NORTH CAROLINA GENERAL ASSEMBLY

JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON HEALTH AND HUMAN SERVICES

REPORT TO THE
2018 SESSION
OF THE
2017 GENERAL ASSEMBLY OF NORTH CAROLINA

APRIL 2018

April 10, 2018

To: Lieutenant Governor Dan Forest, President of the Senate
Senator Phil Berger, President Pro Tempore of the Senate
Representative Tim Moore, Speaker of the House of Representatives
Members of the 2018 Regular Session of the 2017 General Assembly

Pursuant to Article 23A of Chapter 120 of the North Carolina General Statues, the Joint Legislative Oversight Committee on Health and Human Services has been meeting to examine the system wide issues affecting the development, budgeting, financing, administration and delivery of health and human services. Accordingly, the Committee respectfully submits the following report on issues studied during the 2017-2018 interim.

Respectfully,

Senator Louis Pate
Cochair

Representative Josh Dobson
Cochair

Representative Donny Lambeth
Cochair

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COMMITTEE MEMBERSHIP

House Members	Senate Members
Representative Josh Dobson, Cochair	Senator Louis Pate, Cochair
Representative Donny Lambeth, Cochair	Senator Dan Bishop
Representative William Brisson	Senator David L. Curtis
Representative Carla D. Cunningham	Senator Jim Davis
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Representative Beverly M. Earle	Senator Ralph Hise
Representative Jean Farmer-Butterfield	Senator Joyce Krawiec
Representative Bert Jones	Senator Gladys A. Robinson
Representative Chris Malone	Senator Jeff Tarte
Representative Gregory F. Murphy, MD	Senator Tommy Tucker
Representative Donna McDowell White	Senator Mike Woodard
Representative Gale Adcock, Advisory	Senator Tamara Barringer, Advisory
Representative Susan Fisher, Advisory	Senator Michael V. Lee, Advisory

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Julie Ryan	DeAnne Mangum
Pan Briles	

Committee Staff	
Fiscal Research Division:	
Deborah Landry	Steve Owen
Denise Thomas	
Legislative Drafting Division:	
Lisa Wilks	Amy Jo Johnson
Joyce Jones	
Legislative Analysis Division:	
Theresa Matula	Jason Moran-Bates
Jennifer Hillman	Susan Barham
	Jessica Boney

EXECUTIVE SUMMARY OF RECOMMENDATIONS

The following is an executive summary of the recommendations from the Joint Legislative Oversight Committee on Health and Human Services. These recommendations, and the findings upon which they are based, can be found under the Committee Findings and Recommendations section of this report. These recommendations have been arranged by topic.

Aging

RECOMMENDATION 1: CONTINUATION OF THE SUBCOMMITTEE ON AGING.

The Joint Legislative Oversight Committee on Health and Human Services recommends that Cochairs of the Joint Legislative Oversight Committee on Health and Human Services allow the Subcommittee on Aging to continue its study of the State's delivery of services for older adults during the interim period following the 2018 Regular Session of the 2017 North Carolina General Assembly.

Medical Education and Medical Residency

RECOMMENDATION 2: CONTINUED STUDY AND DEVELOPMENT OF A PLAN TO SUPPORT MEDICAL EDUCATION AND MEDICAL RESIDENCY PROGRAMS IN A MANNER THAT ADDRESSES THE HEALTH CARE NEEDS OF THE STATE.

The Joint Legislative Oversight Committee on Health and Human Services encourages the General Assembly to enact legislation [2017-SHz-3] allowing continued study and development of a plan to support medical education and medical residency programs in a manner that addresses the health care needs of the State.

RECOMMENDATION 3: DEVELOPMENT OF MEASURABLE OBJECTIVES TO BE USED WHEN FUNDING MEDICAL EDUCATION AND RESIDENCY PROGRAMS.

The Joint Legislative Oversight Committee on Health and Human Services encourages the General Assembly to enact legislation [2017-SHz-3] requiring the Department of Health and Human Services to gather and report information to facilitate the development of measurable objectives, along with specified timeframes for achievement, which will be used by the State when funding medical education and residency programs addressing the health care needs of residents throughout the State and to provide the Department of Health and Human Services direction in designing programs to support those objectives.

Telemedicine

RECOMMENDATION 4: IMPLEMENTATION OF A STATUTORY FRAMEWORK FOR TELEMEDICINE IN NORTH CAROLINA AND FURTHER STUDY OF ISSUES RELATED TO TELEMEDICINE.

The Joint Legislative Oversight Committee on Health and Human Services encourages the General Assembly to enact legislation [2017-BCz-4] (i) establishing the framework for the practice of telemedicine in the state of North Carolina to include definitions, the provision of services by providers licensed under Chapter 90 of the General Statutes, informed consent standards, guidelines for handling protected health information, and a standard of care; and (ii) directing the Department of Health and Human Services to conduct studies on reimbursement of telemedicine by private health benefit plans, a program to ensure all North Carolina residents have access to broadband internet sufficient to support telemedicine, metrics and other data to be used in assessing the quality of care provided by telemedicine, and licensing standards for individuals providing healthcare through telemedicine.

Psychology Interjurisdictional Compact (PSYPACT)

RECOMMENDATION 5: NORTH CAROLINA PARTICIPATION IN THE PSYCHOLOGY INTERJURISDICTIONAL COMPACT (PSYPACT).

The Joint Legislative Oversight Committee on Health and Human Services encourages the General Assembly to enact legislation [2017-SHz-5] allowing North Carolina to participate in the Psychology Interjurisdictional Compact (PSYPACT) and to require the Department of Health and Human Services and the North Carolina Psychology Board to foster continuity of care by exploring the participation of PSYPACT participants in NC HealthConnex health information exchange.

Health and Local Confinement

RECOMMENDATION 6: HEALTH ISSUES IN LOCAL CONFINEMENT FACILITIES.

The Joint Legislative Oversight Committee on Health and Human Services encourages the General Assembly to enact legislation [2017-SHz-4] to (i) clarify that the death of a prisoner in the custody of a local confinement facility shall be reported regardless of the physical location of the prisoner; (ii) to require the Secretary of the Department of Health and Human Services to undertake a study to improve prisoner health screening to determine when a prisoner has been prescribed life-saving prescription medications and to ensure the timely administration of those prescription medications; and (iii) to encourage the Department of Public Safety, the Department of Health and Human Services, and the Department of Information Technology's Government Data Analytics Center, to pursue State prisons becoming full participants in the NC HealthConnex health information exchange and to explore participation of local confinement facilities in the NC HealthConnex health information exchange.

COMMITTEE PROCEEDINGS

The Joint Legislative Oversight Committee met seven (7) times between October 2017 and April 2018. This section of the report provides a brief overview of topics and presenters for each meeting. Detailed minutes and handouts from each meeting are available in the Legislative Library. Agendas and handouts for each meeting are available at the following link: http://www.ncleg.net/gascripts/DocumentSites/browseDocSite.asp?nID=144

Overview of Topics and Presenters

October 10, 2017

- **Comments from the Secretary** - Mandy Cohen, M.D., Secretary, Department of Health and Human Services (DHHS)
- **Overview of the Committee's Purpose (Article 23A, Chapter 120)** - Lisa Wilks, Committee Staff, Legislative Drafting Division, NCGA
- **2017 Session Resource Materials – Budget and Fiscal Highlights, Conference Committee Report Highlights, and Substantive Enacted HHS Legislation** - Theresa Matula, Committee Staff, Legislative Analysis Division, NCGA
- **Subcommittee Appointments** -Representative Donny Lambeth, Presiding Cochair
- **Child Welfare Updates:**
    - **Implementation of the Federal Program Improvement Plan** (S.L. 2017-57, Sec. 11C.7) - Susan Perry-Manning, Deputy Secretary for Human Services & Michael Becketts, Assistant Secretary for Human Services, DHHS
    - **NC FAST Implementation of the Child Welfare Case Management System** - Sam Gibbs, Deputy Secretary for Technology and Operations & Michael Becketts, Assistant Secretary for Human Services, DHHS
    - **Planning for Implementation of Rylan's Law/Family/Child Protection and Accountability Act (S.L. 2017-41)** - Michael Becketts, Assistant Secretary for Human Services, DHHS
- **NC Pre-K Update on Slots** - Susan Perry-Manning, Deputy Secretary for Human Services, DHHS
- **Overview of Interim Investigative Report of Cardinal Innovations Healthcare Solutions** - Dave Richard, Deputy Secretary, Medical Assistance, DHHS

November 14, 2017

- **Comments from the Secretary** - Mandy Cohen, M.D., Secretary, DHHS
- **Telemedicine Study and Recommendations** - Maggie Sauer, Office of Rural Health, DHHS
- **DHHS Strategic Plan to Address the North Carolina Opioid Crisis** - Mandy Cohen, M.D., Secretary, DHHS & Susan Kansagra, Section Chief Chronic Disease and Injury Section, Division of Public Health, DHHS

- **Controlled Substance Reporting System (CSRS) Update** – Charles Carter, Chief Operating Officer for Technology and Operation, Information Technology Division, DHHS
- **Report on Use of the Dorothea Dix Hospital Property Fund to Increase Licensed Inpatient Behavioral Health Beds** – Steve Owen, Committee Staff, Fiscal Research Division, NCGA & Mark Benton, Deputy Secretary, Health Services, DHHS
- **Traumatic Brain Injury** - Mark Benton, Deputy Secretary, Health Services, DHHS & Dave Richard, Deputy Secretary, Medical Assistance, DHHS

December 12, 2017

- **Comments from the Secretary -** Mandy Cohen, M.D., Secretary, DHHS
- **Report on Contracting Specialist & Certification Program** - Denise Thomas, Committee Staff, Fiscal Research Division, NCGA & Patti Bowers, Director, DHHS Office of Procurement, Contracts and Grants
- **North Carolina Families Accessing Services through Technology (NC FAST) Update** – Angela Taylor, Director, NC FAST, DHHS & Susan Perry-Manning, Deputy Secretary, Human Services, DHHS
- **Other IT Project Updates** – Sam Gibbs, Deputy Secretary, Technology and Operations, DHHS Information Technology Division & Danny Staley, Director, Division of Public Health, DHHS
    - **NCTRACKS**
    - **Health Information Exchange (HIE)**
    - **Health Information Technology (HIT)**
    - **DHHS Data Collection & Services Management Information System**
    - **Women, Infants & Children (WIC)/EBT**
    - **Electronic Death Records**
    - **Medical Examiner Information System**
- **Discussion on Cardinal Innovations** – Mandy Cohen, M.D., Secretary, DHHS & Dave Richard, Deputy Secretary, Medical Assistance, Division of Medical Assistance, DHHS

January 16, 2018

- **Comments from the Secretary -** Mandy Cohen, M.D., Secretary, DHHS
    - **Update on Cardinal Innovations**
    - **Update on Influenza Data in NC**
    - **Other**
- **Office of Program Evaluation Reporting and Accountability (OPERA) Report (S.L. 2017-57, see 11A.11)** – Denise Thomas, Committee Staff, Fiscal Research Division, NCGA & Rod Davis, Chief Financial Officer, DHHS
- **Update on Cherry and Broughton Hospitals** – Mark Benton, Deputy Secretary, Health Services, DHHS
- **Health Information Exchange Update** – Christie Burris, Director, N.C. Health Information Exchange Authority (NC HIEA), Government Data Analytics Center (GDAC), Department of Information Technology

    - **DHHS Collaboration and Partnership Efforts** – Sam Gibbs, Deputy Secretary, Technology and Operations, DHHS
- **LME/MCO Performance Standards and Accomplishments** – Steve Owen, Committee Staff, Fiscal Research Division, NCGA & Mark Benton, Deputy Secretary, Health Services, DHHS & Dave Richard, Deputy Secretary, Division of Medical Assistance, DHHS
- **LME/MCO Approaches to Addressing the Opioid Crisis** – Brian Ingraham, CEO, Vaya Health
- **Status of Strategic Plan for the Improvement of Behavioral Health Services** - Mark Benton, Deputy Secretary, Health Services, DHHS & Dave Richard, Deputy Secretary, Division of Medical Assistance, DHHS

February 28, 2018

- **Comments from the Secretary**- Mandy Cohen, M.D., Secretary, DHHS
    - **Update on Cardinal Innovations**
    - **Update on Influenza**
- **Local Health Department Issues**
    - **Introduction** - Dennis Joyner, President of the NC Association of Local Health Directors, Union County Health Department
    - **Communicable Disease Response** – John Morrow, MD, MPH, Pitt County Health District
    - **Budget Pressures** – Lisa Macon Harrison, Director, Granville-Vance Health District
- **DHHS Jail Oversight** – Steve Lewis, Section Chief, Construction Section, Division of Health Service Regulation, DHHS
- **Study Inmate Health Information Exchange Software** – Joe Prater, Deputy Secretary, Administration, Department of Public Safety
- **Child Welfare Update**
    - **Program Improvement Plan** – Susan Perry-Manning, Deputy Secretary, Human Services, DHHS
    - **NC FAST** – Sam Gibbs, Deputy Secretary, Technology and Operations, DHHS & Susan Perry-Manning, Deputy Secretary, Human Services, DHHS

