2017-2018

HOUSE HEALTH

MINUTES

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HOUSE COMMITTEE ON HEALTH 2017-2018 SESSION

Clerks:

Brenda Olls, Julie Ryan, Theresa Lopez



Rep. Dobson Chairman



Rep. Dollar Chairman



Rep. Jones Chairman



Rep. Lambeth Chairman



Rep. Murphy Chairman



Rep. Brisson Vice-Chairman



Rep. Earle Vice-Chairman



Rep. Farmer-Butterfield Vice-Chairman



Rep. Adcock



Rep. Ball



Rep. Blackwell



Rep. Boswell



Rep. Burr



Rep. Carney



Rep. Cunningham



Rep. Dulin



Rep. Ford



Rep. Howard



Rep. Wray

Rep. White

Rep. Szoka

Rep. Yarborough

Rep. Zachary

HOUSE COMMITTEE ON HEALTH 2017-2018 SESSION

<u>MEMBER</u>		ASSISTANT	PHONE	OFFICE	SEAT
DOBSON, Josh	Chair	Julie Ryan	733-5862	301N	114
DOLLAR, Nelson	Chair	Candace Slate	715-0795	307B	04
JONES, Bert	Chair	Brenda Olls	733-5779	416A	54
LAMBETH, Donny	Chair	Pan Briles	733-5747	303	65
MURPHY, Greg	Chair	Theresa Lopez	733-5757	632	85
BRISSON, William	Vice-Chair	Caroline Stirling	733-5772	405	23
EARLE, Beverly	Vice-Chair	Ann Raeford	715-2530	514	60
FARMER-BUTTERFIELD, Jean	Vice-Chair	Portia Bright	733-5898	1220	33
ADCOCK, Gale		Suzanne Smith	733-5602	1211	119
BALL, Cynthia		James Whelan	733-5860	1319	118
BLACKWELL, Hugh		Dixie Riehm	733-5805	541	102
BOSWELL, Beverly		Beth Strandburg	733-5906	531	97
BURR, Justin		Dina Long	733-5908	307A	1
CARNEY, Becky		Beth LeGrande	733-5827	1221	12
CUNNINGHAM, Carla		Sherrie Burnette	733-5807	1109	59
DULIN, Andy		Wanda Benson	715-3009	609	100
FORD, Carl		Olivia Clapp	733-5881	608	64
HOWARD, Julia		Cody Huneycutt	733-5904	302	01
HUNTER, Howard		Brenda Bennett	733-5780	1307	46
INSKO, Verla		Gina Insko	733-7208	502	72
JACKSON, Darren		Angela McMillan	733-5974	506	57
LEWIS, David		Grace Rogers	715-3015	2301	06
LUCAS, Marvin		Thelma Utley	733-5775	509	22

MALONE, Chris	Christian Campbell	715-3010	1229	38
POTTS, Larry	Caroline Craig	715-0873	306B1	110
ROGERS, David	Baxter Knight	733-5749	418C	86
SETZER, Mitchell	Margaret Herring	733-4948	2204	02
SHEPARD, Phillip	Pamela Pate	715-9644	530	53
SZOKA, John	Beverly Slagle	733-9892	2207	30
WHITE, Donna	Susan Mullins	733-5605	306A2	111
WRAY, Michael	Susan Burleson	733-5662	503	24
YARBOROUGH, Larry	Leslie Murray	715-0850	1301	67
ZACHARY, Lee	Martha Jenkins	715-8361	1002	74

HOUSE HEALTH COMMITTEE STAFF (733-2578)

Theresa Matula (Coordinating Staff person)
Jennifer Mundt
Jason Moran-Bates
Gus Willis

