 A and B
Rationale	Should be amended to change Commissioner to Department throughout.
Recommendation	A. The ~~Commissioner~~ Department may waive compliance with one or more of the requirements of these regulations if, in ~~his~~ the Department's judgment, the waiver would not endanger the safety of the participants, staff, or the public, and would not reduce significantly the quality or quantity of the services to be provided. B. To request a waiver, the applicant or licensee must make a written application to the ~~Commissioner~~ Department which includes the justification for the request for a waiver and must first be reviewed by the appropriate ~~regional superintendent~~ Department staff with approval by the state director.

Other Impacted Entities	None

6. Definitions

Impacted Section	SC Code of Regulations 88-210
Rationale	Should be amended to reflect current definitions.
Recommendation	88-210 Definitions. For the purpose of these regulations the following definitions apply: A. Agency—An organization either public or private which is operated by a board of directors or other governing body and which offers programs to persons with intellectual disability. B. Applicant—Any agency who has applied for a license from the Department. C. Client—A person ~~with intellectual disability~~ who has been deemed eligible for services by the Department and who is participating in a program in the State or is on the waiting list for services from the Department. The Department is required to provide community and residential service programs ~~similar to those provided~~ to persons with intellectual disability to ~~substantially handicapped epileptic, cerebral palsied,~~ autistic, and other developmentally disabled individuals ~~whose treatment and training needs approximate those of the persons with intellectual disability.~~ Eligibility for services shall be determined by the Department. It is intended that the Department not duplicate other State agency programs or develop service modalities which normally would be considered to be the legal and programmatic mandate of another State agency. D. ~~Commissioner~~ Director—The chief administrator of the Department of ~~Mental Retardation~~ Disabilities and Special Needs or his designee. E. Department—The South Carolina Department of Mental Retardation. (SCDMR) F. Developmental Period—The period of time between conception and the twenty-second birthday. G. Governing Board—The individuals or group that have legal responsibility for the agency or organization which operates the day program. H. License—A document issued by the Department to an agency operating a program indicating that the licensee is in compliance with the provisions set forth in these regulations and other standards as specified in these regulations. I. Licensee—The agency who holds the primary responsibility for providing services and compliance with these regulations. J. Licensor—The Department of ~~Mental Retardation~~ Disabilities and Special Needs. K. ~~Mental Retardation—Refers to significantly sub-average general intellectual functioning resulting in or associated with concurrent impairments in adaptive behavior and manifested during the developmental period.~~ Intellectual disability" means significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period.

	L. Participant—Any person with intellectual/related disability, autism or head and spinal cord injury who is participating in a program licensed by the Department. M. ~~Regional Office—The SCDMR office which performs the license survey and issues the license.~~ N. Permit—a written permit, issued by the health authority permitting the food service, camp, swimming pool or natural bathing area to operate under S. C. Department of Health and Environmental Control regulations.
Other Impacted Entities	None

7. Recreational Camps for Persons with Intellectual Disability.

Impacted Section	SC Code of Regulations 88-310 thru 88-395
Rationale	Repeal the regulations as DDSN does not license Recreational Camps for Persons with Intellectual Disabilities.
Recommendation	~~88-310 Definitions.~~ ~~A. Activity Specialist—An individual who has skills in and is responsible for conducting camper-participation activities such as arts and crafts, swimming, sports, camping, etc.~~ ~~B. Aquatic Guard—A waterfront staff member who is responsible to the aquatic supervisor for the supervision of campers during any aquatic activities.~~ ~~C. Aquatic Supervisor—Is in charge at a waterfront for supervising the entire swimming program including, but not limited to, free swim, swim lessons, swimming ability tests, boating, waterfront play and who is also responsible for the supervision of the aquatic guards.~~ ~~D. Camper—A person with intellectual disability who is attending either a licensed Recreation Residential Camp or a Recreation Day Camp.~~ ~~E. Campsite—The land, including the natural and man-made features, where the camp program is being offered.~~ ~~F. Comprehensive Plan—The plan of operation that sets forth all aspects of the camp program including the major program emphasis and the range of participants to be served.~~ ~~G. Counselor—An individual who directly supervises the campers and who is responsible to the camp director.~~ ~~H. Counselor-in-Training—An individual who participates in a specific camper-leadership-development program, but has no direct supervision or responsibility for campers.~~ ~~I. Recreation Day Camp—A program of recreation activities for the camper with intellectual disability with an emphasis on outdoor and camping activities that utilize trained leadership and the natural or man-made outdoor surroundings to contribute to the camper's mental, physical, and social growth and which provides services for less than twenty-four hours a day.~~

~~J. Recreation Residential Camp—A program of recreation activities for the camper with intellectual disability with an emphasis on outdoor and camping activities that utilize trained leadership and the natural or man made outdoor surroundings to contribute to the camper's mental, physical and social growth and which provides four or more consecutive twenty-four hour periods of camp programming at one or more campsites.~~

~~Code Commissioner's Note~~

~~Pursuant to 2011 Act No. 47, Section 14(B), the Code Commissioner substituted "intellectual disability" for "mental retardation" and "person with intellectual disability" or "persons with intellectual disability" for "mentally retarded." At the Code Commissioner's discretion, the substitution was not made for the formal reference to the South Carolina Department of Mental Retardation in this regulation.~~

~~88-315 Campsite.~~

~~The Campsite will meet the appropriate requirements of the Rules and Regulations Governing Camps as published by the South Carolina Department of Health and Environmental Control.~~

~~88-320 Supervision.~~

~~Each camp program shall be under the supervision of a qualified camp director. The director shall designate other staff persons to be in charge during temporary absences. The director is in charge of the camp the entire period campers are present.~~

~~88-325 Personnel.~~

~~A. A residential camp director shall meet the following requirements:~~

~~(1) Be at least 21 years of age;~~

~~(2) Possess an earned baccalaureate degree in recreation, business administration, special education or a related field;~~

~~(3) Have at least two year's experience in camp programs.~~

~~B. A Day camp director shall meet the following criteria:~~

~~(1) Be at least 21 years of age;~~

~~(2) Possess an earned baccalaureate degree in recreation, business administration, special education or a related field;~~

~~(3) Have at least one year experience in camp programs.~~

~~C. Counselors shall:~~

~~(1) Have at least a tenth grade education;~~

~~(2) Be at least sixteen years of age.~~

~~D. Activity Specialists shall:~~

~~(1) Have at least an eighth grade education;~~

~~(2) Be at least sixteen years of age;~~

~~(3) Have training or experience in the program speciality which they will be teaching.~~

~~E. Counselors-in-training shall:~~

~~(1) Have at least an eighth-grade education;~~

~~(2) Be 14 years of age.~~

~~F. Aquatic supervisor will:~~

~~(1) Be at least 17 years of age;~~

~~(2) Have a current water safety instructor certificate from the American Red Cross.~~

~~G. Aquatic guard will be currently certified by the American Red Cross as an Advanced Lifesaver or in Lifeguard Training.~~

~~H. All camp staff will participate in a pre-camp training session. The training session content and participation will be documented.~~

~~88-330 Size of Staff.~~

~~A. There shall be one staff member, excluding dietary, transportation, counselors-in-training, and janitorial staff, for each five campers in a residential program.~~

~~B. There shall be one staff member, excluding dietary, transportation, counselors-in-training and janitorial staff for each ten campers in a day camp program depending on functioning level and needs of campers.~~

~~C. Upon consideration of the ages, the severity of handicapping conditions, and the services needed by the campers, the Department may approve or require a different staff/camper ratio, but in no case shall there be less than one staff member for each ten campers. Counselors-in-training may not be considered in calculating the staff/camper ratio.~~

~~D. The approved staff/camper ratio shall be maintained during all periods when campers are present.~~

~~88-335 Personnel Records.~~

~~A. The camp shall maintain records on each camp employee which contains at a minimum the following:~~

~~(1) Full name;~~

~~(2) Address;~~

~~(3) Age;~~

~~(4) Training;~~

~~(5) Education;~~

~~(6) Work Experience;~~

~~(7) Other qualifications;~~

~~(8) The names and telephone numbers of persons to be notified in the event of emergency;~~

~~(9) Documented evidence of freedom from tuberculosis at the time of employment (dated within one month from date of first day of camp);~~

~~(10) A signed statement indicating the they have never been charged or convicted of a crime of abuse or neglect.~~

88-340 General Health.

A. Health information shall be maintained on every camper which shall include:

(1) A health-status questionnaire on a form approved by the Department, completed and signed by the camper's parent or guardian within ninety (90) days prior to camp.