March 13, 2018

- **Comments from the Secretary -** Mandy Cohen, M.D., Secretary, DHHS
- **Mental Health Issues in Jails**- Eddie Caldwell, Executive Vice President and General Counsel, North Carolina Sheriffs' Association
- **Child Welfare Update**
    - **Program Improvement Plan** – Susan Perry-Manning, Deputy Secretary, Human Services, DHHS
    - **NC FAST** – Sam Gibbs, Deputy Secretary, Technology and Operations, DHHS & Susan Perry-Manning, Deputy Secretary, Human Services, DHHS
- **Subcommittee Reports**

    - **Aging Subcommittee** – Deborah Landry, Subcommittee Staff, Fiscal Research Division, NCGA
    - **GME Joint Subcommittee** – Jason Moran-Bates, Subcommittee Staff, Legislative Analysis Division, NCGA
- **Draft Recommendations from JLOC-HHS to the 2018 Session** – Theresa Matula, Committee Staff, Legislative Analysis Division, NCGA

April 10, 2018

- **Comments from the Secretary** - Mandy Cohen, M.D., Secretary, DHHS
    - **Update on Cherokee County DSS**
- **Social Services Regional Supervision and Collaboration Working Group Report (S.L. 2017-41, Sec. 1.2(e))** - Aimee Wall, UNC School of Government
- **Presentation of Draft Committee Report**- Theresa Matula, Committee Staff, Legislative Analysis Division, NCGA
- **Committee Discussion & Vote on Draft Report**

SUBCOMMITTEE MEMBERSHIP

During the 2017-2018 interim, three subcommittees of the Joint Legislative Oversight Committee on Health and Human Services were appointed. The Subcommittee on Aging and the Joint Subcommittee on Medical Education and Medical Residency Programs presented reports to the Joint Legislative Oversight Committee on March 13, 2018. Minutes for the Subcommittee meetings are on file in the Legislative Library. Handouts and agendas are available online at the following link: http://www.ncleg.net/gascripts/DocumentSites/browseDocSite.asp?nID=144&sFolderName=\JLOC-HHS%20Subcommittees%20by%20Interim\2017-18%20JLOC-HHS%20Subcommittees.

Subcommittee on Aging

S.L. 2017-57, Section 11D.3, allowed the Joint Legislative Oversight Committee on Health and Human Services to appoint a subcommittee on aging. The subcommittee was directed to examine the State's delivery of services for older adults in order to determine their service needs and to make recommendations to the Oversight Committee on how to address those needs.

Below is a list of the Members and staff for the Subcommittee on Aging.

Senate Members	**House Members**
Senator Joyce Krawiec, Cochair	Representative Josh Dobson, Cochair
Senator David L. Curtis	Representative Donna McDowell White
Senator Valerie P. Foushee	Representative Beverly M. Earle
Staff	
Theresa Matula, Legislative Analysis	Deborah Landry, Fiscal
Lisa Wilks, Legislative Drafting	
Clerk	
Julie Ryan	DeAnne Mangum
Pan Briles	

Joint Subcommittee on Medical Education and Medical Residency Programs

S.L. 2017-57, Section 11J.2, directed the Joint Legislative Oversight Committee on Health and Human Services and the Joint Legislative Education Oversight Committee to each appoint a subcommittee to jointly examine the use of State funds to support medical education and medical residency programs. The joint subcommittee was directed to study the following issues:

(1) The health care needs of the State's residents and the State's goals in meeting those health care needs through the support and funding of medical education and medical residency programs located within the State.
(2) The short-term and long-term benefits to the State for allocating State funds to medical education and medical residency programs located within the State.
(3) Recommended changes and improvements to the State's current policies with respect to allocating State funds and providing other support to medical education programs and medical residency programs located within the State.
(4) Development of an evaluation protocol to be used by the State in determining (i) the particular medical education programs and medical residency programs to support with State funds and (ii) the amount of State funds to allocate to these programs.
(5) Any other relevant issues the subcommittees deem appropriate.

Below is a list of the Members and staff for the Medical Education and Medical Residency Programs Subcommittee from the Joint Legislative Oversight Committee on Health and Human Services.

Senate Members	**House Members**
Senator Louis Pate, Cochair	Representative Donny Lambeth, Cochair
Senator Jeff Tarte	Representative Gregory F. Murphy, MD
Senator Mike Woodard	Representative Jean Farmer-Butterfield
Staff	
Jason Moran-Bates, Legislative Analysis	Theresa Matula, Legislative Analysis
Denise Thomas, Fiscal	Steve Owen, Fiscal
Amy Jo Johnson, Legislative Drafting	
Clerk	
Pan Briles	Julie Ryan
DeAnne Mangum	

Behavioral Health Subcommittee

S.L. 2016-94, Section 12F.10, as amended by Section 11F.6 of S.L. 2017-57, required the Joint Legislative Oversight Committee on Health and Human Services and the Joint Legislative Oversight Committee on Medicaid and NC Health Choice to each appoint a subcommittee on Behavioral Health Services. The subcommittees were directed to study the following:

(1) Oversee the Department's development of the strategic plan required by S.L. 2016-94, Section 12F.10, as amended by Section 11F.6 of S.L. 2017-57 of this section.
(2) Review the strategic plan developed by the Department in accordance with S.L. 2016-94, Section 12F.10, as amended by Section 11F.6 of S.L. 2017-57, including a review of all performance-related goals and measures for the delivery of mental health, developmental disabilities, substance abuse, and traumatic brain injury services.
(3) Review consolidated monthly, quarterly, and annual reports and analyses of behavioral health services funded by Medicaid and State-only appropriations.

Below is a list of the Members and staff for the Behavioral Health Subcommittee from the Joint Legislative Oversight Committee on Health and Human Services.

Senate Members	**House Members**
Senator Tommy Tucker, Cochair	Representative Chris Malone, Cochair
Senator Dan Bishop	Representative Bert Jones
Senator Gladys A. Robinson	Representative William Brisson
Staff	
Jennifer Hillman, Legislative Analysis	Joyce Jones, Legislative Drafting
Susan Barham, Legislative Analysis	Steve Owen, Fiscal
Clerk	
DeAnne Mangum	Pan Briles
Julie Ryan	

COMMITTEE FINDINGS AND RECOMMENDATIONS

The findings and recommendations from the Joint Legislative Oversight Committee on Health and Human Services are provided in this section. The findings and recommendations have been categorized by topic.

Aging

FINDING 1: CONTINUATION OF THE SUBCOMMITTEE ON AGING

The Joint Legislative Oversight Committee on Health and Human Services, Subcommittee on Aging, was appointed pursuant to S.L. 2017-57, Section 11D.3. The purpose of the Subcommittee was to examine the State's delivery of services for older adults in order to (i) determine their service needs and to (ii) make recommendations to the Oversight Committee on how to address those needs. Additionally, the enacted legislation encouraged the Subcommittee to seek input from a variety of stakeholders and interest groups, including the Division of Aging and Adult Services and the Division of Social Services, Department of Health and Human Services; the North Carolina Coalition on Aging; the North Carolina Senior Tar Heel Legislature; and the Governor's Advisory Council on Aging.

The Subcommittee on Aging met three times and heard from 23 presenters on a range of programs and services for older adults in North Carolina. During its first meeting, the Subcommittee heard a presentation on the amount of money the State spends to support services for older adults, and it heard from the Division of Aging and Adult Services, Department of Health and Human Services (DHHS) on the current and projected population of older adults in North Carolina. During the second meeting the Subcommittee heard from the following: Public Consulting Group (PCG); NC Coalition on Aging; AARP of NC; North Carolina Senior Tar Heel Legislature; Alzheimer's Association; NC PACE Association; two Area Agencies on Aging; and two Senior Centers. During the third meeting, the Subcommittee heard from the Association for Home and Hospice Care of NC; North Carolina Health Care Facilities Association; NC Association of Long Term Care Facilities; Adult Day Care/Day Health; a county Department of Social Services on Adult Protective Services; and heard a presentation on Project C.A.R.E.

The authorizing legislation provided that if the subcommittee was appointed, it was required to submit an interim report of its findings and recommendations, including any proposed legislation, to the Joint Legislative Oversight Committee on Health and Human Services on or before March 1, 2018, and to submit a final report of its findings and recommendations, including any proposed legislation, on or before November 1, 2018, at which time it shall terminate unless reappointed by the cochairs of the Oversight Committee under the authority granted in G.S. 120-208.2(d). Due to winter weather issues, sessions of the North Carolina General Assembly, and scheduling conflicts, the

subcommittee was not able to schedule more than three meetings prior to the March reporting requirement. The Joint Legislative Oversight Committee on Health and Human Services, Subcommittee on Aging, found that continued study of the State's delivery of services for older adults is necessary and requests that the Cochairs of the Joint Legislative Oversight Committee on Health and Human Services allow the Subcommittee on Aging to continue its work during the interim period following the 2018 Regular Session of the 2017 North Carolina General Assembly.

The Subcommittee on Aging presented its report to the Joint Legislative Oversight Committee on Health and Human Services on March 13, 2018. The Joint Legislative Oversight Committee on Health and Human Services endorses the findings and the recommendation to encourage the Cochairs of the Oversight Committee to allow the Subcommittee on Aging to continue its study of the delivery of services to older adults by endorsing the recommendation that follows.

RECOMMENDATION 1: CONTINUATION OF THE SUBCOMMITTEE ON AGING.

The Joint Legislative Oversight Committee on Health and Human Services recommends that Cochairs of the Joint Legislative Oversight Committee on Health and Human Services allow the Subcommittee on Aging to continue its study of the State's delivery of services for older adults during the interim period following the 2018 Regular Session of the 2017 North Carolina General Assembly.

Medical Education and Medical Residency

FINDING 2: CONTINUED STUDY AND DEVELOPMENT OF A PLAN TO SUPPORT MEDICAL EDUCATION AND MEDICAL RESIDENCY PROGRAMS IN A MANNER THAT ADDRESSES THE HEALTH CARE NEEDS OF THE STATE.

S.L. 2017-57, Section 11J.2(d), required a subcommittee appointed by the Joint Legislative Oversight Committee on Health and Human Services and a subcommittee appointed by the Joint Legislative Education Oversight Committee to jointly "develop a proposal for a statewide plan to support medical education programs and medical residency programs within North Carolina in a manner that maximizes the State's financial and other support of these programs and addresses the short-term and long-term health care needs of the State's residents." The authorizing legislation required a report to the respective Oversight Committees by March 15, 2018. Due to a late start, the Joint Subcommittee on Medical Education and Medical Residency Programs was only able to hold two meetings prior to the reporting date.

The Joint Subcommittee on Medical Education and Medical Residency Programs found that there is continued interest in examining ways to support medical education and medical residency programs with a goal of addressing the short-term and long-term health care needs of the State's residents. The Joint Subcommittee also found that it is important for any subcommittee appointed to be in a position to begin work as soon as possible. However, the Joint Legislative Oversight Committee on Health and Human Services and

the Joint Legislative Education Oversight Committee may find it necessary to prioritize their interim work and both Committees may not be in a position to appoint a subcommittee to work jointly. Therefore, the respective oversight committees may wish to encourage the General Assembly to enact legislation for continued study with a mechanism allowing flexibility for two appointed subcommittees to work jointly, or for one or more appointed subcommittees to work independently. Additionally, in order to devote sufficient time to these complex and important topics, the Joint Subcommittee finds that it would be beneficial for the study to take place over two interim periods with a final reporting deadline of March 1, 2020.

The Joint Subcommittee on Medical Education and Medical Residency Programs presented their report to the Joint Legislative Oversight Committee on Health and Human Services on March 13, 2018. The Joint Legislative Oversight Committee on Health and Human Services endorses the findings and the recommendation for continued study and development of a plan to support medical education and medical residency programs in a manner that addresses the health care needs of the State.

RECOMMENDATION 2: CONTINUED STUDY AND DEVELOPMENT OF A PLAN TO SUPPORT MEDICAL EDUCATION AND MEDICAL RESIDENCY PROGRAMS IN A MANNER THAT ADDRESSES THE HEALTH CARE NEEDS OF THE STATE.