ATTENDANCE

HEALTH

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CHAIRMAN													
BURR, Justin	/	/	/	/	V	V	/		V	/			
DOBSON, Josh	/	/	/	/	V	V	1	/	V	V			
JONES, Bert	/	~	/	/	V	V,	/	/	V	1/			
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MURPHY, Greg	V		/	/	/	/	/	/	V	V			
VICE-CHAIRMAN													
BRISSON, William	/	V	V				/	V		V			
DOLLAR, Nelson		/	/	/	V	V	/	V		/			
EARLE, Beverly		V	/	/	1	V	V	V	1	V			
FARMER-BUTTERFIELD, Jean		/	V		V	V			V				
ADCOCK, Gale		/	/	/	V	1	V	V	/	V			
BALL, Cynthia	V	/	V	/	V	V	/	V	V	V			
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CUNNINGHAM, Carla	V		1	V	V	V	V	/	V	V			
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JACKSON, Darren	V		/	/		V	V			V	,		
LEWIS, David										1			

ATTENDANCE HEALTH

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POTTS, Larry	/	/	1	/	V	1	V	V	V	V				
ROGERS, David	1		1		/	/	V	V	V	V				
SETZER, Mitchell	V	/	V	/	1	V	V	V	V		,	-		
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SZOKA, John	/	/	V	V		1	~	/	V	il				
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WRAY, Michael	V	1	1	1	V	V	1	V		V				
YARBOROUGH, Larry	V	/	V	/	1	V	1	V	V	,				
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Dina Long	1	1	~	/	V	1	V		V	V				
Julie Ryan	1	/	/	V	V	1	/	/	V	V				
Theresa Lopez	/	V	X	X	V		V	V	/					
STAFF														
Theresa Matula	/	/	V	/	V	V	/	V	V	1				
Jennifer Mundt	/	/	/	/	V	V	V	V	V	/				
Jason Moran-Bates	/	/	V	/	1	V	V	V	1	1				
Gus Willis	1	/	/	/	1	V	V	/	/	V				

Beginning April 19th New Chair

ATTENDANCE

COMMITTEE ON HEALTH

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DATES	Dril 1920	pri (25 !	April 26/	April 27	18×10,2017	une 2/20,				
CHAIRMAN	#	· As	1		1	.,				
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DOLLAR, Nelson	V	V	V	V	V	V				
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MURPHY, Greg	V	V	V	V	V	/				
VICE-CHAIRMAN							/			
BRISSON, William	V			V	V	V				
EARLE, Beverly	V	V	V	V	V	V				
FARMER-BUTTERFIELD, Jean	V		V	/	V	V			 +	
ADCOCK, Gale		V	V	/	V	V				
BALL, Cynthia	V	V	1	/	1	V				
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CUNNINGHAM, Carla	V	V	V	/	V	V				
DULIN, Andy	V			V	~	V				
FORD, Carl		V	/		V	V				
HOWARD, Julia				V	V	V				
HUNTER, Howard			V	V	V	~				
INSKO, Verla	V					V				
JACKSON, Darren	V		V	V	V	1				
LEWIS, David										

ATTENDANCE

COMMITTEE on HEALTH

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House Committee on Health Wednesday, February 8, 2017 at 11:00 A.M. Room 643

MINUTES

The House Committee on Health met at 11:00 A.M. on February 8, 2017 in Room 643. Representatives Adcock, Ball, Boswell, Brisson, Burr, Carney, Cunningham, Dobson, Dulin, Ford, Hunter, Insko, Jackson, Jones, Lucas, Malone, Murphy, Potts, Rogers, Setzer, Szoka, White, Wray, Yarborough, and Zachary attended.

Representative Justin Burr presided.

The UNC Gillings School of Global Public Health presented the Committee with information relating to their research areas.

Barbara K. Rimer, DrPH, MPH, Dean and Alumni Distinguished Professor, gave an overview of their mission.

Wizdom Powell, PhD, MPH, discussed eliminating health disparities in vulnerable boys and men in North Carolina.

Mark Holmes, PhD, presented information on improving rural health in North Carolina and beyond.

Chris Ringwalt, DrPH, discussed prescription drug overdose and the Controlled Substances Reporting System (CSRS).

Questions were taken from members.

The meeting adjourned at 12:00 P.M.