(2) A report of a physical examination performed by a licensed physician within twelve months preceding entry into camp, or a statement, signed by the camper's parent/guardian, that having been advised that examination by a physician is required, the parent/guardian requests that this requirement be waived and state reason in writing.

B. Every camp shall have a written policy which provides for daily health surveillance of campers and staff. If a camper or staff member is suspected of having a communicable disease, he shall be isolated and medical treatment obtained.

C. Health records shall be readily available to all camp personnel and shall include:

(1) Camper's name, address, telephone number of parent/guardian or person to contact in case of emergency;

(2) Authorization for emergency medical care signed by the parent/guardian of each camper;

(3) Written authorization to administer any medication signed by the parent/guardian;

(4) A list of known allergies or drug reactions.

D. Injury and Illness Reports

(1) If an injury or illness is judged by the camp director to be serious, the camp health director shall be notified immediately and the camper's parent/guardian will then be notified. A record of each contact or each attempt to contact the parent/guardian shall be maintained. The camp director will be responsible for obtaining the necessary medical services and informing the appropriate regional office within 5 hours of injury or illness.

(2) A medical log shall be maintained which contains a list of dates, names of patients, ailments, and treatments prescribed.

(3) A report for each serious injury, illness, abuse, neglect or fatality which occurs at camp shall be recorded in a critical incident log which shall be submitted for review by the regional office staff of the Department and other authorized personnel.

E. Health Staff

(1) A residential camp shall have on duty at all times campers are present, a camp health director who is one of the following:

(a) Currently certified by the American Red Cross in Advanced First Aid and Emergency Care;

(b) A licensed physician;

(c) A registered nurse;

(d) A licensed practical nurse;

(e) A licensed Emergency Medical Technician.

(2) A day camp shall have on duty at all times campers are present, a camp health director who is one of the following:

~~(a) Currently certified by American Red Cross in Basic or Standard First Aid;~~
~~(b) A licensed physician;~~
~~(c) A registered nurse;~~
~~(d) A licensed practical nurse;~~
~~(e) A licensed Emergency Medical Technician.~~
~~F. Medication~~
~~(1) Medication prescribed for campers or staff members shall be kept in the original containers bearing the pharmacy label which shows drug name, the prescription number, date filled, physician's name, direction for use, and patient's name.~~
~~(2) Medication shall be stored in a locked container.~~
~~(3) The health director shall:~~
~~(a) Record all in-coming medication;~~
~~(b) Inventory all medication daily;~~
~~(c) Be responsible for proper maintenance and storage of all medication.~~
~~(4) When any medication is administered to a camper, the date, dosage, time and name of staff member administering the medication shall be recorded in the medical log.~~
~~(5) When no longer needed, medications shall be returned to parents/guardian or other authorized persons and a record of the disposition of unused medication shall be maintained which includes the camper's name, the drug name, the prescription number, the amount disposed of, the name of the staff disposing of the medication and the manner and date of disposition.~~

~~88-345 General Safety.~~
~~A. Equipment and facilities used in a camp program shall be of good quality and designed to minimize the likelihood of injury.~~
~~B. Potentially hazardous equipment such as archery equipment, shall be placed in locked storage when not in use. The camp director shall designate a person to be responsible for safe keeping of potentially hazardous equipment.~~
~~C. Power equipment shall not be stored, operated or left unattended without proper safeguards. All power tools will be stored in a locked place which is not accessible to campers. Campers will not use power equipment unless supervised by a qualified person.~~
~~D. Equipment used for arts and crafts shall be in good repair and properly installed.~~
~~E. Playground equipment shall be securely anchored, safe and in good repair.~~
~~F. All watercraft shall be equipped with US Coast Guard approved personal flotation devices of types I, II, or III which are prescribed for the specific type of craft and number and age of occupants. Each camper aboard a watercraft shall wear an approved life jacket.~~

~~G. All swimming and diving areas shall be provided with a bell or whistle, two assist poles and a ring buoy that are in good usable condition.~~

~~H. All piers, floats and platforms shall be in good repair.~~

~~I. All potentially hazardous camp activities such as archery, aquatics, and riding shall be supervised by a qualified activity specialist. Camps which provide such activities shall submit with the license application a description of the safety practices which are designed to minimize the likelihood of injury.~~

~~88-350 Emergency Procedures.~~

~~A. Emergency procedures for serious accidents, illness, lost camper, missing swimmer, and for evacuation in case of fire or natural disaster will be prominently posted at the campsite.~~

~~B. Appropriate telephone numbers for emergency services will be legible and prominently posted at the camp site.~~

~~C. Each staff member of the camp shall be informed in advance of his duties in case of emergency. Documentation of staff training and evidence of staff awareness of his duties shall be on file at the camp site.~~

~~D. Fire and emergency drills shall be conducted the first day of camp and documented at least once each camp period or once every week.~~

~~E. Coordination with county Disaster Preparedness Office is required and must be documented.~~

~~88-355 General Sanitation Requirements.~~

~~The camp shall meet the requirements of the S. C. Department of Health and Environmental Control's Regulation 61-39. A current S. C. Department of Health and Environmental Control inspection report and plan for correction of deficiencies shall be maintained in the camp's records. Campgrounds, pools and natural bathing areas which are permitted by the S. C. Department of Health and Environmental Control will be deemed to have met this requirement.~~

~~88-360 Housing in Residential Camps.~~

~~All housing facilities in a residential camp shall meet the appropriate requirements of SCDHEC.~~

~~88-365 Nutrition and Food Service.~~

~~A. In camps where central food service facilities are provided, the facilities shall be constructed and operated in accordance with S. C. Department of Health and Environmental Control Regulation 61-25. A current permit and inspection report shall be maintained in the camp.~~

~~B. Each camp shall establish written procedures for its nutrition and food service program. These policies shall include meal patterns, meal hours, types of food served, staff responsibilities during the meal time and the administration of the food service program.~~

~~C. When a camper needs a special diet, it shall only be administered according to the orders of a licensed physician. Records of special diets and menus will be kept at the camp. Separate arrangements shall be made by camper's parent/guardian for any special diets beyond the capability of the camp.~~

~~D. Menus shall be planned at least a week in advance and shall be dated as to the week of use. The current week's menus shall be posted in the food preparation area. Substitutes shall be noted on the menus in writing. After use, the menus shall be kept on file for the period of the camping session.~~

~~E. Mealtimes shall be scheduled to meet the camper's needs and spaced so there are no more than fourteen hours between evening meal and breakfast. At least three nutritionally balanced meals shall be served in a residential camp each full day of operation.~~

~~F. Meals shall be prepared as close to serving time as possible and served in portions appropriate to the nutritional needs of the camper.~~

~~88-370 Transportation.~~

~~A. Responsibility for campers being transported~~

~~(1) When a camp provides transportation for a camper, it shall also provide staff supervision other than the driver on the vehicle between the pickup site and the delivery site.~~

~~(2) Travel time of campers to and from day camps shall not exceed two hours per one-way trip.~~

~~(3) Ten hours travel time shall be the maximum permitted in any twenty-four (24) hour period for campers when traveling to and from field trips.~~

~~B. Responsibilities in Transit~~

~~(1) Only that number of campers for whom there is seating space shall be transported in a vehicle. The maximum capacity of the vehicle shall clearly be indicated and posted in the vehicle.~~

~~(2) In all vehicles used, seats, benches and or wheelchairs must be securely fastened to the floor. Open body or stake bed vehicles are not permitted for transportation of passengers.~~

~~(3) All vehicles (except school buses) should have seatbelts which are used by all passengers and drivers when vehicle is in motion.~~

~~C. Responsibility for Drivers and Vehicles~~

~~(1) Vehicle operators shall:~~

~~(a) Be licensed drivers;~~

~~(b) Have a proven good driving record.~~

~~(2) All road vehicles shall be equipped with a first aid kit, fire extinguisher, flares and/or reflectors.~~

~~(3) All road vehicles shall be maintained in safe operating condition as evidenced by a vehicle maintenance schedule. All vehicles will have a current safety inspection sticker.~~

~~(4) Campers shall not be allowed to repair or assist in the repair of any vehicle if there is danger of injury to the camper either by the process of repair or from the environment in which the repair is to be conducted.~~

~~88-375 Program.~~

~~A. A comprehensive plan of operation shall be developed. It shall include a statement of major program emphases designed for camper development. A written outline of the methods by which the programs for camper development are to be conducted shall be included in the comprehensive plan.~~

~~B. The program shall have a broad spectrum of activities and experiences appropriate to the campers' levels of abilities and needs. All components of the camp's environment shall offer opportunities by which campers shall learn and broaden their bases of experience.~~