The Joint Legislative Oversight Committee on Health and Human Services encourages the General Assembly to enact legislation [2017-SHz-3] allowing continued study and development of a plan to support medical education and medical residency programs in a manner that addresses the health care needs of the State.

FINDING 3: DEVELOPMENT OF MEASURABLE OBJECTIVES TO BE USED WHEN FUNDING MEDICAL EDUCATION AND RESIDENCY PROGRAMS.

S.L. 2017-57, Section 11J.2, requires the two subcommittees to jointly "develop a proposal for a statewide plan to support medical education programs and medical residency programs within North Carolina in a manner that maximizes the State's financial and other support of these programs and addresses the short-term and long-term health care needs of the State's residents." The Joint Subcommittee received good information this interim, but more information is needed to identify specific measurable objectives, along with specified timeframes for achievement, which will be used by the State when funding medical education and residency programs that address healthcare needs throughout the State, particularly increased health care access in rural areas, and to provide the Department of Health and Human Services direction in designing programs to support those objectives.

The Joint Subcommittee on Medical Education and Medical Residency Programs heard a variety of presentations regarding medical education and residency programs. The presentations highlighted the need for transparency with regard to the funding related to medical residency programs, the data needed to track residents throughout their career, and the lack of one specific entity in the State to gather this information. Presentations also pointed out that the variety of medical schools in the State have differing goals and objectives. The Subcommittee finds that the State does not appear to have a specific set of objectives for medical education and residency programs.

There was not enough data presented to the Subcommittee to make specific recommendations on a statewide plan to support medical education programs and medical residency programs. The Joint Subcommittee found that more information is needed and should be provided by the Department of Health and Human Services in collaboration with the Cecil G. Sheps Center for Health Services Research, the North Carolina Area Health Education Centers, the North Carolina Institute of Medicine, the University of North Carolina at Chapel Hill School of Medicine, and the Brody School of Medicine at East Carolina University.

The Joint Subcommittee on Medical Education and Medical Residency Programs presented its report to the Joint Legislative Oversight Committee on Health and Human Services on March 13, 2018. The Joint Legislative Oversight Committee on Health and Human Services endorses the findings and the recommendation to encourage the General Assembly to enact legislation requiring the Department of Health and Human Services to gather and report information to facilitate the development of measurable objectives, along with specified timeframes for achievement, to be used when funding medical education and residency programs addressing the health care needs of residents throughout the State.

RECOMMENDATION 3: DEVELOPMENT OF MEASURABLE OBJECTIVES TO BE USED WHEN FUNDING MEDICAL EDUCATION AND RESIDENCY PROGRAMS.

The Joint Legislative Oversight Committee on Health and Human Services encourages the General Assembly to enact legislation [2017-SHz-3] requiring the Department of Health and Human Services to gather and report information to facilitate the development of measurable objectives, along with specified timeframes for achievement, which will be used by the State when funding medical education and residency programs addressing the health care needs of residents throughout the State and to provide the Department of Health and Human Services direction in designing programs to support those objectives.

Telemedicine

FINDING 4: IMPLEMENTATION OF A STATUTORY FRAMEWORK FOR TELEMEDICINE IN NORTH CAROLINA AND FURTHER STUDY OF ISSUES RELATED TO TELEMEDICINE.

S.L. 2017-133, Section 1, directed the Department of Health and Human Services to examine telemedicine laws in other states and to submit a report to the Joint Legislative Oversight Committee on Health and Human Services recommending standards for a telemedicine policy for the State. The legislation specifically required the Department to examine the laws of other states as they pertained to: (i) the definition of the term telemedicine; (ii) the scope of services that can be covered by telemedicine; (iii) acceptable communication and data transfer standards necessary to ensure the privacy of health information and appropriate for insurance reimbursement; (iv) informed consent standards; (v) online prescribing standards; (vi) telemedicine provider licensing standards; and (vii) private payer telemedicine reimbursement standards. The Department presented its report to the Committee on November 14, 2017. The report recommended that North Carolina adopt a definition of telemedicine as "the use of electronic information and telecommunication technologies to support and promote long distance clinical health care,

patient and professional health-related education, public health, and health administration," and that the terms "telemedicine" and "telehealth" be used interchangeably. The report also made specific recommendations that the State should (i) support the provision of healthcare services through telemedicine by medical providers; (ii) adopt guidelines for handling protected health information in the use of telemedicine; and (iii) develop a standard of care for providing telemedicine services, including online prescribing standards.

The Committee finds that additional investigation is necessary to develop a full telemedicine policy for the State and recommends the Department of Health and Human Services be directed to investigate several issues to allow for a complete telemedicine policy for the State. The Committee believes the General Assembly should enact legislation requiring the Department to (i) work with the Department of Insurance to conduct a study on the reimbursement of telemedicine by private health insurers; (ii) work with the Department of Information Technology to develop a program to ensure all State residents have sufficient broadband coverage to use telemedicine services; (iii) conduct a study to determine the proper framework for ensuring quality of telemedical care; and (iv) conduct a study to determine standards for licensing providers who provide care through telemedicine.

RECOMMENDATION 4: IMPLEMENTATION OF A STATUTORY FRAMEWORK FOR TELEMEDICINE IN NORTH CAROLINA AND FURTHER STUDY OF ISSUES RELATED TO TELEMEDICINE.

The Joint Legislative Oversight Committee on Health and Human Services encourages the General Assembly to enact legislation [2017-BCz-4] (i) establishing the framework for the practice of telemedicine in the state of North Carolina to include definitions, the provision of services by providers licensed under Chapter 90 of the General Statutes, informed consent standards, guidelines for handling protected health information, and a standard of care; and (ii) directing the Department of Health and Human Services to conduct studies on reimbursement of telemedicine by private health benefit plans, a program to ensure all North Carolina residents have access to broadband internet sufficient to support telemedicine, metrics and other data to be used in assessing the quality of care provided by telemedicine, and licensing standards for individuals providing healthcare through telemedicine.

Psychology Interjurisdictional Compact

FINDING 5: NORTH CAROLINA PARTICIPATION IN THE PSYCHOLOGY INTERJURISDICTIONAL COMPACT (PSYPACT).

According to the Association of State and Provincial Psychology Boards (ASPPB), the Psychology Interjurisdictional Compact (PSYPACT) is an interstate compact, which is an agreement between states to enact legislation and enter into a contract for a specific, limited purpose or address a particular policy issue. It was created to facilitate telehealth and temporary in-person, face-to-face practice of psychology across jurisdictional boundaries. PSYPACT was approved by the ASPPB Board of Directors in February 2015. S.L. 2017-133, Section 2, required the Department of Health and Human Services (DHHS) to submit

a report containing findings and a recommendation on the PSYPACT to the Joint Legislative Oversight Committee on Health and Human Services. It further provided that based on the Department's report, the Committee must consider making a recommendation to the 2017 General Assembly during the 2018 Regular Session on PSYPACT.

The Department of Health and Human Services presented a report to the Committee on November 14, 2017. The report provided that "DHHS supports the position of the North Carolina Psychological Association, that North Carolina should create legislation to participate in PSYPACT as this will help to address behavioral health workforce issues." The report also recommended that, "Participation on PSYPACT should be contingent upon upholding patient-centered models and data reporting for continuity of care, such as participating in NC HealthConnex." PSYPACT becomes operational when seven states enact the PSYPACT legislation. A map provided by the ASPPB currently indicates that three states have enacted PSYPACT, it is pending in five states, and has been endorsed by the psychology licensing boards in four states. The Committee believes that continuity of care is important, but given the current status of PSYPACT and the ongoing progress of NC HealthConnex health information exchange, the Committee recommends the General Assembly require the Department of Health and Human Services and the North Carolina Psychology Board to foster continuity of care by exploring the participation of PSYPACT participants in NC HealthConnex health information exchange.

RECOMMENDATION 5: NORTH CAROLINA PARTICIPATION IN THE PSYCHOLOGY INTERJURISDICTIONAL COMPACT (PSYPACT).
The Joint Legislative Oversight Committee on Health and Human Services encourages the General Assembly to enact legislation [2017-SHz-5] allowing North Carolina to participate in the Psychology Interjurisdictional Compact (PSYPACT) and to require the Department of Health and Human Services and the North Carolina Psychology Board to foster continuity of care by exploring the participation of PSYPACT participants in NC HealthConnex health information exchange.

Health and Local Confinement

FINDING 6: HEALTH ISSUES IN LOCAL CONFINEMENT FACILITIES.
During two meetings the Committee explored select health issues in local confinement facilities and prisons. During the meeting on February 28, 2018, the Committee heard a presentation on the Oversight of Jail Death Reporting by Steven Lewis, Section Chief, Construction Section, Division of Health Service Regulation, Department of Health and Human Services (DHHS). The Committee also heard from Joe Prater, Deputy Secretary of Administration, Department of Public Safety (DPS), on the Study of Health Information Exchange Software, as required by S.L. 2017-57, Section 16C.11A. This provision required DPS and DHHS to study the feasibility of the State acquiring and implementing an inmate health information exchange program to allow for the secure and effective transfer of pertinent medical information for an inmate. On March 13, 2018, the Committee heard a presentation on mental health issues in jails from Eddie Caldwell, Executive Vice President and General Counsel, NC Sheriffs' Association, Inc.

G.S. 153A-217(5) defines a local confinement facility as "a county or city jail, a local lockup, a regional or district jail, a juvenile detention facility, a detention facility for adults operated by a local government, and any other facility operated by a local government for confinement of persons awaiting trial or service sentences except that it shall not include a county satellite jail/work release unit governed by Part 3 of Article 10 of Chapter 153A." G.S. 153A-216 establishes the legislative policy of the General Assembly with respect to local confinement facilities. G.S. 153A-225(b) provides the following, "If a prisoner in a local confinement facility dies, the medical examiner and the coroner shall be notified immediately. Within five days after the day of the death, the administrator of the facility shall make a written report to the local or district health director and to the Secretary of Health and Human Services." There is a question as to whether a local confinement facility has to report the death of a prisoner if the death does not occur in the local confinement facility. The Committee finds that the statute is vague and recommends that this language be clarified.

There are several other states that address the health and welfare of prisoners in local confinement facilities. G.S. 153A-216 (1) states that "Local confinement facilities should provide secure custody of persons confined therein in order to protect the community and should be operated so as to protect the health and welfare of prisoners and provide for their humane treatment." G.S. 153A-216 (3) provides, "The State should provide services to local governments to help improve the quality of administration and local confinement facilities. These services should include inspection, consultation, technical assistance, and other appropriate services." G.S. 153A-220 establishes the Social Services Commission as having "policy responsibility for providing and coordinating State services to local government with respect to local confinement facilities." G.S. 153A-221 requires the Secretary of the Department of Health and Human Services to develop and publish minimum standards for the operation of local confinement facilities. According to G.S. 153A-221(b), when developing standards and amendments, the Secretary is required to consult with "organizations representing local government and local law enforcement, including the North Carolina Association of County Commissioners, the North Carolina League of Municipalities, the North Carolina Sheriffs' Association, and the North Carolina Police Executives' Association. The Secretary shall also consult with interested State departments and agencies, including the Division of Adult Correction of the Department of Public Safety, the Department of Health and Human Services, the Department of Insurance, and the North Carolina Criminal Justice Education and Training Standards Commission, and the North Carolina Sheriffs' Education and Training Standards Commission." G.S. 153A-225 requires each unit that operates a local confinement facility to develop a plan for providing medical care for prisoners in the facility. The Committee finds that the medical screening process and the prescription medication administration plan may need to be improved. The Committee recommends that the Secretary of the Department of Health and Human Services should undertake a study to improve prisoner health screening that will include determining when a prisoner has been prescribed life-saving prescription medications and to helping facility staff ensure the timely administration of those prescription medications.

The February presentation by the Department of Public Safety (DPS) indicated that the Department has recently developed and is implementing a statewide internal electronic

health record system. They reported that the electronic health record system "is capable of integrating with a viable state-wide health information exchange (HIE) system." The presentation from DPS stated that DPS and DHHS recommend "the Department of Public Safety work collaboratively with the Department of Health and Human Services and the Department of Information Technology's (DIT) Government Data Analytics Center (GDAC) to utilize the NC HealthConnex health information system for the secure and effective transfer of pertinent health information on inmates." In light of the concern surrounding the provision of health services in local confinement facilities, the Committee finds that it is also important to explore participation by local confinement facilities in the NC HealthConnex health information exchange and prescription medication, but realizes this will require time and study.

Based on the information shared during the February and March meetings and the corresponding Committee discussion, the Committee makes the recommendation below.

RECOMMENDATION 6: HEALTH ISSUES IN LOCAL CONFINEMENT FACILITIES.

The Joint Legislative Oversight Committee on Health and Human Services encourages the General Assembly to enact legislation [2017-SHz-4] to (i) clarify that the death of a prisoner in the custody of a local confinement facility shall be reported regardless of the physical location of the prisoner; (ii) to require the Secretary of the Department of Health and Human Services to undertake a study to improve prisoner health screening to determine when a prisoner has been prescribed life-saving prescription medications and to ensure the timely administration of those prescription medications; and (iii) to encourage the Department of Public Safety, the Department of Health and Human Services, and the Department of Information Technology's Government Data Analytics Center, to pursue State prisons becoming full participants in the NC HealthConnex health information exchange and to explore participation of local confinement facilities in the NC HealthConnex health information exchange.

PROPOSED LEGISLATION

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2017

U **D**

BILL DRAFT 2017-SHz-3 [v.6] (02/09)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
02/20/2018 12:08:27 PM

Short Title:	Medical Education & Residency Study.	(Public)
Sponsors:		
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO STUDY MEDICAL EDUCATION AND MEDICAL RESIDENCY PROGRAMS, AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON HEALTH AND HUMAN SERVICES AND THE JOINT LEGISLATIVE EDUCATION OVERSIGHT COMMITTEE.

Whereas, S.L. 2017-57, Section 11J.2, authorized the Joint Legislative Oversight Committee on Health and Human Services and the Joint Legislative Education Oversight Committee to each appoint a subcommittee to jointly examine the use of State funds to support medical education and medical residency programs; and

Whereas, the Joint Subcommittee on Medical Education and Medical Residency Programs, appointed by the Joint Legislative Oversight Committee on Health and Human Services and the Joint Legislative Education Oversight Committee, was not able to conduct a thorough examination of medical education and residency programs and to develop a plan to support them in a manner that addresses the health care needs of the State prior to the March 15, 2018, reporting deadline; and

Whereas, there is continued interest in examining ways to support medical education and medical residency programs with a goal of addressing the short-term and long-term health care needs of the State's residents; and

Whereas, the Joint Legislative Oversight Committee on Health and Human Services and the Joint Legislative Education Oversight Committee may find it necessary to prioritize their interim work and both Committees may not be in a position to appoint a subcommittee to work jointly; and

Whereas, the intent of the act is to create a mechanism allowing flexibility for two appointed subcommittees to work jointly, or for one or more appointed subcommittees to work independently; and

Whereas, the Joint Subcommittee on Medical Education and Medical Residency Programs identified data and information that will be needed to inform the work of future subcommittees in order to more thoroughly examine medical education and residency programs in order to identify objectives for those programs throughout the State and to provide direction to the Department of Health and Human Services in designing programs to that meet the needs of the State; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1. The Joint Legislative Oversight Committee on Health and Human Services and the Joint Legislative Education Oversight Committee may each appoint a subcommittee to study medical education and medical residency programs. If appointed, the subcommittees may consult each other and may elect to meet jointly, but each subcommittee is authorized to work independently and report to its respective oversight committee.

SECTION 2.(a) The medical education and medical residency study may include examination of the following:

(1) The health care needs of the State's residents and the State's goals in meeting those health care needs through the support and funding of medical education and medical residency programs located within the State.

(2) The short-term and long-term benefits to the State for allocating State funds to medical education and medical residency programs located within the State.

(3) Recommended changes and improvements to the State's current policies with respect to allocating State funds and providing other support to medical education programs and medical residency programs located within the State.

(4) Development of an evaluation protocol to be used by the State in determining (i) the particular medical education programs and medical residency programs to support with State funds and (ii) the amount of State funds to allocate to these programs.

(5) Any other relevant issues deemed appropriate.

SECTION 2.(b) The study may include input from other states, stakeholders, and national experts on medical education programs, medical residency programs, and health care, as deemed necessary.

SECTION 2.(c) The study may examine the reports provided by the Department of Health and Human Services and The University of North Carolina in accordance with S.L. 2017-57, Section 11J.2.(c), and the report provided by the Department of Health and Human Services in accordance with Section 3 of this act.

SECTION 3. No later than August 1, 2019, the Department of Health and Human Services shall submit to the Joint Legislative Oversight Committee on Health and Human Services, the Joint Legislative Education Oversight Committee, and the Joint Legislative Oversight Committee on Medicaid and NC Health Choice, a report on medical education and residency programs. This report shall be developed in collaboration with the Cecil G. Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill, the North Carolina Area Health Education Centers, the North Carolina Institute of Medicine, the University of North Carolina at Chapel Hill School of Medicine, and the Brody School of Medicine at East Carolina University. The report shall be used to facilitate the development of measurable objectives, along with specified timeframes for achievement, which will be used by the State when funding medical education and residency programs addressing the health care needs throughout the State, particularly increased health care access in rural areas. The report shall contain the following information:

(1) Detailed information about North Carolina medical school student slots, residency slots, and intern slots, including the number of slots for each medical school and residency program and how these slots have changed over time. This information shall include the slot caps set by Medicare and other agencies, the methodology used to establish those slot caps, information on how the slot caps have changed over time, and how changes to the slot caps may be accomplished in the future. This information shall also include an assessment of the effect of the slot caps on each medical school and residency program in North Carolina.

(2) Suggested overall objectives for the medical education and residency programs in the State, including identified outcomes and goals to meet the needs of rural areas.

(3) Total funding for the North Carolina Area Health Education Centers for the past three fiscal years, the primary purposes of the funding, and outcomes that have been achieved relative to those purposes.

(4) Total funding for the University of North Carolina at Chapel Hill School of Medicine and the Brody School of Medicine at East Carolina University for the past three fiscal years. This shall include an analysis of the cost of operating each school of medicine compared to the total funding for each school of medicine.

(5) The total reimbursement paid to hospitals related to Graduate Medical Education (GME) through the Medicaid program, including all of the following methodologies: receipts, claims payments, cost settlements, enhanced payments, and equity supplemental payments. This shall include an analysis of the funding source for this reimbursement, including how much of the funding is provided by the State, by hospitals, and by the federal government.

(6) A detailed explanation of all Medicaid GME reimbursement methodologies that the Department of Health and Human Services intends to use, or is using, under the transformed North Carolina Medicaid and North Carolina Health Choice programs as described in S.L. 2015-245, as amended by Section 2 of S.L. 2016-121, Section 11H.17 of S.L. 2017-57, and Section 4 of 2017-186. This explanation shall include a rationale for any changes made to the Medicaid GME reimbursement methodology, outcomes to be achieved by these changes, and methods by which to measure these outcomes.

(7) Strategies, outside of the publically-funded programs, used by hospitals and communities to attract and retain health care providers to rural areas.

(8) Any recommendations regarding a body to compile and oversee the State's medical education and residency programs data, including whether this additional oversight body is necessary. If an oversight body is recommended, this recommendation shall also include the composition of that body, the recommended agency to house the body, the duties of the body, the specific information the body is to oversee, the mechanism by which the body will collect the data, and any funding needs for the body.

(9) An analysis of how other states have modified or developed funding to meet the need in rural areas regarding the recruitment and retention of health care providers, including the use of Medicaid funding, loan forgiveness, and loan repayment. This analysis should include the processes by which other states have identified the need for health care providers by specialty or location and the outcomes achieved.

(10) Any limitations or parameters set by other entities that may restrict the State's ability to modify programs that support the State's objectives, including (i) Medicaid reimbursement for GME, (ii) loan forgiveness, (iii) loan repayment, or (iv) other sources of funding.

SECTION 4. A subcommittee authorized by this act and appointed shall develop a proposal for a statewide plan to support medical education programs and medical residency programs within North Carolina in a manner that maximizes the impact of financial and other support provided by the State for these programs and addresses the short-term and long-term

health care needs of the State's residents, particularly increased health care access in rural areas. A subcommittee authorized by this act and appointed, may provide an interim report to its respective oversight committee by November 1, 2018, and shall report to its respective oversight committee on or before March 1, 2020, at which time a subcommittee authorized by this act shall terminate.

SECTION 5. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2017

S **D**

BILL DRAFT 2017-BCz-4 [v.13] (02/09)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
03/23/2018 09:53:17 AM

Short Title:	Telemedicine Policy. (Public)
Sponsors:	
Referred to:	

A BILL TO BE ENTITLED

AN ACT ESTABLISHING A TELEMEDICINE POLICY FOR THE STATE OF NORTH CAROLINA AND DIRECTING THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO STUDY AND REPORT RECOMMENDATIONS FOR VARIOUS TELEMEDICINE STANDARDS, AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON HEALTH AND HUMAN SERVICES.

The General Assembly of North Carolina enacts:

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

"**ARTICLE 1L.**

"**NORTH CAROLINA TELEMEDICINE PRACTICE ACT.**

"**§ 90-21.130. Title.**

This Article shall be known and may be cited as the "North Carolina Telemedicine Practice Act.

"**§ 90-21.131. Definitions.**

The following definitions apply in this Article:

(1) Business associate. – As defined in 45 CFR § 160.103.

(2) Business associate contract. – As defined in 45 C.F.R. § 160.103

(3) Covered Entity. – As defined in 45 C.F.R. § 160.103.

(4) Department. – The North Carolina Department of Health and Human Services.

(5) HIE Network. – As defined in G.S. 90-414.3(8).

(6) In-home monitoring. – The use of a non-portable medical device or equipment, in combination with an internet connection, to collect and store vital signs, or other health information, and transmit it to a healthcare provider.

(7) Protected health information. – As defined in 45 CFR 160.103.

(8) Remote patient monitoring. – The use of a portable medical device, smart phone and dedicated application software, portable monitoring sensor, or other wearable technology, in combination with an internet connection, to collect and store vital signs or other health information and transmit it to a healthcare provider.

(9) Store-and-forward imaging. – The acquisition and storing of clinical data, including images, sound, or video, that is asynchronously transmitted to another site for clinical evaluation.

(10) Telemedicine or telehealth. – The use of electronic information and telecommunication technologies to support and promote long-distance clinical health care, patient and professional health-related education, public health, and health administration. Technologies include video conferencing, the internet, store-and-forward imaging, streaming media, terrestrial and wireless communications, remote patient monitoring, and in-home monitoring. Telemedicine or telehealth does not include the provision of healthcare services through audio-only telephone or teleconference, email, or facsimile.

"**§ 90-21.132. Practice of telemedicine.**

Any individual licensed as a healthcare provider in the State of North Carolina under Chapter 90 of the General Statutes may provide healthcare services, consistent with the provider's licensed scope of practice, via telemedicine to any individual located in the State of North Carolina.

"**§ 90-21.133. Informed consent.**

(a) Before a healthcare provider delivers healthcare via telemedicine, the healthcare provider shall obtain written or verbal informed consent from the patient. If the consent is written, a copy shall be placed in the patient's medical record. If the consent is obtained verbally, a notation shall be made in the patient's medical record.

(b) Consent to receive healthcare services via telemedicine is informed only if all of the following conditions are satisfied:

(1) The patient has been informed of his or her rights when receiving telemedicine treatment, including the right to stop or refuse treatment.

(2) The patient has been informed of his or her own responsibilities when receiving telemedicine treatment.

(3) The telemedicine provider has established a formal complaint or grievance process to resolve any potential ethical concerns or issues that might arise as a result of practicing telemedicine, and the patient has been informed of that process.

(4) A description of the potential benefits, constraints, and risks of telemedicine has been provided to the patient.

(5) The patient has been informed of what will happen in the case of technology or equipment failures during telemedicine sessions and a contingency plan has been developed and communicated to the patient.

(6) The telemedicine provider has made a determination that the patient is comfortable operating the technology being used to deliver health care services via telemedicine.

"**§ 90-21.134. Secure handling of protected health information.**

(a) Covered entities and business associates engaged in the practice of telemedicine shall comply with all federal and State laws and regulations to secure protected health information. Any dedicated software application provided by a covered entity to a telemedicine patient shall ensure that all data is stored and transmitted in accordance with all federal and State laws and regulations for the secure storage and transmission of protected health information.

(b) Before any healthcare provider, covered entity, or business associate engages in the practice of telemedicine or handles any protected health information obtained through the practice of telemedicine, the healthcare provider, covered entity, or business associate shall first

conduct risk analyses and install administrative, physical, and technical safeguards, as determined to be appropriate by the Department or the Department of Information Technology, to ensure the secure handling of protected health information.

"**§ 90-21.135. Standard of care.**

(a) Each healthcare provider engaged in the practice of telemedicine is responsible for ensuring that health care delivered to telemedicine patients adheres to the same standard of care applicable to in-person patients. In addition, healthcare providers engaged in the practice of telemedicine shall ensure all of the following as part of the standard of care for delivering health care via telemedicine:

(1) All healthcare providers and their staff members who provide care via telemedicine shall be trained in the use of telemedicine equipment and technology and its operation.