~~C. If in the comprehensive plan the purpose of the camp is to include any carry over of goals from the individual education plan designed by the school or the individual program plan designed by the day program, the camp must obtain program recommendations from the regular program prior to camp start up.~~

~~D. The rationale for separating the campers into groups must be outlined in the plan and approval obtained from the Department.~~

~~88-380 Waterfront Activity.~~

~~A. Waterfront Staff~~

~~(1) When swimming or when watercraft activities are in progress, the aquatic activity supervisor shall be in attendance to supervise the program.~~

~~(2) The aquatic staff shall not be engaged in recreational swimming or boating while on waterfront duty.~~

~~(3) One aquatic supervisor or one aquatic guard shall be on duty for every ten, or fraction thereof, campers in the water. Other staff members shall be present and on duty to maintain the staff/camper ratio required in R. 88-330 A, B, C and D.~~

~~(4) When waterfront activities are occurring at more than one location simultaneously there will be at least one aquatic guard present for every ten campers at each location.~~

~~(5) The aquatic supervisor shall ensure that the ratio is adjusted to meet such factors as water conditions, number and types of swimmers, and functional level of the swimmers.~~

~~B. Swimming Areas~~

~~(1) The swimming area shall be maintained in a clean and safe condition. Any known hazard such as rocks, holes or hidden dangers shall be properly safeguarded and posted.~~

~~(2) The permanent swimming area of a camp shall have a delineation of areas for non-swimmers, intermediates, and advanced swimmers, in accordance with the standards of the American Red Cross or Boy Scouts of America.~~

~~(3) Lifesaving equipment shall be provided at all swimming areas and placed so it is immediately available in case of an emergency.~~

~~(4) Swimming at sites other than the permanent camp waterfront is prohibited except by prior written approval from the Department.~~

~~C. Swimming Procedures~~

~~(1) Swimming ability tests either recognized by American Red Cross or Boy Scouts of America will be administered to each camper at the beginning of the camping session. Campers will then be confined to an area equal to their identified swimming ability or to areas requiring lesser skills.~~

~~(2) A method approved in writing by the Department for the supervision and checking of swimmers shall be written by the camp director and enforced by the aquatic staff. The method used shall require each swimmer to be checked at least every ten minutes. A written "lost swimmer" plan shall be established and all staff members shall know in advance exactly what their duties are in case of an emergency at the waterfront.~~

~~(3) Swimming is prohibited during the hours of darkness in the ocean, lakes, or rivers. Nighttime swimming in lighted swimming pools shall be prohibited unless the activity is included as part of the comprehensive plan.~~

~~(4) There shall be provided a regularly scheduled ten minute relief break each hour for waterfront staff and a rotation of assigned areas will occur every hour. Guards shall not leave their assigned areas until properly relieved.~~

~~D. Seizure Client Procedures~~

~~(1) The camp shall have written permission from parents/guardians for clients with seizures to engage in any waterfront or aquatic activities.~~

~~(2) All seizure clients will be clearly visually identifiable while engaging in any aquatic activity.~~

~~(3) Staff shall be knowledgeable of client reactions to seizure, and written procedures for care shall be visibly posted within the waterfront area.~~

~~88-385 General Care of Campers.~~

~~A. Policies and practices for managing the behavior of a camper shall be clearly stated and furnished in writing to all employees of the camp.~~

~~B. A camper shall not be subjected to any of the following as a means of punishment:~~

~~(1) Corporal punishment;~~

~~(2) Food deprivation;~~

~~(3) Abusive physical exercise.~~

~~C. If the camp permits the involuntary removal of a camper from social contact with others, there shall be a written policy which has been approved by DMR which describes the conditions under which and the manner in which it shall be done. Each such incident shall be documented.~~

~~D. Policies and procedures for removal of a camper from the camp will be clearly outlined in writing and contain provisions for:~~

~~(1) Naming camp staff authorized to make decision to remove;~~

	~~(2) Consultation and approval from regional office prior to dismissal or removal;~~ ~~(3) Conditions which would cause the action to occur which will include:~~ ~~(a) Danger to self or others;~~ ~~(b) Medical causes;~~ ~~(c) Severe behavior disruptions;~~ ~~(d) Family intervention.~~ ~~88-390 Confidentiality.~~ ~~All information in a camper's record shall be considered privileged and confidential. Staff shall not disclose or knowingly permit the disclosure of any information concerning the client or family directly or indirectly to any unauthorized person.~~ ~~88-395 Reserve Clause.~~ ~~The Department reserves the right to require a camp to correct or eliminate any specific condition not covered in these regulations if the correction or elimination of such condition is deemed necessary for the preservation of life and the prevention of injury or illness at the camp.~~
Other Impacted Entities	None

8. Personnel

Impacted Section	SC Code of Regulations 88-410(2)
Rationale	Amend to reflect current staff qualifications, ratios and supervision.
Recommendation	2) Direct Care Staff - The direct care staff will meet the following qualifications: (a) Be at least eighteen years old. (b) Have a valid high school diploma or its <u>certified equivalent.</u> B. Participant/Staff Ratios (1)~~There will be at least the following minimum participant/staff ratio for each program: (a) Child Development Center - 5:1;~~ ~~(b) Adult Activity Center - 7:1; (c) Work Activity Center - 7:1; (d) Sheltered Workshop - 10:1.~~ <u>Ratios for each program should be determined based on each participant's supervision needs as outlined in DDSN Directives with a minimum participant/staff ratio of 7:1.</u> (2) Upon consideration of the ~~ages, the severity of handicapping conditions, and the services needed by the participants,~~ <u>the support needs ~~and the~~ of the participant</u>, the Department may approve a different

	participant/staff ratio. D. Supervision of Clients ~~(1) A designated responsible staff member must be present and in charge at all times a participant is present. The staff member left in charge must know how to contact the Director at all times.~~ ~~(1)~~ ~~At no time shall any participant be without supervision unless a specified activity which allows for an adult participant's independent functioning is planned and documented.~~ Each participant will be supervised as needed based on DDSN Directives to allow for maximum independence.
Other Impacted Entities	None

9. Evaluations

Impacted Section	SC Code of Regulation 88-430
Rationale	Amend to reflect current practice.
Recommendation	~~sychological evaluations will be required according to the following schedule:~~ ~~(1) Children shall be evaluated by using a restrictive test of intelligence administered by a licensed or certified psychologist once upon entry into a day program and once more between ages three and five or prior to matriculation to Headstart or public school unless entry into the program occurs after the age of two years.~~ ~~(2) Adults shall be tested using a restrictive test of intelligence administered by a licensed or certified psychologist on program entry, re-entry or at age twenty-two (22) whichever occurs first, unless there is a valid psychological evaluation completed within three years of admission on record.~~ ~~B. Social History-A social history which includes basic information on participant's personal history, family situation and specific problem areas will be completed on admission to the day program and updated annually thereafter. Information from the parents/guardian will be included in the history. The update shall indicate any change in the family situation or living environment that may affect participant's progress and need for continued enrollment.~~ ~~C. Assessment of Skills-Each participant in both adult and child programs will be assessed using an approved assessment tool(s) within thirty (30) calendar days of enrollment and annually thereafter. The assessment of needs will contain evaluations in the following areas:~~ ~~(1) Children:~~ ~~(a) Sensorimotor skills; 1. Gross motor;~~ ~~2. Fine motor;~~ ~~(b) Communication and language; (c) Social interaction/play;~~ ~~(d) Self-help skills; (e) Cognitive skills; (f)~~

	~~Behavior needs.~~ ~~(2) Adults:~~ ~~(a) Self-care (e.g., hygiene, appearance, nutrition, eating habits, dressing, toileting, physical fitness, sex education etc.)~~ ~~(b) Community Living Skills (e.g., budgeting, shopping, cooking, laundry, telephone usage, transportation, appropriate use of leisure etc.)~~ ~~(c) Communication (e.g., speech, language, sign language, or other communication skills etc.)~~ ~~(d) Socialization (e.g., appropriate behaviors for successful interaction with others, recreation and leisure)~~ ~~(e) Vocational (e.g., physical capabilities, psychomotor skills, work habits, job seeking skills, knowledge of work practices, work related skills etc.)~~ ~~(f) Education (e.g., academic and cognitive skills etc.)~~ ~~(g) Behavioral needs (behavioral management plans)~~ ~~(h) Motor Development (e.g. gross motor, fine motor and perceptual motor needs)~~ The participant must be evaluated and determined eligible for DDSN services pursuant to Department Directives. The participant must be determined to require or likely benefit from day services.
Other Impacted Entities	None

10. Programs

Impacted Section	SC Code of Regulations 88-430
Rationale	Amend to reflect current practice and consistent with new federal regulations.
Recommendation	A. Plan-Each participant will have a written plan developed and approved by the Individual Support ~~program~~ team within thirty days of admission ~~for adults and for children~~ and annually thereafter. ~~The plan will be based on the professional evaluations, regional recommendations, the assessment of skills, parent/guardian and/or community residence staff conferences, staff and client recommendations and discussed in a team meeting. The date and signature of all team members will be documented on the plan.~~ The plan will be based on an assessment of the participant's abilities, interests, preferences and needs. The date and signature of those in attendance will be documented. (1) The plan will contain written, individualized, ~~long-range and short-range~~ goals ~~which are time limited and measurable~~ ~~1)~~ The plan will contain written objectives which may include a training ~~schedule~~ and /or ongoing supports and the method of evaluation of progress. (3) ~~The plan will contain documented evidence of parent/guardian involvement in the meeting.~~ The plan will document the participant's, Individual Support team, and the legal guardian's (if applicable) involvement in the meeting.