(2) All telemedicine technology and equipment used by healthcare providers must be sufficient to accurately assess, diagnose, and treat the patient; however, a telemedicine provider may use physical findings obtained by a physical examination of the patient by another licensed healthcare provider as part of the assessment.

(3) All telemedicine providers shall maintain a complete record of the telemedicine patient's care according to prevailing medical records standards. The record must include an appropriate evaluation of the patient's symptoms and all elements of the electronic professional interaction.

(4) No healthcare provider shall prescribe a controlled substance for the treatment of pain unless that provider has, within the last twelve months, conducted an in-person physical examination of the patient for the condition causing the pain for which the prescription is sought."

SECTION 2(a). By September 1, 2019, The Department of Health and Human Services shall study and report to the Joint Legislative Oversight Committee on Health and Human Services recommendations for telemedicine reimbursement standards for private health benefit plans. In conducting this study, the Department of Health and Human Services shall (i) solicit the input from the Department of Insurance and relevant stakeholders and (ii) consider at least all of the following:

(1) The health benefit plan reimbursement standards of other states and the results of those standards on cost and access to care.

(2) The specific telemedicine modalities for which health benefit plans should be required to provide reimbursement.

(3) The areas of care for which health benefit plans should be required to provide reimbursement.

(3) Whether private health benefit plans should be required to provide reimbursement for health care delivered via telemedicine on the same terms as reimbursement for in-person care.

(4) How to ensure the State's telemedicine reimbursement policy remains flexible enough to evolve with innovation.

(5) How to best encourage market competition and ensure private health benefit plans retain sufficient flexibility to realize efficiencies.

(6) Any other issues the Department deems appropriate.

SECTION 2(b). By September 1, 2019, the Department of Health and Human Services shall study and report to the Joint Legislative Oversight Committee on Health and Human Services recommendations for a plan to ensure that all North Carolina residents have sufficiently advanced internet connectivity to receive healthcare via telemedicine. In conducting

this study, the Department of Health and Human Services shall solicit input from the Department of Information Technology and consider at least all of the following:

(1) The best manner in which to incentivize investment in next-generation, future-proof broadband infrastructure and reduce barriers to deployment of that infrastructure.

(2) How to create community-based broadband adoption, utilization, and initiatives.

(3) How to ensure all healthcare providers are connected to the North Carolina HIE Network.

(4) Any other issues the Department deem appropriate.

SECTION 2(c). By September 1, 2019, the Department of Health and Human Services, in consultation with the North Carolina Institute of Medicine and the North Carolina Medical Board shall study and report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division on recommended performance metrics to be used by the Department of Health and Human Services in assessing the quality of telemedicine services provided in the State. In conducting this study, the Department is encouraged to examine all of the following:

(1) The final report entitled "Creating a Framework to Support Measure Development for Telehealth" released by the National Quality Forum in August 2017.

(2) Guidelines established by the Agency for Healthcare Research and Quality.

(3) Any other sources the Department deems appropriate.

SECTION 2(d). September 1, 2019, the Department of Health and Human Services shall report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division on recommended State licensing standards, credentialing processes, and prescribing standards for telemedicine providers, including any proposed legislation. The report shall include at least all of the following:

(1) A proposal for a standardized and centralized credentialing process for all providers that is consistent with the language in the 1115 Medicaid waiver submitted by the Department to the Centers for Medicare and Medicaid Services.

(2) A recommendation as to whether North Carolina should participate in the Interstate Medical Licensure Compact formulated by the Federation of State Medical Boards.

(3) Any other issues the Department deems appropriate.

SECTION 3. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2017

U **D**

BILL DRAFT 2017-SHz-5 [v.1] (01/30)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
03/23/2018 11:20:51 AM

Short Title:	Psychology Interjdtl. Compact (PSYPACT).	(Public)
Sponsors:		
Referred to:		

A BILL TO BE ENTITLED

AN ACT ESTABLISHING A PSYCHOLOGY INTERJURISDICTIONAL COMPACT (PSYPACT), AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON HEALTH AND HUMAN SERVICES.

Whereas, states license psychologists, in order to protect the public through verification of education, training, and experience and ensure accountability for professional practice; and

Whereas, this Compact is intended to regulate the day-to-day practice of telepsychology (i.e., the provision of psychological services using telecommunication technologies) by psychologists across state boundaries in the performance of their psychological practice as assigned by an appropriate authority; and

Whereas, this Compact is intended to regulate the temporary in-person, face-to-face practice of psychology by psychologists across state boundaries for 30 days within a calendar year in the performance of their psychological practice as assigned by an appropriate authority; and

Whereas, this Compact is intended to authorize State Psychology Regulatory Authorities to afford legal recognition, in a manner consistent with the terms of the Compact, to psychologists licensed in another state; and

Whereas, this Compact recognizes that states have a vested interest in protecting the public's health and safety through their licensing and regulation of psychologists and that such state regulation will best protect public health and safety; and

Whereas, this Compact does not apply when a psychologist is licensed in both the Home and Receiving States; and

Whereas, this Compact does not apply to permanent in-person, face-to-face practice, it does allow for authorization of temporary psychological practice; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1. Article 18A of Chapter 90 of the General Statutes, G.S. 90-270.1 through G.S. 90-270.22, is recodified as Article 18G of Chapter 90 of the General Statutes, G.S. 90-270.135 through G.S. 90-270.159.

SECTION 2. Chapter 90 of the General Statutes is amended by adding a new Article to read:

"Article 18H.

"Psychology Interjurisdictional Licensure Compact.

"**§ 90-270.160. Purpose.**

This Compact is designed to achieve the following purposes and objectives:

(1) Increase public access to professional psychological services by allowing for telepsychological practice across state lines as well as temporary in-person, face-to-face services into a state which the psychologist is not licensed to practice psychology.

(2) Enhance the states' ability to protect the public's health and safety, especially client/patient safety.

(3) Encourage the cooperation of Compact States in the areas of psychology licensure and regulation.

(4) Facilitate the exchange of information between Compact States regarding psychologist licensure, adverse actions, and disciplinary history.

(5) Promote compliance with the laws governing psychological practice in each Compact State.

(6) Invest all Compact States with the authority to hold licensed psychologists accountable through the mutual recognition of Compact State licenses.

"**§ 90-270.161. Definitions.**

(1) Adverse action. – Any action taken by a State Psychology Regulatory Authority which finds a violation of a statute or regulation that is identified by the State Psychology Regulatory Authority as discipline and is a matter of public record.

(2) Association of State and Provincial Psychology Boards (ASPPB). – The recognized membership organization composed of State and Provincial Psychology Regulatory Authorities responsible for the licensure and registration of psychologists throughout the United States and Canada.

(3) Authority to Practice Interjurisdictional Telepsychology. – A licensed psychologist's authority to practice telepsychology, within the limits authorized under this Compact, in another Compact State.

(4) Bylaws. – Those Bylaws established by the Psychology Interjurisdictional Compact Commission pursuant to § 90-270.169 for its governance, or for directing and controlling its actions and conduct.

(5) Client/patient. – The recipient of psychological services, whether psychological services are delivered in the context of health care, corporate, supervision, and/or consulting services.

(6) Commissioner. – The voting representative appointed by each State Psychology Regulatory Authority pursuant to § 90-270.169.

(7) Compact State. – A state, the District of Columbia, or United States territory that has enacted this Compact legislation and which has not withdrawn pursuant to § 90-270.172(c), or been terminated pursuant to § 90-270.171(b).

(8) Coordinated Licensure Information System or Coordinated Database. – An integrated process for collecting, storing, and sharing information on psychologists' licensure and enforcement activities related to psychology licensure laws, which is administered by the recognized membership organization composed of State and Provincial Psychology Regulatory Authorities.

(9) Confidentiality. – The principle that data or information is not made available or disclosed to unauthorized persons and/or processes.

(10) Day. – Any part of a day in which psychological work is performed.

(11) Distant State. – The Compact State where a psychologist is physically present (not through the use of telecommunications technologies), to provide temporary in-person, face-to-face psychological services.

(12) E.Passport. – A certificate issued by the Association of State and Provincial Psychology Boards (ASPPB) that promotes the standardization in the criteria of interjurisdictional telepsychology practice and facilitates the process for licensed psychologists to provide telepsychological services across state lines.

(13) Executive Board. – A group of directors elected or appointed to act on behalf of, and within the powers granted to them by, the Commission.

(14) Home State. – A Compact State where a psychologist is licensed to practice psychology. If the psychologist is licensed in more than one Compact State and is practicing under the Authorization to Practice Interjurisdictional Telepsychology, the Home State is the Compact State where the psychologist is physically present when the telepsychological services are delivered. If the psychologist is licensed in more than one Compact State and is practicing under the Temporary Authorization to Practice, the Home State is any Compact State where the psychologist is licensed.

(15) Identity History Summary. – A summary of information retained by the FBI, or other designee with similar authority, in connection with arrests and, in some instances, federal employment, naturalization, or military service.

(16) In-person, face-to-face. – Interactions in which the psychologist and the client/patient are in the same physical space and which does not include interactions that may occur through the use of telecommunication technologies.

(17) Interjurisdictional Practice Certificate (IPC). – A certificate issued by the Association of State and Provincial Psychology Boards (ASPPB) that grants temporary authority to practice based on notification to the State Psychology Regulatory Authority of intention to practice temporarily and verification of one's qualifications for such practice.

(18) License. – Authorization by a State Psychology Regulatory Authority to engage in the independent practice of psychology, which would be unlawful without the authorization.

(19) Non-Compact State. – Any State which is not at the time a Compact State.

(20) Psychologist. – An individual licensed for the independent practice of psychology.

(21) Psychology Interjurisdictional Compact Commission (Commission). – The national administration of which all Compact States are members.

(22) Receiving State. – A Compact State where the client/patient is physically located when the telepsychological services are delivered.

(23) Rule. – A written statement by the Psychology Interjurisdictional Compact Commission promulgated pursuant to § 90-270.170 of the Compact that is of general applicability, implements, interprets, or prescribes a policy or provision of the Compact, or an organizational, procedural, or practice requirement of the Commission and has the force and effect of statutory law in a Compact State, and includes the amendment, repeal, or suspension of an existing rule.

(24) Significant investigatory information. –

a. Investigative information that a State Psychology Regulatory Authority, after a preliminary inquiry that includes notification and an

opportunity to respond if required by state law, has reason to believe, if proven true, would indicate more than a violation of state statute or ethics code that would be considered more substantial than minor infraction; or

b. Investigative information that indicates that the psychologist represents an immediate threat to public health and safety regardless of whether the psychologist has been notified and/or had an opportunity to respond.

(25) State. – A state, commonwealth, territory, or possession of the United States, the District of Columbia.

(26) State Psychology Regulatory Authority. – The Board, office or other agency with the legislative mandate to license and regulate the practice of psychology.

(27) Telepsychology. – The provision of psychological services using telecommunication technologies.

(28) Temporary Authorization to Practice. – A licensed psychologist's authority to conduct temporary in-person, face-to-face practice, within the limits authorized under this Compact, in another Compact State.

(29) Temporary in-person, face-to-face practice. – Where a psychologist is physically present (not through the use of telecommunications technologies), in the Distant State to provide for the practice of psychology for 30 days within a calendar year and based on notification to the Distant State.

"**§ 90-270.162. Home State Licensure.**

(a) The Home State shall be a Compact State where a psychologist is licensed to practice psychology.

(b) A psychologist may hold one or more Compact State licenses at a time. If the psychologist is licensed in more than one Compact State, the Home State is the Compact State where the psychologist is physically present when the services are delivered as authorized by the Authority to Practice Interjurisdictional Telepsychology under the terms of this Compact.

(c) Any Compact State may require a psychologist not previously licensed in a Compact State to obtain and retain a license to be authorized to practice in the Compact State under circumstances not authorized by the Authority to Practice Interjurisdictional Telepsychology under the terms of this Compact.

(d) Any Compact State may require a psychologist to obtain and retain a license to be authorized to practice in a Compact State under circumstances not authorized by Temporary Authorization to Practice under the terms of this Compact.

(e) A Home State's license authorizes a psychologist to practice in a Receiving State under the Authority to Practice Interjurisdictional Telepsychology only if the Compact State:

(1) Currently requires the psychologist to hold an active E.Passport;

(2) Has a mechanism in place for receiving and investigating complaints about licensed individuals;

(3) Notifies the Commission, in compliance with the terms herein, of any adverse action or significant investigatory information regarding a licensed individual;

(4) Requires an Identity History Summary of all applicants at initial licensure, including the use of the results of fingerprints or other biometric data checks compliant with the requirements of the Federal Bureau of Investigation (FBI), or other designee with similar authority, no later than 10 years after activation of the Compact; and

(5) Complies with the Bylaws and Rules of the Commission.

(f) A Home State's license grants Temporary Authorization to Practice to a psychologist in a Distant State only if the Compact State:

(1) Currently requires the psychologist to hold an active IPC;

(2) Has a mechanism in place for receiving and investigating complaints about licensed individuals;

(3) Notifies the Commission, in compliance with the terms herein, of any adverse action or significant investigatory information regarding a licensed individual;

(4) Requires an Identity History Summary of all applicants at initial licensure, including the use of the results of fingerprints or other biometric data checks compliant with the requirements of the Federal Bureau of Investigation (FBI), or other designee with similar authority, no later than 10 years after activation of the Compact; and

(5) Complies with the Bylaws and Rules of the Commission.

"**§ 90-270.163. Compact Privilege to Practice Telepsychology.**

(a) Compact States shall recognize the right of a psychologist, licensed in a Compact State in conformance with § 90-270.162, to practice telepsychology in other Compact States (Receiving States) in which the psychologist is not licensed, under the Authority to Practice Interjurisdictional Telepsychology as provided in the Compact.

(b) To exercise the Authority to Practice Interjurisdictional Telepsychology under the terms and provisions of this Compact, a psychologist licensed to practice in a Compact State must:

(1) Hold a graduate degree in psychology from an institute of higher education that was, at the time the degree was awarded:

a. Regionally accredited by an accrediting body recognized by the U.S. Department of Education to grant graduate degrees, or authorized by Provincial Statute or Royal Charter to grant doctoral degrees; or

b. A foreign college or university deemed to be equivalent to sub-subdivision a. of this subdivision by a foreign credential evaluation service that is a member of the National Association of Credential Evaluation Services (NACES) or by a recognized foreign credential evaluation service; and

(2) Hold a graduate degree in psychology that meets the following criteria:

a. The program, wherever it may be administratively housed, must be clearly identified and labeled as a psychology program. Such a program must specify in pertinent institutional catalogues and brochures its intent to educate and train professional psychologists;

b. The psychology program must stand as a recognizable, coherent, organizational entity within the institution;

c. There must be a clear authority and primary responsibility for the core and specialty areas whether or not the program cuts across administrative lines;

d. The program must consist of an integrated, organized sequence of study;

e. There must be an identifiable psychology faculty sufficient in size and breadth to carry out its responsibilities;

f. The designated director of the program must be a psychologist and a member of the core faculty;

g. The program must have an identifiable body of students who are matriculated in that program for a degree;

h. The program must include supervised practicum, internship, or field training appropriate to the practice of psychology;

i. The curriculum shall encompass a minimum of three academic years of full- time graduate study for doctoral degree and a minimum of one academic year of full-time graduate study for master's degree;

j. The program includes an acceptable residency as defined by the Rules of the Commission.

(3) Possess a current, full, and unrestricted license to practice psychology in a Home State which is a Compact State;

(4) Have no history of adverse action that violate the Rules of the Commission;

(5) Have no criminal record history reported on an Identity History Summary that violates the Rules of the Commission;

(6) Possess a current, active E.Passport;

(7) Provide attestations in regard to areas of intended practice, conformity with standards of practice, competence in telepsychology technology; criminal background; and knowledge and adherence to legal requirements in the home and receiving states, and provide a release of information to allow for primary source verification in a manner specified by the Commission; and

(8) Meet other criteria as defined by the Rules of the Commission.

(c) The Home State maintains authority over the license of any psychologist practicing into a Receiving State under the Authority to Practice Interjurisdictional Telepsychology.

(d) A psychologist practicing into a Receiving State under the Authority to Practice Interjurisdictional Telepsychology will be subject to the Receiving State's scope of practice. A Receiving State may, in accordance with that state's due process law, limit or revoke a psychologist's Authority to Practice Interjurisdictional Telepsychology in the Receiving State and may take any other necessary actions under the Receiving State's applicable law to protect the health and safety of the Receiving State's citizens. If a Receiving State takes action, the state shall promptly notify the Home State and the Commission.

(e) If a psychologist's license in any Home State, another Compact State, or any Authority to Practice Interjurisdictional Telepsychology in any Receiving State is restricted, suspended, or otherwise limited, the E.Passport shall be revoked and, therefore, the psychologist shall not be eligible to practice telepsychology in a Compact State under the Authority to Practice Interjurisdictional Telepsychology.

"**§ 90-270.164. Compact Temporary Authorization to Practice.**

(a) Compact States shall also recognize the right of a psychologist, licensed in a Compact State in conformance with § 90-270.162, to practice temporarily in other Compact States (Distant States) in which the psychologist is not licensed, as provided in the Compact.

(b) To exercise the Temporary Authorization to Practice under the terms and provisions of this Compact, a psychologist licensed to practice in a Compact State must:

(1) Hold a graduate degree in psychology from an institute of higher education that was, at the time the degree was awarded:

a. Regionally accredited by an accrediting body recognized by the U.S. Department of Education to grant graduate degrees, or authorized by Provincial Statute or Royal Charter to grant doctoral degrees; or

b. A foreign college or university deemed to be equivalent to sub-subdivision a. of this subdivision by a foreign credential evaluation service that is a member of the National Association of Credential Evaluation Services (NACES) or by a recognized foreign credential evaluation service; and

(2) Hold a graduate degree in psychology that meets the following criteria:

a. The program, wherever it may be administratively housed, must be clearly identified and labeled as a psychology program. Such a program must specify in pertinent institutional catalogues and brochures its intent to educate and train professional psychologists;

b. The psychology program must stand as a recognizable, coherent, organizational entity within the institution;

c. There must be a clear authority and primary responsibility for the core and specialty areas whether or not the program cuts across administrative lines;

d. The program must consist of an integrated, organized sequence of study;

e. There must be an identifiable psychology faculty sufficient in size and breadth to carry out its responsibilities;

f. The designated director of the program must be a psychologist and a member of the core faculty;

g. The program must have an identifiable body of students who are matriculated in that program for a degree;

h. The program must include supervised practicum, internship, or field training appropriate to the practice of psychology;

i. The curriculum shall encompass a minimum of three academic years of full-time graduate study for doctoral degrees and a minimum of one academic year of full-time graduate study for master's degree;

j. The program includes an acceptable residency as defined by the Rules of the Commission.

(3) Possess a current, full, and unrestricted license to practice psychology in a Home State which is a Compact State;

(4) No history of adverse action that violate the Rules of the Commission;

(5) No criminal record history that violates the Rules of the Commission;

(6) Possess a current, active IPC

(7) Provide attestations in regard to areas of intended practice and work experience and provide a release of information to allow for primary source verification in a manner specified by the Commission; and

(8) Meet other criteria as defined by the Rules of the Commission.

(c) A psychologist practicing into a Distant State under the Temporary Authorization to Practice shall practice within the scope of practice authorized by the Distant State.

(d) A psychologist practicing into a Distant State under the Temporary Authorization to Practice will be subject to the Distant State's authority and law. A Distant State may, in accordance with that state's due process law, limit or revoke a psychologist's Temporary Authorization to Practice in the Distant State and may take any other necessary actions under the Distant State's applicable law to protect the health and safety of the Distant State's citizens. If a Distant State takes action, the state shall promptly notify the Home State and the Commission.

(e) If a psychologist's license in any Home State, another Compact State, or any Temporary Authorization to Practice in any Distant State is restricted, suspended, or otherwise limited, the IPC shall be revoked and therefore the psychologist shall not be eligible to practice in a Compact State under the Temporary Authorization to Practice.

"**§ 90-270.165. Conditions of telepsychology practice in a Receiving State.**

A psychologist may practice in a Receiving State under the Authority to Practice Interjurisdictional Telepsychology only in the performance of the scope of practice for

psychology as assigned by an appropriate State Psychology Regulatory Authority, as defined in the Rules of the Commission, and under the following circumstances:

(1) The psychologist initiates a client/patient contact in a Home State via telecommunications technologies with a client/patient in a Receiving State.

(2) Other conditions regarding telepsychology as determined by Rules promulgated by the Commission.

"**§ 90-270.166. Adverse actions.**

(a) A Home State shall have the power to impose adverse action against a psychologist's license issued by the Home State. A Distant State shall have the power to take adverse action on a psychologist's Temporary Authorization to Practice within that Distant State.

(b) A Receiving State may take adverse action on a psychologist's Authority to Practice Interjurisdictional Telepsychology within that Receiving State. A Home State may take adverse action against a psychologist based on an adverse action taken by a Distant State regarding temporary in-person, face-to-face practice.

(c) If a Home State takes adverse action against a psychologist's license, that psychologist's Authority to Practice Interjurisdictional Telepsychology is terminated and the E.Passport is revoked. Furthermore, that psychologist's Temporary Authorization to Practice is terminated and the IPC is revoked.

(1) All Home State disciplinary orders which impose adverse action shall be reported to the Commission in accordance with the Rules promulgated by the Commission. A Compact State shall report adverse actions in accordance with the Rules of the Commission.

(2) In the event discipline is reported on a psychologist, the psychologist will not be eligible for telepsychology or temporary in-person, face-to-face practice in accordance with the Rules of the Commission.

(3) Other actions may be imposed as determined by the Rules promulgated by the Commission.

(d) A Home State's Psychology Regulatory Authority shall investigate and take appropriate action with respect to reported inappropriate conduct engaged in by a licensee which occurred in a Receiving State as it would if such conduct had occurred by a licensee within the Home State. In such cases, the Home State's law shall control in determining any adverse action against a psychologist's license.

(e) A Distant State's Psychology Regulatory Authority shall investigate and take appropriate action with respect to reported inappropriate conduct engaged in by a psychologist practicing under Temporary Authorization Practice which occurred in that Distant State as it would if such conduct had occurred by a licensee within the Home State. In such cases, Distant State's law shall control in determining any adverse action against a psychologist's Temporary Authorization to Practice.

(f) Nothing in this Compact shall override a Compact State's decision that a psychologist's participation in an alternative program may be used in lieu of adverse action and that such participation shall remain non-public if required by the Compact State's law. Compact States must require psychologists who enter any alternative programs to not provide telepsychology services under the Authority to Practice Interjurisdictional Telepsychology or provide temporary psychological services under the Temporary Authorization to Practice in any other Compact State during the term of the alternative program.

(g) No other judicial or administrative remedies shall be available to a psychologist in the event a Compact State imposes an adverse action pursuant to subsection (c) of this section.

"**§ 90-270.167. Additional authorities invested in a Compact State's Psychology Regulatory Authority.**

In addition to any other powers granted under state law, a Compact State's Psychology Regulatory Authority shall have the authority under this Compact to:

(1) Issue subpoenas, for both hearings and investigations, which require the attendance and testimony of witnesses and the production of evidence. Subpoenas issued by a Compact State's Psychology Regulatory Authority for the attendance and testimony of witnesses and/or the production of evidence from another Compact State shall be enforced in the latter state by any court of competent jurisdiction, according to that court's practice and procedure in considering subpoenas issued in its own proceedings. The issuing State Psychology Regulatory Authority shall pay any witness fees, travel expenses, mileage and other fees required by the service statutes of the state where the witnesses and/or evidence are located.

(2) Issue cease and desist and/or injunctive relief orders to revoke a psychologist's Authority to Practice Interjurisdictional Telepsychology and/or Temporary Authorization to Practice.

(3) During the course of any investigation, a psychologist may not change his/her Home State licensure. A Home State Psychology Regulatory Authority is authorized to complete any pending investigations of a psychologist and to take any actions appropriate under its law. The Home State Psychology Regulatory Authority shall promptly report the conclusions of such investigations to the Commission. Once an investigation has been completed, and pending the outcome of said investigation, the psychologist may change his/her Home State licensure. The Commission shall promptly notify the new Home State of any such decisions as provided in the Rules of the Commission. All information provided to the Commission or distributed by Compact States pursuant to the psychologist shall be confidential, filed under seal, and used for investigatory or disciplinary matters. The Commission may create additional rules for mandated or discretionary sharing of information by Compact States.

"**§ 90-270.168. Coordinated Licensure Information System.**

(a) The Commission shall provide for the development and maintenance of a Coordinated Licensure Information System (Coordinated Database) and reporting system containing licensure and disciplinary action information on all psychologists individuals to whom this Compact is applicable in all Compact States as defined by the Rules of the Commission.