(4)Summary notations of progress made toward goals are made monthly by staff involved in the training and/or ongoing supports. The notes will be signed and dated.

(5)When a goal is reached a new goal will be set.

(6) When the participant is observed to be making no progress in reaching a goal after three months of working on the same goal, the methodology and objective will be reviewed and evaluated ~~by the team~~ with the participant and a new goal will be set, the methodology or objective changed or the recommendation may be made to continue the goal. If no progress has been made after ~~one year the goal or methodology will be changed.~~ six (6) months, the methodology or objective is to be re-evaluated or recommendation to the Individual Support Team for a new goal to be written.

(7) The plan will be reviewed and updated by the ~~program~~ Individual Support team at least annually with input from the participant and their legal guardian (if applicable).

(9) The plan will address the participant's movement ~~toward a less restrictive program and include goals and objectives which will help him progress to a higher level program~~ toward their personal goals in the least restrictive environment.

B. Services

(1) The services offered at the program will be ~~directed toward the identified needs of the participant.~~ based on the participant's abilities, interests, preferences and needs.

~~He~~ He/She will be involved in activities which will help ~~him~~ him/her progress toward goals identified in the plan. Activities should be age appropriate and allow for choices by the participant.

(2) ~~The services for children will include the following: (a) Gross motor development;~~

~~(b) Fine motor development;~~

~~(c) Communication and language; (d) Socialization;~~

~~(e) Self-help skills;~~

~~(f) Cognitive development;~~

~~(g)Behavior management;~~

(3) The services for adults will include but not be limited to the following:

(a)) Activities of daily living, AAC, WAC;

(b) Independent living skills, AAC, WAC;

(c)) Socialization, AAC, WAC;

(d) Recreation/Leisure Skills, AAC, WAC;

(e)) Habilitation/Vocational/Work Related, AAC, WAC, ~~and SW;~~

(f) Behavior management, AAC, WAC~~, SW;~~

(g) Physical development, AAC, WAC;

(h) Communication/Language, AAC, WAC;

	(4) The program may offer the services at the home of the participant, in the community, in the center, or any other appropriate site which can be arranged by the program and which is deemed appropriate by the Individual Support team. C. ~~Hours of the Program~~ ~~(1) Each program will have a current activity schedule posted~~ ~~(2) The schedule will reflect the hours the facility is open and the hours the program offers supervised services.~~ ~~(3) The schedule must reflect the scheduled activities of the day.~~
Other Impacted Entities	None

11. Records

Impacted Section	SC Code of Regulations 88-440
Rationale	Amend to reflect current practice
Recommendation	B. Participant-A record shall be maintained for each participant which contains, as a minimum, the items listed below. All documents and entries shall be legible, dated, and signed by the person making the entry. If symbols are used, explanatory legends must be provided. (1) Report of a medical examination which was performed not more than twelve (12) months prior to admission; (2) Report of psychological evaluation(s) as required by R. 88-430A; (3) Report of Social History ~~which is updated annually,~~ as available; (4) Current Individual Program Plan as required by R88-435 A; (5) Monthly summary notations of progress; (6) Record of unusual behavior incidents which are recorded at the time of occurrence; (7) Record of illness and accidents; (8) Authorization for emergency medical service; (9) Record of critical incidents. C. ~~Confidentiality-All information in a participant's record shall be considered privileged and confidential. Staff shall not disclose or knowingly permit the disclosure of any information concerning the client or his family directly to any unauthorized person.~~ Compliance with HIPAA
Other Impacted Entities	None

12. Application for License of an Unclassified Program.

Impacted Section	SC Code of Regulations 88-915
Rationale	Amend to reflect current practice
Recommendation	B. Name and address of the ~~Administrator~~ Executive Director
Other Impacted Entities	None

13. Determination by the Department.

Impacted Section	SC Code of Regulations 88-920
Rationale	Amend to reflect current language
Recommendation	(1) Provides a beneficial service to its ~~developmentally disabled clients~~ participants. ~~(4)~~ Does not exploit the ~~developmentally disabled,~~ participants, their families or the public.
Other Impacted Entities	None

APPENDIX A. CORRESPONDENCE SUPPORTING STATUTORY RECOMMENDATION 7

Patrick Maley
Interim State Director
Rufus Britt
Interim Associate State Director
Operations
Susan Kreh Beck
Associate State Director
Policy
Lisa Weeks
Interim Associate State Director
Administration

SOUTH CAROLINA
Department
OF
Disabilities
AND
Special Needs

3440 Harden Street Ext (29203)
PO Box 4706, Columbia, South Carolina 29240
803/898-9600
Toll Free: 888/DSN-INFO
Home Page: www.ddsn.sc.gov

COMMISSION
Eva R. Ravenel
Chairman
Gary C. Lemel
Vice Chairman
Vicki A. Thompson
Secretary
Sam F. Broughton, Ph.D.
Chris G. Neeley
Lorri S. Unumb

July 16, 2018

Representative G. Murrell Smith, Jr.
House Ways and Means Committee-Healthcare Subcommittee
420B Blatt Bldg.
Columbia, South Carolina 29201

Representative Phyllis J. Henderson
Legislative Oversight Committee-Healthcare and Regulatory Subcommittee
522B Blatt Bldg.
Columbia, South Carolina 29201

Re: Request Introduction of Legislation to Amend the Adult Health Care Consent Act
S.C. Code Ann. § 44-66-10 et seq. (2018)

Dear Representatives Henderson and Smith:

The purpose of this letter is to request assistance from the South Carolina House of Representatives to introduce a clarifying legislation amendment to the Adult Health Care Consent Act (AHCA) S.C. Code Ann. § 44-66-10 et seq. (2018). Representative Smith has previously provided assistance on the AHCA. Representative Henderson's current review of the Department of Disabilities and Special Needs (DDSN) through the Legislative Oversight Committee also provides a logical avenue to pursue a legislative solution. DDSN defers to the legislative members on the proper avenue.

The Act's most recent amendment, effective June 3, 2016, created an inconsistency between the DDSN legislation providing authority to utilize the Act and DDSN's priority in the Act itself. This inconsistency has created uncertainty among DDSN and its community provider network using this traditional AHCA authority to consent for medical treatment for consumers under their care, who have no family available or willing to serve in such a capacity. This impacts approximately 50 DDSN consumers in Regional Centers (672 total consumers) and many more in community provider residential settings which serve 4374 consumers. DDSN and providers

use this authority on a regular basis for these consumers unable to consent, due to their lifelong disabilities, for even routine medical issues.

As an interim measure, DDSN relied on in-house counsel's legal opinion to reconcile the inconsistency between the AHCA with DDSN's statutory authority, which concluded DDSN and its provider network still had the authority and priority in the AHCA and S.C. Code Ann. § 44-26-10 et seq. (2018). The South Carolina Attorney General provided an opinion on this situation, dated June 22, 2018, which concurred with DDSN's legal analysis and authority to continue to rely on the AHCA (Attachment 4). Still, DDSN deems it critical to resolve the ambiguity with finality with a legislative clarification to the AHCA.

Chronology of the AHCA Issue

As you are aware, the AHCA was amended in 2016 wherein the list of those given priority to make health care decisions for person deemed not able to consent to their own health care were changed. In that process, the previous priority listing for a person given authority to make health care decisions for the patient by another statutory provision, was deleted. In the 2015 version of the act, this was S.C. Code Ann. § 44-66-30 (8) (Attachment 1).