(b) Notwithstanding any other provision of state law to the contrary, a Compact State shall submit a uniform data set to the Coordinated Database on all licensees as required by the Rules of the Commission, including:

(1) Identifying information;

(2) Licensure data;

(3) Significant investigatory information;

(4) Adverse actions against a psychologist's license;

(5) An indicator that a psychologist's Authority to Practice Interjurisdictional Telepsychology and/or Temporary Authorization to Practice is revoked;

(6) Non-confidential information related to alternative program participation information;

(7) Any denial of application for licensure and the reasons for such denial; and

(8) Other information which may facilitate the administration of this Compact, as determined by the Rules of the Commission.

(c) The Coordinated Database administrator shall promptly notify all Compact States of any adverse action taken against, or significant investigative information on, any licensee in a Compact State.

(d) Compact States reporting information to the Coordinated Database may designate information that may not be shared with the public without the express permission of the Compact State reporting the information.

(e) Any information submitted to the Coordinated Database that is subsequently required to be expunged by the law of the Compact State reporting the information shall be removed from the Coordinated Database.

"**§ 90-270.169. Establishment of the Psychology Interjurisdictional Compact Commission.**

(a) The Compact States hereby create and establish a joint public agency known as the Psychology Interjurisdictional Compact Commission.

(1) The Commission is a body politic and an instrumentality of the Compact States.

(2) Venue is proper and judicial proceedings by or against the Commission shall be brought solely and exclusively in a court of competent jurisdiction where the principal office of the Commission is located. The Commission may waive venue and jurisdictional defenses to the extent it adopts or consents to participate in alternative dispute resolution proceedings.

(3) Nothing in this Compact shall be construed to be a waiver of sovereign immunity.

(b) Membership, Voting, and Meetings. –

(1) The Commission shall consist of one voting representative appointed by each Compact State who shall serve as that state's Commissioner. The State Psychology Regulatory Authority shall appoint its delegate. This delegate shall be empowered to act on behalf of the Compact State. This delegate shall be limited to:

a. Executive Director, Executive Secretary, or similar executive;

b. Current member of the State Psychology Regulatory Authority of a Compact State; or

c. Designee empowered with the appropriate delegate authority to act on behalf of the Compact State.

(2) Any Commissioner may be removed or suspended from office as provided by the law of the state from which the Commissioner is appointed. Any vacancy occurring in the Commission shall be filled in accordance with the laws of the Compact State in which the vacancy exists.

(3) Each Commissioner shall be entitled to one (1) vote with regard to the promulgation of Rules and creation of Bylaws and shall otherwise have an opportunity to participate in the business and affairs of the Commission. A Commissioner shall vote in person or by such other means as provided in the Bylaws. The Bylaws may provide for Commissioners' participation in meetings by telephone or other means of communication.

(4) The Commission shall meet at least once during each calendar year. Additional meetings shall be held as set forth in the Bylaws.

(5) All meetings shall be open to the public, and public notice of meetings shall be given in the same manner as required under the rule-making provisions in § 90-270.170.

(6) The Commission may convene in a closed, nonpublic meeting if the Commission must discuss:

a. Noncompliance of a Compact State with its obligations under the Compact;

b. The employment, compensation, discipline, or other personnel matters, practices, or procedures related to specific employees or other matters related to the Commission's internal personnel practices and procedures;

c. Current, threatened, or reasonably anticipated litigation against the Commission;

d. Negotiation of contracts for the purchase or sale of goods, services, or real estate;

e. Accusation against any person of a crime or formally censuring any person;

f. Disclosure of trade secrets or commercial or financial information which is privileged or confidential;

g. Disclosure of information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy;

h. Disclosure of investigatory records compiled for law enforcement purposes;

i. Disclosure of information related to any investigatory reports prepared by or on behalf of or for use of the Commission or other committee charged with responsibility for investigation or determination of compliance issues pursuant to the Compact; or

j. Matters specifically exempted from disclosure by federal and state statute.

(7) If a meeting, or portion of a meeting, is closed pursuant to this provision, the Commission's legal counsel or designee shall certify that the meeting may be closed and shall reference each relevant exempting provision. The Commission shall keep minutes which fully and clearly describe all matters discussed in a meeting and shall provide a full and accurate summary of actions taken, of any person participating in the meeting, and the reasons therefore, including a description of the views expressed. All documents considered in connection with an action shall be identified in such minutes. All minutes and documents of a closed meeting shall remain under seal, subject to release only by a majority vote of the Commission or order of a court of competent jurisdiction.

(c) The Commission shall, by a majority vote of the Commissioners, prescribe Bylaws and/or Rules to govern its conduct as may be necessary or appropriate to carry out the purposes and exercise the powers of the Compact, including, but not limited to:

(1) Establishing the fiscal year of the Commission;

(2) Providing reasonable standards and procedures:

a. For the establishment and meetings of other committees; and

b. Governing any general or specific delegation of any authority or function of the Commission;

(3) Providing reasonable procedures for calling and conducting meetings of the Commission, ensuring reasonable advance notice of all meetings and providing an opportunity for attendance of such meetings by interested parties, with enumerated exceptions designed to protect the public's interest, the privacy of individuals of such proceedings, and proprietary information, including trade secrets. The Commission may meet in closed session only

after a majority of the Commissioners vote to close a meeting to the public in whole or in part. As soon as practicable, the Commission must make public a copy of the vote to close the meeting revealing the vote of each Commissioner with no proxy votes allowed;

(4) Establishing the titles, duties, and authority and reasonable procedures for the election of the officers of the Commission;

(5) Providing reasonable standards and procedures for the establishment of the personnel policies and programs of the Commission. Notwithstanding any civil service or other similar law of any Compact State, the Bylaws shall exclusively govern the personnel policies and programs of the Commission;

(6) Promulgating a Code of Ethics to address permissible and prohibited activities of Commission members and employees;

(7) Providing a mechanism for concluding the operations of the Commission and the equitable disposition of any surplus funds that may exist after the termination of the Compact after the payment and/or reserving of all of its debts and obligations;

(8) The Commission shall publish its Bylaws in a convenient form and file a copy thereof and a copy of any amendment thereto with the appropriate agency or officer in each of the Compact States;

(9) The Commission shall maintain its financial records in accordance with the Bylaws; and

(10) The Commission shall meet and take such actions as are consistent with the provisions of this Compact and the Bylaws.

(d) The Commission shall have the following powers:

(1) The authority to promulgate uniform rules to facilitate and coordinate implementation and administration of this Compact. The rule shall have the force and effect of law and shall be binding in all Compact States;

(2) To bring and prosecute legal proceedings or actions in the name of the Commission, provided that the standing of any State Psychology Regulatory Authority or other regulatory body responsible for psychology licensure to sue or be sued under applicable law shall not be affected;

(3) To purchase and maintain insurance and bonds;

(4) To borrow, accept, or contract for services of personnel, including, but not limited to, employees of a Compact State;

(5) To hire employees, elect or appoint officers, fix compensation, define duties, grant such individuals appropriate authority to carry out the purposes of the Compact, and to establish the Commission's personnel policies and programs relating to conflicts of interest, qualifications of personnel, and other related personnel matters;

(6) To accept any and all appropriate donations and grants of money, equipment, supplies, materials, and services and to receive, utilize, and dispose of the same, provided that at all times the Commission shall strive to avoid any appearance of impropriety and/or conflict of interest;

(7) To lease, purchase, accept appropriate gifts or donations of, or otherwise to own, hold, improve, or use any property, real, personal, or mixed, provided that at all times the Commission shall strive to avoid any appearance of impropriety;

(8) To sell, convey, mortgage, pledge, lease, exchange, abandon, or otherwise dispose of any property, real, personal, or mixed;

(9) To establish a budget and make expenditures;
(10) To borrow money;
(11) To appoint committees, including advisory committees comprised of members, state regulators, state legislators or their representatives, and consumer representatives, and such other interested persons as may be designated in this Compact and the Bylaws;
(12) To provide and receive information from, and to cooperate with, law enforcement agencies;
(13) To adopt and use an official seal; and
(14) To perform such other functions as may be necessary or appropriate to achieve the purposes of this Compact consistent with the state regulation of psychology licensure, temporary in-person, face-to-face practice, and telepsychology practice.

(e) The Executive Board. – The elected officers shall serve as the Executive Board, which shall have the power to act on behalf of the Commission according to the terms of this Compact.
(1) The Executive Board shall be comprised of six members:
a. Five voting members who are elected from the current membership of the Commission by the Commission.
b. One ex-officio, nonvoting member from the recognized membership organization composed of State and Provincial Psychology Regulatory Authorities.
(2) The ex-officio member must have served as staff or member on a State Psychology Regulatory Authority and will be selected by its respective organization.
(3) The Commission may remove any member of the Executive Board as provided in Bylaws.
(4) The Executive Board shall meet at least annually.
(5) The Executive Board shall have the following duties and responsibilities:
a. Recommend to the entire Commission changes to the Rules or Bylaws, changes to this Compact legislation, fees paid by Compact States such as annual dues and any other applicable fees;
b. Ensure Compact administration services are appropriately provided, contractual or otherwise;
c. Prepare and recommend the budget;
d. Maintain financial records on behalf of the Commission;
e. Monitor Compact compliance of member states and provide compliance reports to the Commission;
f. Establish additional committees as necessary; and
g. Other duties as provided in Rules or Bylaws.

(f) Financing of the Commission. –
(1) The Commission shall pay or provide for the payment of the reasonable expenses of its establishment, organization, and ongoing activities.
(2) The Commission may accept any and all appropriate revenue sources, donations, and grants of money, equipment, supplies, materials, and services.
(3) The Commission may levy on and collect an annual assessment from each Compact State or impose fees on other parties to cover the cost of the operations and activities of the Commission and its staff which must be in a total amount sufficient to cover its annual budget as approved each year for which revenue is not provided by other sources. The aggregate annual

assessment amount shall be allocated based upon a formula to be determined by the Commission which shall promulgate a rule binding upon all Compact States.

(4) The Commission shall not incur obligations of any kind prior to securing the funds adequate to meet the same; nor shall the Commission pledge the credit of any of the Compact States, except by and with the authority of the Compact State.

(5) The Commission shall keep accurate accounts of all receipts and disbursements. The receipts and disbursements of the Commission shall be subject to the audit and accounting procedures established under its Bylaws. However, all receipts and disbursements of funds handled by the Commission shall be audited yearly by a certified or licensed public accountant and the report of the audit shall be included in and become part of the annual report of the Commission.

(g) Qualified Immunity, Defense, and Indemnification. –

(1) The members, officers, Executive Director, employees and representatives of the Commission shall be immune from suit and liability, either personally or in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties or responsibilities, provided that nothing in this subdivision shall be construed to protect any such person from suit and/or liability for any damage, loss, injury, or liability caused by the intentional or willful or wanton misconduct of that person.

(2) The Commission shall defend any member, officer, Executive Director, employee or representative of the Commission in any civil action seeking to impose liability arising out of any actual or alleged act, error, or omission that occurred within the scope of Commission employment, duties, or responsibilities, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities, provided that nothing herein shall be construed to prohibit that person from retaining his or her own counsel; and provided further, that the actual or alleged act, error, or omission did not result from that person's intentional or willful or wanton misconduct.

(3) The Commission shall indemnify and hold harmless any member, officer, Executive Director, employee, or representative of the Commission for the amount of any settlement or judgment obtained against that person arising out of any actual or alleged act, error, or omission that occurred within the scope of employment, duties, or responsibilities, or that such person had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities, provided that the actual or alleged act, error, or omission did not result from the intentional or willful or wanton misconduct of that person.

"**§ 90-270.170. Rule making.**

(a) The Commission shall exercise its rule-making powers pursuant to the criteria set forth in this section and the Rules adopted thereunder. Rules and amendments shall become binding as of the date specified in each rule or amendment.

(b) If a majority of the legislatures of the Compact States rejects a rule, by enactment of a statute or resolution in the same manner used to adopt the Compact, then such rule shall have no further force and effect in any Compact State.

(c) Rules or amendments to the rules shall be adopted at a regular or special meeting of the Commission.

(d) Prior to promulgation and adoption of a final rule or Rules by the Commission, and at least 60 days in advance of the meeting at which the rule will be considered and voted upon, the Commission shall file a Notice of Proposed Rule Making:

(1) On the Web site of the Commission; and

(2) On the Web site of each Compact States' Psychology Regulatory Authority or the publication in which each state would otherwise publish proposed rules.

(e) The Notice of Proposed Rule Making shall include:

(1) The proposed time, date, and location of the meeting in which the rule will be considered and voted upon;

(2) The text of the proposed rule or amendment and the reason for the proposed rule;

(3) A request for comments on the proposed rule from any interested person; and

(4) The manner in which interested persons may submit notice to the Commission of their intention to attend the public hearing and any written comments.

(f) Prior to adoption of a proposed rule, the Commission shall allow persons to submit written data, facts, opinions and arguments, which shall be made available to the public.

(g) The Commission shall grant an opportunity for a public hearing before it adopts a rule or amendment if a hearing is requested by:

(1) At least 25 persons who submit comments independently of each other;

(2) A governmental subdivision or agency; or

(3) A duly appointed person in an association that has having at least 25 members.

(h) If a hearing is held on the proposed rule or amendment, the Commission shall publish the place, time, and date of the scheduled public hearing.

(1) All persons wishing to be heard at the hearing shall notify the Executive Director of the Commission or other designated member in writing of their desire to appear and testify at the hearing not less than five business days before the scheduled date of the hearing.

(2) Hearings shall be conducted in a manner providing each person who wishes to comment a fair and reasonable opportunity to comment orally or in writing.

(3) No transcript of the hearing is required, unless a written request for a transcript is made, in which case the person requesting the transcript shall bear the cost of producing the transcript. A recording may be made in lieu of a transcript under the same terms and conditions as a transcript. This subsection shall not preclude the Commission from making a transcript or recording of the hearing if it so chooses.

(4) Nothing in this section shall be construed as requiring a separate hearing on each rule. Rules may be grouped for the convenience of the Commission at hearings required by this section.

(i) Following the scheduled hearing date, or by the close of business on the scheduled hearing date if the hearing was not held, the Commission shall consider all written and oral comments received.

(j) The Commission shall, by majority vote of all members, take final action on the proposed rule and shall determine the effective date of the rule, if any, based on the rule-making record and the full text of the rule.

(k) If no written notice of intent to attend the public hearing by interested parties is received, the Commission may proceed with promulgation of the proposed rule without a public hearing.

(*l*) Upon determination that an emergency exists, the Commission may consider and adopt an emergency rule without prior notice, opportunity for comment, or hearing, provided that the usual rule-making procedures provided in the Compact and in this section shall be retroactively applied to the rule as soon as reasonably possible, in no event later than 90 days after the effective date of the rule. For the purposes of this provision, an emergency rule is one that must be adopted immediately in order to:

(1) Meet an imminent threat to public health, safety, or welfare;

(2) Prevent a loss of Commission or Compact State funds;

(3) Meet a deadline for the promulgation of an administrative rule that is established by federal law or rule; or

(4) Protect public health and safety.

(m) The Commission or an authorized committee of the Commission may direct revisions to a previously adopted rule or amendment for purposes of correcting typographical errors, errors in format, errors in consistency, or grammatical errors. Public notice of any revisions shall be posted on the Web site of the Commission. The revision shall be subject to challenge by any person for a period of 30 days after posting. The revision may be challenged only on grounds that the revision results in a material change to a rule. A challenge shall be made in writing, and delivered to the Chair of the Commission prior to the end of the notice period. If no challenge is made, the revision will take effect without further action. If the revision is challenged, the revision may not take effect without the approval of the Commission.

"**§ 90-270.171. Oversight, dispute resolution, and enforcement.**

(a) Oversight. –

(1) The executive, legislative, and judicial branches of state government in each Compact State shall enforce this Compact and take all actions necessary and appropriate to effectuate the Compact's purposes and intent. The provisions of this Compact and the rules promulgated hereunder shall have standing as statutory law.

(2) All courts shall take judicial notice of the Compact and the rules in any judicial or administrative proceeding in a Compact State pertaining to the subject matter of this Compact which may affect the powers, responsibilities, or actions of the Commission.

(3) The Commission shall be entitled to receive service of process in any such proceeding and shall have standing to intervene in such a proceeding for all purposes. Failure to provide service of process to the Commission shall render a judgment or order void as to the Commission, this Compact, or promulgated rules.

(b) Default, Technical Assistance, and Termination. –

(1) If the Commission determines that a Compact State has defaulted in the performance of its obligations or responsibilities under this Compact or the promulgated rules, the Commission shall:

a. Provide written notice to the defaulting state and other Compact States of the nature of the default, the proposed means of remedying the default, and/or any other action to be taken by the Commission; and

b. Provide remedial training and specific technical assistance regarding the default.

(2) If a state in default fails to remedy the default, the defaulting state may be terminated from the Compact upon an affirmative vote of a majority of the Compact States and all rights, privileges and benefits conferred by this Compact shall be terminated on the effective date of termination. A remedy of the default does not relieve the offending state of obligations or liabilities incurred during the period of default.

(3) Termination of membership in the Compact shall be imposed only after all other means of securing compliance have been exhausted. Notice of intent to suspend or terminate shall be submitted by the Commission to the Governor, the majority and minority leaders of the defaulting state's legislature, and each of the Compact States.

(4) A Compact State which has been terminated is responsible for all assessments, obligations, and liabilities incurred through the effective date of termination, including obligations which extend beyond the effective date of termination.

(5) The Commission shall not bear any costs incurred by the state which is found to be in default or which has been terminated from the Compact, unless agreed upon in writing between the Commission and the defaulting state.

(6) The defaulting state may appeal the action of the Commission by petitioning the U.S. District Court for the state of Georgia or the federal district where the Compact has its principal offices. The prevailing member shall be awarded all costs of such litigation, including reasonable attorneys' fees.

(c) Dispute Resolution. –

(1) Upon request by a Compact State, the Commission shall attempt to resolve disputes related to the Compact which arise among Compact States and between Compact and Non-Compact States.

(2) The Commission shall promulgate a rule providing for both mediation and binding dispute resolution for disputes that arise before the Commission.

(d) Enforcement. –

(1) The Commission, in the reasonable exercise of its discretion, shall enforce the provisions and Rules of this Compact.

(2) By majority vote, the Commission may initiate legal action in the United States District Court for the State of Georgia or the federal district where the Compact has its principal offices against a Compact State in default to enforce compliance with the provisions of the Compact and its promulgated Rules and Bylaws. The relief sought may include both injunctive relief and damages. In the event judicial enforcement is necessary, the prevailing member shall be awarded all costs of such litigation, including reasonable attorneys' fees.

(3) The remedies herein shall not be the exclusive remedies of the Commission. The Commission may pursue any other remedies available under federal or state law.

"**§ 90-270.172. Date of implementation of the Psychology Interjurisdictional Compact Commission and associated rules, withdrawal, and amendments.**

(a) The Compact shall come into effect on the date on which the Compact is enacted into law in the seventh Compact State. The provisions which become effective at that time shall be limited to the powers granted to the Commission relating to assembly and the promulgation of rules. Thereafter, the Commission shall meet and exercise rule-making powers necessary to the implementation and administration of the Compact.

(b) Any state which joins the Compact subsequent to the Commission's initial adoption of the rules shall be subject to the rules as they exist on the date on which the Compact becomes

law in that state. Any rule which has been previously adopted by the Commission shall have the full force and effect of law on the day the Compact becomes law in that state.

(c) Any Compact State may withdraw from this Compact by enacting a statute repealing the same.

(1) A Compact State's withdrawal shall not take effect until six months after enactment of the repealing statute.

(2) Withdrawal shall not affect the continuing requirement of the withdrawing State's Psychology Regulatory Authority to comply with the investigative and adverse action reporting requirements of this act prior to the effective date of withdrawal.

(d) Nothing contained in this Compact shall be construed to invalidate or prevent any psychology licensure agreement or other cooperative arrangement between a Compact State and a Non-Compact State which does not conflict with the provisions of this Compact.

(e) This Compact may be amended by the Compact States. No amendment to this Compact shall become effective and binding upon any Compact State until it is enacted into the law of all Compact States.

"**§ 90-270.173. Construction and severability.**

This Compact shall be liberally construed so as to effectuate the purposes thereof. If this Compact shall be held contrary to the constitution of any state member thereto, the Compact shall remain in full force and effect as to the remaining Compact States."

SECTION 3. This act becomes effective when at least seven states have enacted the Psychology Interjurisdictional Compact (PSYPACT) set forth in Section 2 of this act. The North Carolina Psychology Board shall report to the Revisor of Statutes when the Psychology Interjurisdictional Compact (PSYPACT) set forth in Section 2 of this act has been enacted by the seven member states.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2017

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BILL DRAFT 2017-SHz-4 [v.9] (03/13)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
03/23/2018 01:34:47 PM

Short Title:	Health-Local Confinement/Prison HealthConnex.	(Public)
Sponsors:		
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO ADDRESS HEALTH ISSUES IN LOCAL CONFINEMENT FACILITIES AND TO ENSURE THAT STATE PRISONS ARE FULL PARTICIPANTS IN THE NC HEALTH INFORMATION EXCHANGE KNOWN AS NC HEALTHCONNEX, AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON HEALTH AND HUMAN SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 153A-225 reads as rewritten:

"**§ 153A-225. Medical care of prisoners.**

(a) Each unit that operates a local confinement facility shall develop a plan for providing medical care for prisoners in the facility. The plan:

(1) Shall be designed to protect the health and welfare of the prisoners and to avoid the spread of contagious disease;

(2) Shall provide for medical supervision of prisoners and emergency medical care for prisoners to the extent necessary for their health and welfare;

(3) Shall provide for the detection, examination and treatment of prisoners who are infected with tuberculosis or venereal diseases; and

(4) May utilize Medicaid coverage for inpatient hospitalization or for any other Medicaid services allowable for eligible prisoners, provided that the plan includes a reimbursement process which pays to the State the State portion of the costs, including the costs of the services provided and any administrative costs directly related to the services to be reimbursed, to the State's Medicaid program.

The unit shall develop the plan in consultation with appropriate local officials and organizations, including the sheriff, the county physician, the local or district health director, and the local medical society. The plan must be approved by the local or district health director after consultation with the area mental health, developmental disabilities, and substance abuse authority, if it is adequate to protect the health and welfare of the prisoners. Upon a determination that the plan is adequate to protect the health and welfare of the prisoners, the plan must be adopted by the governing body.

As a part of its plan, each unit may establish fees of not more than twenty dollars ($20.00) per incident for the provision of nonemergency medical care to prisoners and a fee of not more than ten dollars ($10.00) for a 30-day supply or less of a prescription drug. In establishing fees

pursuant to this section, each unit shall establish a procedure for waiving fees for indigent prisoners.

(b) If a prisoner in the custody of a local confinement facility dies, the medical examiner and the coroner shall be notified ~~immediately.~~ immediately, regardless of the physical location of the prisoner at the time of death. Within five days after the day of the death, the administrator of the facility shall make a written report to the local or district health director and to the Secretary of Health and Human Services. The report shall be made on forms developed and distributed by the Department of Health and Human Services.

(b1) Whenever a local confinement facility transfers a prisoner from that facility to another local confinement facility, the transferring facility shall provide the receiving facility with any health information or medical records the transferring facility has in its possession pertaining to the transferred prisoner.

(c) If a person violates any provision of this section (including the requirements regarding G.S. 130-97 and 130-121), he is guilty of a Class 1 misdemeanor."

SECTION 2. Consistent with the requirements of G.S. 153A-216(3) and G.S. 153A-221, the Department of Health and Human Services shall study how to improve prisoner health screening with a goal of improving the determination that a prisoner in a local confinement facility has been prescribed life-saving prescription medications and a process to ensure the timely administration of those prescription medications by appropriate personnel. On or before November 1, 2018, the Department shall provide a report on this study to the Joint Legislative Oversight Committee on Health and Human Services.

SECTION 3.(a) The Department of Health and Human Services and the Government Data Analytics Center within the Department of Information Technology shall jointly collaborate with organizations representing local government and local law enforcement to explore participation by local confinement facilities in the North Carolina Health Information Exchange Network ("HIE Network"), known as NC HealthConnex, in order to facilitate the secure electronic transmission of individually identifiable health information pertaining to prisoners in the custody of local confinement facilities.

SECTION 3.(b) The Department of Public Safety, the Department of Health and Human Services, and the Government Data Analytics Center within the Department of Information Technology, shall work collaboratively to ensure North Carolina prison facilities are full participants in the HIE Network, known as NC HealthConnex, in order to facilitate the secure electronic transmission of individually identifiable health information pertaining to inmates in the custody of the Division of Adult Correction and Juvenile Justice of the Department of Public Safety.

SECTION 3.(c) On or before October 1, 2018, the Department of Health and Human Services and the Government Data Analytics Center within the Department of Information Technology, shall provide an interim report to the Joint Legislative Oversight Committee on Health and Human Services on the actions required by this section. On or before October 1, 2019, the Department of Health and Human Services and the Government Data Analytics Center within the Department of Information Technology, shall provide a final report to the Joint Legislative Oversight Committee on Health and Human Services on the actions required by this section

SECTION 4. This act is effective when it becomes law.