In an effort to correct the omission of the priority of a person given authority to make health care decisions for the patient by another statutory provision, Bill 4013 was introduced in 2017. In Bill 4013, the previously deleted priority listing of a person given authority to make health care decisions for the patient by another statutory provision is now listed as number (3) in the list of those granted priority to make health care decisions (Attachment 2). In hindsight, this was a mistake. This created the authority and appearance DDSN was ahead of families in priority, which was not its practice nor intent.

DDSN is requesting that priority (3) a person given authority to make health care decisions for the patient by another statutory provision in Bill 4013 be moved to number 10 in the priority listing. It will follow the now existing S.C. Code Ann. 44-66-30(A) 9 (2018) which states:

> any other adult relative by blood or marriage who reasonably is believed by the health care professions to have close personal relationship with the patient or if the patient has more than one other adult relative, a majority of those other adult relatives who are reasonably available for consultation.

In addition, the Commission would like the new number three (3) in Bill 4013 to be amended to say that:

> (3) a person given priority to make healthcare decisions for the patient when the agency has taken custody of the patient by another statutory provision

The DDSN Commission is requesting the changes because there is a perception that the agency, by having the authority to make health care decisions for those deemed not able to consent on their own at priority (3), puts the agency ahead of the ability of families to make these decisions for their loved ones. This has never been the practice of the agency as DDSN looks to family

members to make these health care decisions for their loved ones. The agency is requesting that the statute be clarified to reflect the current practice of the agency. I have included a copy of what the new legislation would look like if the agency's requested changes in the priority listing are adopted.

As the bill notes, changes would have to be made to S.C. Code Ann. § 44-26-40, S.C. Code Ann. § 44-26-50 and S.C. Code Ann. § 44-26-60 to come into conformity with the changes to S.C. Code § 44-60-30 effective in 2016. I have included those changes as well (Attachment 3).

DDSN Legislative Request

Bill 4013 has expired with the recent legislative session. The agency is requesting that this bill with the modifications set forth in Attachment 3 be pre-filed in the next legislative session. If you have any questions, please feel free to contact me (cell 803/360-6014).

Sincerely,

Patrick J. Maley
Interim State Director

Attachment #1

SC Law 2015 before changes made in 2016.
Please see highlighted area on Page 2.

CHAPTER 66
Adult Health Care Consent Act

SECTION 44-66-10. Short title.

This chapter may be cited as the "Adult Health Care Consent Act".

HISTORY: 1990 Act No. 472, Section 1.

SECTION 44-66-20. Definitions.

As used in this chapter:

(1) "Health care" means a procedure to diagnose or treat a human disease, ailment, defect, abnormality, or complaint, whether of physical or mental origin. Health care also includes the provision of intermediate or skilled nursing care; services for the rehabilitation of injured, disabled, or sick persons; and the placement in or removal from a facility that provides these forms of care.

(2) "Health care provider" or "provider" means a person, health care facility, organization, or corporation licensed, certified, or otherwise authorized or permitted by the laws of this State to administer health care.

(3) "Health care professional" means an individual who is licensed, certified, or otherwise authorized by the laws of this State to provide health care to members of the public.

(4) "Patient" means an individual sixteen years of age or older who presents or is presented to a health care provider for treatment.

(5) "Person" includes, but is not limited to, an individual, a state agency, or a representative of a state agency.

(6) "Physician" means an individual who is licensed to practice medicine or osteopathy pursuant to Chapter 47, Title 40.

(7) "Treatment" means the broad range of emergency, outpatient, intermediate, and inpatient services and care that may be extended to a patient to diagnose and treat a human disease, ailment, defect, abnormality, or complaint, whether of physical or mental origin. Treatment includes, but is not limited to, psychiatric, psychological, substance abuse, and counseling services.

(8) "Unable to consent" means unable to appreciate the nature and implications of the patient's condition and proposed health care, to make a reasoned decision concerning the proposed health care, or to communicate that decision in an unambiguous manner. This term does not apply to minors, and this chapter does not affect the delivery of health care to minors unless they are married or have been determined judicially to be emancipated. A patient's inability to consent must be certified by two licensed physicians, each of whom has examined the patient. However, in an emergency the patient's inability to consent may be certified by a health care professional responsible for the care of the patient if the health care professional states in writing in the patient's record that the delay occasioned by obtaining certification from two licensed physicians would be detrimental to the patient's health. A certifying physician or other health care professional shall give an opinion regarding the cause and nature of the inability to consent, its extent, and its probable duration. If a patient unable to consent is being admitted to hospice care pursuant to a physician certification of a terminal illness required by Medicare, that certification meets the certification requirements of this item.

HISTORY: 1990 Act No. 472, Section 1; 1992 Act No. 306, Section 3; 2002 Act No. 351, Sections 2, eff July 20, 2002; 2013 Act No. 39, Section 2, eff January 1, 2014.

Effect of Amendment

The 2002 amendment, in paragraph (6), added the last sentence relating to certification requirements for a hospice patient unable to consent.

The 2013 amendment substituted "Health care" for "It" in the second sentence in paragraph (1); inserted new text in paragraph (4) and redesignated former paragraphs (4) and (5) as paragraph (5) and (6); inserted paragraph (7); redesignated former paragraph (6) as paragraph (8); substituted "pursuant to Chapter 47,

Title 40" for "under Chapter 47 of Title 40" in paragraph (6); and substituted "This term does not apply to minors" for "This definition does not include minors" in paragraph (8).

SECTION 44-66-30. Persons who may make health care decisions for patient who is unable to consent; order of priority; exceptions.

(A) Where a patient is unable to consent, decisions concerning his health care may be made by the following persons in the following order of priority:

(1) a guardian appointed by the court pursuant to Article 5, Part 3 of the South Carolina Probate Code, if the decision is within the scope of the guardianship;

(2) an attorney-in-fact appointed by the patient in a durable power of attorney executed pursuant to Section 62-5-501, if the decision is within the scope of his authority;

(3) a person given priority to make health care decisions for the patient by another statutory provision;

(4) a spouse of the patient unless the spouse and the patient are separated pursuant to one of the following:

(a) entry of a pendente lite order in a divorce or separate maintenance action;

(b) formal signing of a written property or marital settlement agreement;

(c) entry of a permanent order of separate maintenance and support or of a permanent order approving a property or marital settlement agreement between the parties;

(5) a parent or adult child of the patient;

(6) an adult sibling, grandparent, or adult grandchild of the patient;

(7) any other relative by blood or marriage who reasonably is believed by the health care professional to have a close personal relationship with the patient;

(8) a person given authority to make health care decisions for the patient by another statutory provision.

(B) If persons of equal priority disagree on whether certain health care should be provided to a patient who is unable to consent, an authorized person, a health care provider involved in the care of the patient, or any other person interested in the welfare of the patient may petition the probate court for an order determining what care is to be provided or for appointment of a temporary or permanent guardian.

(C) Priority under this section must not be given to a person if a health care provider responsible for the care of a patient who is unable to consent determines that the person is not reasonably available, is not willing to make health care decisions for the patient, or is unable to consent as defined in Section 44-66-20(6).

(D) An attending physician or other health care professional responsible for the care of a patient who is unable to consent may not give priority or authority under subsections (A)(5) through (8) to a person if the attending physician or health care professional has actual knowledge that, before becoming unable to consent, the patient did not want that person involved in decisions concerning his care.

(E) This section does not authorize a person to make health care decisions on behalf of a patient who is unable to consent if, in the opinion of the certifying physicians, the patient's inability to consent is temporary, and the attending physician or other health care professional responsible for the care of the patient determines that the delay occasioned by postponing treatment until the patient regains the ability to consent will not result in significant detriment to the patient's health.

(F) A person authorized to make health care decisions under subsection (A) of this section must base those decisions on the patient's wishes to the extent that the patient's wishes can be determined. Where the patient's wishes cannot be determined, the person must base the decision on the patient's best interest.

(G) A person authorized to make health care decisions under subsection (A) of this section either may consent or withhold consent to health care on behalf of the patient.

HISTORY: 1990 Act No. 472, Section 1; 1992 Act No. 306, Section 4.

SECTION 44-66-40. Provision of health care without consent where there is serious threat to health of patient, or to relieve suffering; person having highest priority to make health care decision.

Attachment #2

South Carolina General Assembly
122nd Session, 2017-2018

Download This Bill in Microsoft Word format

~~Indicates Matter Stricken~~
Indicates New Matter

H. 4013

STATUS INFORMATION

General Bill
Sponsors: Rep. G.M. Smith
Document Path: l:\council\bills\cc\15121vr17.docx

Introduced in the House on March 21, 2017
Currently residing in the House Committee on **Judiciary**

Summary: Health care decisions for adults unable to consent

HISTORY OF LEGISLATIVE ACTIONS

Date	Body	Action Description with journal page number
3/21/2017	House	Introduced and read first time (House Journal-page 121)
3/21/2017	House	Referred to Committee on **Judiciary** (House Journal-page 121)

View the latest legislative information at the website

VERSIONS OF THIS BILL

3/21/2017

(Text matches printed bills. Document has been reformatted to meet World Wide Web specifications.)

A BILL

TO AMEND SECTION 44-66-30, AS AMENDED, CODE OF LAWS OF SOUTH CAROLINA, 1976, RELATING TO PERSONS WHO MAY MAKE HEALTH CARE DECISIONS FOR ADULTS UNABLE TO CONSENT, SO AS TO ADD A PERSON GIVEN THE AUTHORITY TO MAKE THOSE HEALTH CARE DECISIONS PURSUANT TO ANOTHER STATUTORY PROVISION; AND TO AMEND SECTIONS 44-26-40, 44-26-50, AND 44-26-60, ALL AS AMENDED, ALL RELATING TO RIGHTS OF CLIENTS OF THE SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS, SO AS TO MAKE CONFORMING CHANGES.

Be it enacted by the General Assembly of the State of South Carolina:

SECTION 1. Section 44-66-30(A) of the 1976 Code, as last amended by Act 226 of 2016, is further amended to read:

"(A) Where a patient is unable to consent, decisions concerning his health care may be made by the following persons in the following order of priority:

(1) a guardian appointed by the court pursuant to Article 5, Part 3 of the South Carolina Probate Code, if the decision is within the scope of the guardianship;

(2) an attorney-in-fact appointed by the patient in a durable power of attorney executed pursuant to Section 62-5-501, if the decision is within the scope of his authority;

(3) a person given authority to make health care decisions for the patient by another statutory provision;

(4) a person given priority to make health care decisions for the patient by another statutory provision;

~~(4)~~(5) a spouse of the patient unless the spouse and the patient are separated pursuant to one of the following:

(a) entry of a pendente lite order in a divorce or separate maintenance action;

(b) formal signing of a written property or marital settlement agreement; or

(c) entry of a permanent order of separate maintenance and support or of a permanent order approving a property or marital settlement agreement between the parties;

~~(5)~~(6) an adult child of the patient, or if the patient has more than one adult child, a majority of the adult children who are reasonably available for consultation;

~~(6)~~(7) a parent of the patient;

~~(7)~~(8) an adult sibling of the patient, or if the patient has more than one adult sibling, a majority of the adult siblings who are reasonably available for consultation;

~~(8)~~(9) a grandparent of the patient, or if the patient has more than one grandparent, a majority of the grandparents who are reasonably available for consultation;

~~(9)~~(10) any other adult relative by blood or marriage who reasonably is believed by the health care professional to have a close personal relationship with the patient, or if the patient has more than one other adult relative, a majority of those other adult relatives who are reasonably available for consultation."

SECTION 2. Section 44-26-40 of the 1976 Code, as last amended by Act 47 of 2011, is further amended to read:

"Section 44-26-40. If a client resides in a facility operated by or contracted to by the department, the determination of that client's competency to consent to or refuse major medical treatment must be made pursuant to ~~Section 44-66-20(6) of~~ the Adult Health Care Consent Act. The department shall abide by the decision of a client found competent to consent."

SECTION 3. Section 44-26-50 of the 1976 Code, as last amended by Act 47 of 2011, is further amended to read:

"Section 44-26-50. If the client is found incompetent to consent to or refuse major medical treatment, the decisions concerning his health care must be made pursuant to ~~Section 44-66-30 of~~ the Adult Health Care Consent Act. An authorized designee of the department may make a health care decision pursuant to Section 44-66-30~~(8)~~(3) of the Adult Health Care Consent Act. The person making the decision must be informed of the need for major medical treatment, alternative treatments, and the nature and implications of the proposed health care and shall consult the attending physician before making decisions. When feasible, the person making the decision shall observe or consult with the client found to be incompetent."

SECTION 4. Section 44-26-60(C) of the 1976 Code, as last amended by Act 47 of 2011, is further amended to read:

"(C) Priority under this section must not be given to a person if a health care provider, responsible for the care of a client who is unable to consent, determines that the person is not reasonably available, is not willing to make health care decisions for the client, or is unable to consent as defined in Section 44-66-20~~(6)~~(8) of the Adult Health Care Consent Act."

SECTION 5. This act takes effect upon approval by the Governor.

----XX----

This web page was last updated on March 24, 2017 at 1:13 PM

Attachment #3

Bill 4013

TO AMEND SECTION 44-66-30, AS AMENDED, CODE OF LAWS OF SOUTH CAROLINA, 1976, RELATING TO PERSONS WHO MAY MAKE HEALTH CARE DECISIONS FOR ADULTS UNABLE TO CONSENT, SO AS TO ADD A PERSON GIVEN THE AUTHORITY TO MAKE THOSE HEALTH CARE DECISIONS PURSUANT TO ANOTHER STATUTORY PROVISION; AND TO AMEND SECTIONS 44-26-40, 44-26-50, AND 44-26-60, ALL AS AMENDED, ALL RELATING TO RIGHTS OF CLIENTS OF THE SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS, SO AS TO MAKE CONFORMING CHANGES.

Be it enacted by the General Assembly of the State of South Carolina:

SECTION 1. Section 44-66-30(A) of the 1976 Code, as last amended by Act 226 of 2016, is further amended to read:

"(A) Where a patient is unable to consent, decisions concerning his health care may be made by the following persons in the following order of priority:

(1) a guardian appointed by the court pursuant to Article 5, Part 3 of the South Carolina Probate Code, if the decision is within the scope of the guardianship;

(2) an attorney-in-fact appointed by the patient in a durable power of attorney executed pursuant to Section 62-5-501, if the decision is within the scope of his authority;

(3) a person given priority to make health care decisions for the patient when the agency has taken custody of the patient by another statutory provision

(4) a spouse of the patient unless the spouse and the patient are separated pursuant to one of the following:

(a) entry of a pendente lite order in a divorce or separate maintenance action;

(b) formal signing of a written property or marital settlement agreement; or

(c) entry of a permanent order of separate maintenance and support or of a permanent order approving a property or marital settlement agreement between the parties;

(5) an adult child of the patient, or if the patient has more than one adult child, a majority of the adult children who are reasonably available for consultation;

(6) a parent of the patient;

(7) an adult sibling of the patient, or if the patient has more than one adult sibling, a majority of the adult siblings who are reasonably available for consultation;

(8) a grandparent of the patient, or if the patient has more than one grandparent, a majority of the grandparents who are reasonably available for consultation;

(9) any other adult relative by blood or marriage who reasonably is believed by the health care professional to have a close personal relationship with the patient, or if the patient has more than one other adult relative, a majority of those other adult relatives who are reasonably available for

consultation."

(10) a person given authority to make health care decisions for the patient by another statutory provision

SECTION 2. Section 44-26-40 of the 1976 Code, as last amended by Act 47 of 2011, is further amended to read:

"Section 44-26-40. If a client resides in a facility operated by or contracted to by the department, the determination of that client's competency to consent to or refuse major medical treatment must be made pursuant to Section 44-66-20(8) of the Adult Health Care Consent Act. The department shall abide by the decision of a client found competent to consent."

SECTION 3. Section 44-26-50 of the 1976 Code, as last amended by Act 47 of 2011, is further amended to read:

"Section 44-26-50. If the client is found incompetent to consent to or refuse major medical treatment, the decisions concerning his health care must be made pursuant to Section 44-66-30 of the Adult Health Care Consent Act. An authorized designee of the department may make a health care decision pursuant to Section 44-66-30(10) of the Adult Health Care Consent Act. The person making the decision must be informed of the need for major medical treatment, alternative treatments, and the nature and implications of the proposed health care and shall consult the attending physician before making decisions. When feasible, the person making the decision shall observe or consult with the client found to be incompetent."

SECTION 4. Section 44-26-60(C) of the 1976 Code, as last amended by Act 47 of 2011, is further amended to read:

"(C) Priority under this section must not be given to a person if a health care provider, responsible for the care of a client who is unable to consent, determines that the person is not reasonably available, is not willing to make health care decisions for the client, or is unable to consent as defined in Section 44-66-20(8) of the Adult Health Care Consent Act."

Attachment #4

ALAN WILSON
ATTORNEY GENERAL

June 21, 2018

Mr. Patrick J. Maley
Interim State Director
South Carolina Department of Disability and Special Needs
P.O. Box 4706
Columbia, SC 29240

Dear Director Maley:

Attorney General Alan Wilson has referred your letter to the Opinions section. Your letter states the following:

> South Carolina Department of Disability and Special Needs (DDSN) provides services for person with Intellectual, Related Disabilities, Autism and Head and Spinal Cord Injuries. Many of the consumers that receive services also have health care concerns that must be addressed. Therefore, DDSN is requesting an opinion concerning the Adult Health Care Consent Act, S.C. Code Ann. § 44-66-10 et Seq. (2018), as it relates to S.C. Code Ann. § 44-26-50 (2018).
>
> There was a change that occurred in the statute in 2016 that removed one of the listed priorities of persons that can give consent, when a person is determined by two licensed physicians to be unable to consent on their own behalf to health care. The change removed S.C. Code Ann. § 44-66-30(8) which stated "a person given authority make health care decision for the patient by a different statutory provision." However, there remains S.C. Code Ann. §44-66-30(3) (2018) which states a person given priority to make health care decisions for the patient by another statutory provision. For DDSN, the statutory provision that gives the agency priority and authority is S.C. Code Ann. § 44-26-50 (2018). This refers back to S.C. Code Ann. § 44-66-30 (8) (2018) which now is listed as grandparents.
> ...
>
> DDSN would like an opinion from your office to clarify the issue of the agency's authority to make health care decisions.

REMBERT C. DENNIS BUILDING • POST OFFICE BOX 11549 • COLUMBIA, SC 29211-1549 • TELEPHONE 803-734-3970 • FACSIMILE 803-253-6283

Law/Analysis

As stated in the request letter, the Adult Health Care Consent Act lists the order of priority of persons who may make health care decisions when a patient is unable to consent. S.C. Code Ann. § 44-66-30. As originally adopted, the listed order of priority was as follows:

> (A) Where a patient is unable to consent, decisions concerning his health care may be made by the following persons in the following order of priority:
>
> > (1) a guardian appointed by the court pursuant to Article 5, Part 3 of the South Carolina Probate Code, if the decision is within the scope of the guardianship;
> >
> > (2) an attorney-in-fact appointed by the patient in a durable power of attorney executed pursuant to Section 62-5-501, if the decision is within the scope of his authority;
> >
> > (3) a person given priority to make health care decisions for the patient by another statutory provision;
> >
> > (4) a spouse of the patient unless the spouse and the patient are separated pursuant to one of the following:
> >
> > > (a) entry of a pendente lite order in a divorce or separate maintenance action;
> > >
> > > (b) formal signing of a written property or marital settlement agreement;
> > >
> > > (c) entry of a permanent order of separate maintenance and support or of a permanent order approving a property or marital settlement agreement between the parties;
> >
> > (5) a parent or adult child of the patient;
> >
> > (6) an adult sibling, grandparent, or adult grandchild of the patient;
> >
> > (7) any other relative by blood or marriage who reasonably is believed by the health care professional to have a close personal relationship with the patient;

> (8) a person given authority to make health care decisions for the patient by another statutory provision.

1990 Act No. 472, § 1.[1] In 1992, DDSN was given authority to make health care decisions for a client that is "found incompetent to consent or refuse medical treatment" by 1992 Act No. 366, § 1. This authority is codified at Section 44-26-50 of the South Carolina Code of Laws as follows:

> If the client is found incompetent to consent to or refuse major medical treatment, the decisions concerning his health care must be made pursuant to Section 44-66-30 of the Adult Health Care Consent Act. An authorized designee of the department may make a health care decision pursuant to Section 44-66-30(8) of the Adult Health Care Consent Act. The person making the decision must be informed of the need for major medical treatment, alternative treatments, and the nature and implications of the proposed health care and shall consult the attending physician before making decisions. When feasible, the person making the decision shall observe or consult with the client found to be incompetent.

S.C. Code Ann. § 44-26-50 (Supp. 2017) (emphasis added).[2] This statute granted DDSN the final listed priority after any relative of the patient by blood or marriage.

However, following the enactment of Section 44-26-50 and its 2011 amendment, S.C. Code Ann. § 44-66-30 was amended by 2016 Act No. 226 (H.3999), § 1 (the "2016 Act"). The act is titled as follows:

> AN ACT TO AMEND SECTION 44–66–30, CODE OF LAWS OF SOUTH CAROLINA, 1976, RELATING TO PERSONS WHO MAY MAKE HEALTH CARE DECISIONS FOR PATIENTS WHO ARE UNABLE TO PROVIDE CONSENT, SO AS TO MAKE CHANGES TO THE ORDER OF PRIORITY, TO ADD CLASSES OF PERSONS WITH THE AUTHORITY TO MAKE THESE HEALTH CARE DECISIONS, AND FOR OTHER PURPOSES.

Id. As the stated intention in the act's title is to make changes to the order of priority, Section 44-66-30 was amended to list the order of priority as follows:

> (A) Where a patient is unable to consent, decisions concerning his health care may be made by the following persons in the following order of priority:

[1] S.C. Code Ann. § 44-66-30 was subsequently amended by 1992 Act No. 306, § 4, but this act did not affect the order of priority.
[2] SC Code Ann 44-26-50 was subsequently amended by 2011 Act No. 47, § 6, but this act did not affect the order of priority.

(1) a guardian appointed by the court pursuant to Article 5, Part 3 of the South Carolina Probate Code, if the decision is within the scope of the guardianship;

(2) an attorney-in-fact appointed by the patient in a durable power of attorney executed pursuant to Section 62-5-501, if the decision is within the scope of his authority;

(3) a person given priority to make health care decisions for the patient by another statutory provision;

(4) a spouse of the patient unless the spouse and the patient are separated pursuant to one of the following:

(a) entry of a pendente lite order in a divorce or separate maintenance action;

(b) formal signing of a written property or marital settlement agreement; or

(c) entry of a permanent order of separate maintenance and support or of a permanent order approving a property or marital settlement agreement between the parties;

(5) an adult child of the patient, or if the patient has more than one adult child, a majority of the adult children who are reasonably available for consultation;

(6) a parent of the patient;

(7) an adult sibling of the patient, or if the patient has more than one adult sibling, a majority of the adult siblings who are reasonably available for consultation;

(8) a grandparent of the patient, or if the patient has more than one grandparent, a majority of the grandparents who are reasonably available for consultation;

(9) any other adult relative by blood or marriage who reasonably is believed by the health care professional to have a close personal relationship with the patient, or if the patient has more than one other adult

> relative, a majority of those other adult relatives who are reasonably available for consultation.

S.C. Code Ann. § 44-66-30 (Supp. 2017) (emphasis added). The 2016 Act removed the priority description which DDSN was assigned at former subsection (8). Subsection (8) now assigns priority to "a grandparent of the patient, or if the patient has more than one grandparent, a majority of the grandparents who are reasonably available for consultation." It is also important to note that subsection (8) is no longer the final listed priority. Subsection (9) now lists "any other adult relative by blood or marriage who reasonably is believed by the health care professional to have a close personal relationship with the patient" as the final priority.

This opinion will give this Office's analysis of what authority DDSN has to make health care decisions under the Adult Health Care Consent Act as amended after the 2016 Act according to the rules of statutory interpretation. Statutory interpretation of the South Carolina Code of Laws requires a determination of the General Assembly's intent. Mitchell v. City of Greenville, 411 S.C. 632, 634, 770 S.E.2d 391, 392 (2015) ("The cardinal rule of statutory interpretation is to ascertain and effectuate the legislative intent whenever possible."). Where a statute's language is plain and unambiguous, "the text of a statute is considered the best evidence of the legislative intent or will." Hodges v. Rainey, 341 S.C. 79, 85, 533 S.E.2d 578, 581 (2000). The Supreme Court of South Carolina has stated, however, that where the plain meaning of the words in a statute "would lead to a result so plainly absurd that it could not have been intended by the General Assembly... the Court will construe a statute to escape the absurdity and carry the [legislative] intention into effect." Duke Energy Corp. v. S. Carolina Dep't of Revenue, 415 S.C. 351, 355, 782 S.E.2d 590, 592 (2016); Wade v. State, 348 S.C. 255, 259, 559 S.E.2d 843, 845 (2002) ("[C]ourts are not confined to the literal meaning of a statute where the literal import of the words contradicts the real purpose and intent of the lawmakers."). "A statute as a whole must receive a practical, reasonable and fair interpretation consonant with the purpose, design, and policy of lawmakers." State v. Henkel, 413 S.C. 9, 14, 774 S.E.2d 458, 461 (2015), *reh'g denied* (Aug. 5, 2015). Where statutes deal with the same subject matter, it is well established that they "are in *pari materia* and must be construed together, if possible, to produce a single, harmonious result." Penman v. City of Columbia, 387 S.C. 131, 138,691 S.E.2d 465, 468 (2010) (quoting Joiner ex rel. Rivas v. Rivas, 342 S.C. 102, 109, 536 S.E.2d 372, 375 (2000)); see also Busby v. State Farm Mut. Auto. Ins. Co., 280 S.C. 330, 335, 312 S.E.2d 716, 719 (Ct. App. 1984) ("The sections here are part of the same statute, thereby presenting an even stronger case that they be construed together and reconciled.").

Yet, there are instances where the terms and purposes of statutes cannot be reconciled harmoniously. In such instances, the Supreme Court of South Carolina has stated that the law clearly provides, "the latest statute passed should prevail so as to repeal the earlier statute to the extent of the repugnancy." Hair v. State, 305 S.C. 77, 79, 406 S.E.2d 332, 334 (1991); Penman, 387 S.C. at 138, 691 S.E.2d at 468 ("[W]here two statutes are in conflict, the more recent and specific statute should prevail so as to repeal the earlier, general statute."). However, it is equally

clear that the Court has consistently found the law disfavors this method of repeal by implication. Mullinax v. J.M. Brown Amusement Co., 333 S.C. 89, 95-96, 508 S.E.2d 848, 851 (1998) ("Repeal by implication is disfavored and is found only when two statutes are incapable of reconcilement."); Mims v. Alston, 312 S.C. 311, 313, 440 S.E.2d 357, 359 (1994); City of Rock Hill v. South Carolina Dept. of Health & Envtl. Control, 302 S.C. 161, 167, 394 S.E.2d 327, 331 (1990) ("[T] he repugnancy must not only be plain, but the provisions of the two statutes must be incapable of any reasonable reconcilement; for if they can be construed so that both can stand, the [c]ourt will so construe them."); In Interest of Shaw, 274 S.C. 534, 539, 265 S.E.2d 522, 524 (1980) ("If the provisions of the two statutes can be construed so that both can stand, this Court will so construe them."). The South Carolina Court of Appeals explained the basis for disfavoring implied repeal as follows, "It must be presumed that the legislature intended to achieve a consistent body of law. In accord with this principle, subsequent legislation is not presumed to effectuate a repeal of existing law in the absence of expressed intent." Busby, 280 S.C. at 334, 312 S.E.2d at 719; see also Justice v. Pantry, 330 S.C. 37, 43-44, 496 S.E.2d 871, 874 (Ct. App. 1998), *aff'd as modified sub nom.* Justice v. The Pantry, 335 S.C. 572, 518 S.E.2d 40 (1999) ("It is presumed that the Legislature [is] familiar with prior legislation, and that if it intend[s] to repeal existing laws it would ... expressly [do] so ..." (quoting State v. Hood, et al., 181 S.C. 488, 491, 188 S.E. 134, 136 (1936))). With these principles in mind, we turn back to the relevant statutes and legislative acts to determine whether there is a conflict and, if so, how our state courts would likely resolve such a conflict.

It is this Office's opinion that a court would likely find the 2016 Act did not create a conflict between S.C. Code Ann. § 44-66-30 and S.C. Code Ann. § 44-26-50 such that the two statutes are incapable of being reconciled. While legislative clarification is warranted to resolve the ambiguity with finality, a court would likely construe the statutes in a way that would allow both statutes to remain operative. There are several different ways of interpreting DDSN's resulting priority under S.C. Code Ann. § 44-66-30.

First, one could interpret DDSN to retain priority at S.C. Code Ann. § 44-66-30(8) in the 2016 Act even though the former description in that subsection was struck through and replaced with a separate description, namely the priority given to a patient's grandparents. However, even accepting such an unsuitable description, such an interpretation would give DDSN priority ahead of "any other adult relative by blood or marriage who reasonably is believed by the health care professional to have a close personal relationship with the patient" in subsection (9). It is this Office's opinion that a court would not find the General Assembly intended to grant DDSN an order of priority between degrees of familial relations without a clearer statement of legislative intent.

Second, one could interpret DDSN to have the priority listed at S.C. Code Ann. § 44-66-30(3). Subsection (3) grants priority to "a person given priority to make health care decisions for the patient by another statutory provision." Indeed, DDSN was statutorily granted authority to act on behalf of a patient according to another statute, S.C. Code Ann. § 44-26-50. However, the description in subsection (3) existed prior to the 2016 Act and Section 44-26-50 continues to

designate DDSN's priority at subsection (8). Had the General Assembly intended such a result, it likely would have included a conforming amendment to Section 44-26-50 in the 2016 Act. It is this Office's opinion that a court would not find the General Assembly intended to grant DDSN an order of priority higher than that explicitly listed in Section 44-26-50 and higher than that of all familial relations without a clearer statement of legislative intent.

Third, DDSN's priority designation could be interpreted to have been repealed entirely by the 2016 Act because the former priority description which DDSN was assigned at S.C. Code Ann. § 44-66-30(8) was removed from the statute. However, S.C. Code Ann. § 44-26-50, which directs DDSN to make decisions for clients "pursuant to Section 44-66-30," was not repealed or even addressed in the 2016 Act. As discussed above, our state courts presume subsequent legislation does not "effectuate a repeal of existing law in the absence of expressed intent." Busby, *supra*. If possible, a court will endeavor to reconcile S.C. Code Ann. § 44-66-30 and S.C. Code Ann. § 44-26-50 so that they both remain effective. City of Rock Hill, *supra*. It is this Office's opinion that a court would not construe S.C. Code Ann. § 44-26-50 as having been repealed by the 2016 Act, but would instead reconcile the statutes in the manner described below.

It is this Office's opinion that a court would reconcile S.C. Code Ann. § 44-66-30 and S.C. Code Ann. § 44-26-50 by construing DDSN's priority to come after "any other adult relative by blood or marriage" of the patient under Section 44-66-30(9). As discussed above, prior to the 2016 Act, DDSN was assigned the final listed priority after any relative of the patient by blood or marriage. S.C. Code Ann. § 44-66-30 (Supp. 2015). Without a clearer statement of legislative intent, it is this Office's opinion that a court would resolve the ambiguity created by the 2016 Act's removal of former subsection (8) description by maintaining DDSN's priority relative to the rest of the listed classifications. While the 2016 Act altered the listed order of priority, none of the listed priority classifications were moved to a higher priority. Rather, the classes of persons within the same order of priority were split to simplify the determination of which persons would exercise priority. See, e.g., S.C. Code Ann. §§ 44-66-30(5) (Supp. 2015) ("a parent or adult child of the patient"); 44-66-30(5) (Supp. 2017) ("an adult child of the patient, or if the patient has more than one adult child, a majority of the adult children who are reasonably available for consultation"); 44-66-30(6) (Supp. 2017) (" a parent of the patient"). Therefore, rather than interpret DDSN's status as being repealed or given a higher priority, it appears more consistent with legislative intent to construe DDSN's priority to remain at the relative position within the order of priority when S.C. Code Ann. § 44-26-50 was last amended. Although this conclusion is not free from doubt, it is this Office's opinion that a court would likely adopt this interpretation of placing DDSN's priority after that of all other listed priorities.

Conclusion

It is this Office's opinion that a court would likely find the 2016 Act did not create a conflict between S.C. Code Ann. § 44-66-30 and S.C. Code Ann. § 44-26-50 such that the two statutes are incapable of being reconciled. While legislative clarification is warranted to resolve the ambiguity with finality, a court would likely construe the statutes in a way that would allow both statutes to remain operative. It is this Office's opinion that a court would reconcile S.C. Code Ann. § 44-66-30 and S.C. Code Ann. § 44-26-50 by construing DDSN's priority to come after "any other adult relative by blood or marriage" of the patient under Section 44-66-30(9). As discussed above, prior to the 2016 Act, DDSN had the final listed priority after any relative of the patient by blood or marriage. S.C. Code Ann. § 44-66-30 (Supp. 2015). Rather than interpret DDSN's status as being repealed or given a higher priority, it appears more consistent with legislative intent to construe DDSN's priority to remain at the relative position within the order of priority when S.C. Code Ann. § 44-26-50 was last amended.

Sincerely,

Matthew Houck
Assistant Attorney General

REVIEWED AND APPROVED BY:

Robert D. Cook
Solicitor General

COMMITTEE CONTACT INFORMATION

- Website - http://www.scstatehouse.gov/CommitteeInfo/HouseLegislativeOversightCommittee.php
- Phone Number - 803-212-6810
- Email - HCommLegOv@schouse.gov
- Location - Blatt Building, Room 228