Representative Justin P. Burr

Presiding

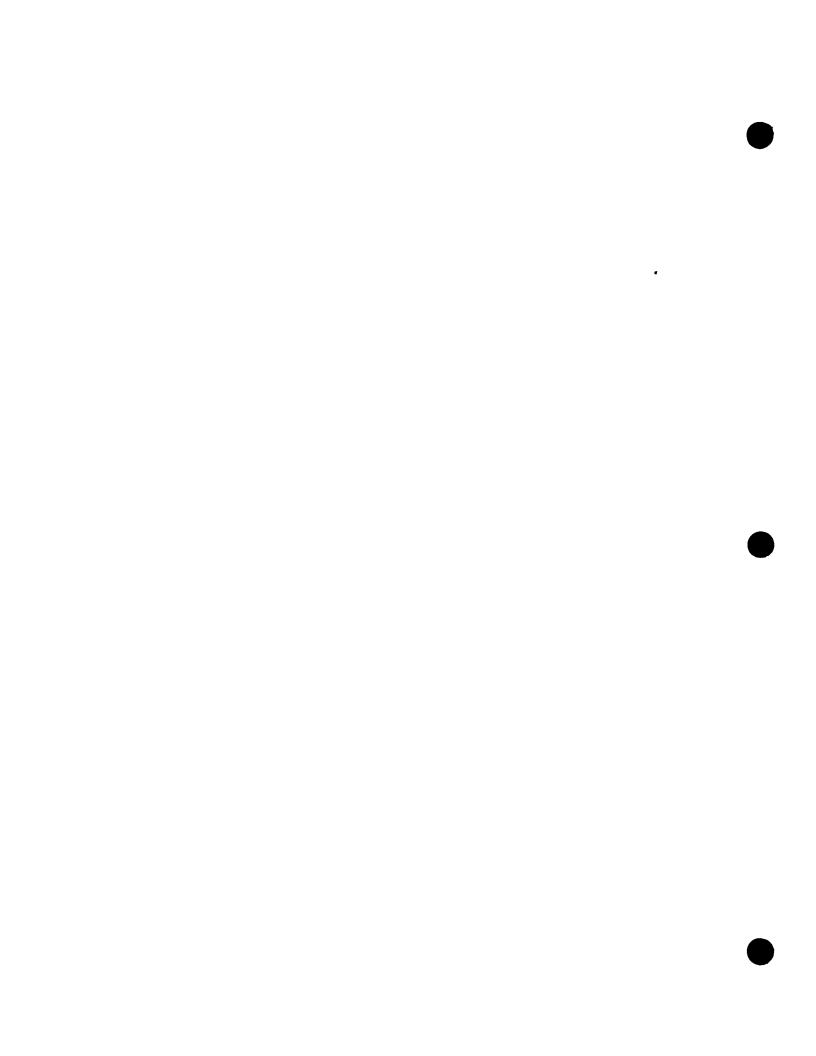
Dina Long, Committee Clerk

The Bun

NORTH CAROLINA HOUSE OF REPRESENTATIVES COMMITTEE MEETING NOTICE AND BILL SPONSOR NOTIFICATION 2017-2018 SESSION

You are hereby notified that the House Committee on Health will meet as follows:

Tou are hereby hi	otified that the House Com	militiee on Hearth will ineed as follows.
TIME: LOCATION: COMMENTS:		esented at this meeting. There will be presentations
		Respectfully,
		Representative Justin P. Burr, Co-Chair Representative Josh Dobson, Co-Chair Representative Bert Jones, Co-Chair Representative Donny Lambeth, Co-Chair Representative Gregory F. Murphy, MD, Co-Chair
I hereby certify the Monday, February	•	ommittee assistant at the following offices at 5:02 PM or
	Principal Clerk Reading Clerk – House Ch	amber
Brenda Olls (Con	nmittee Assistant)	



House Committee on Health Wednesday, February 8, 2017, 11:00 AM 643 Legislative Office Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

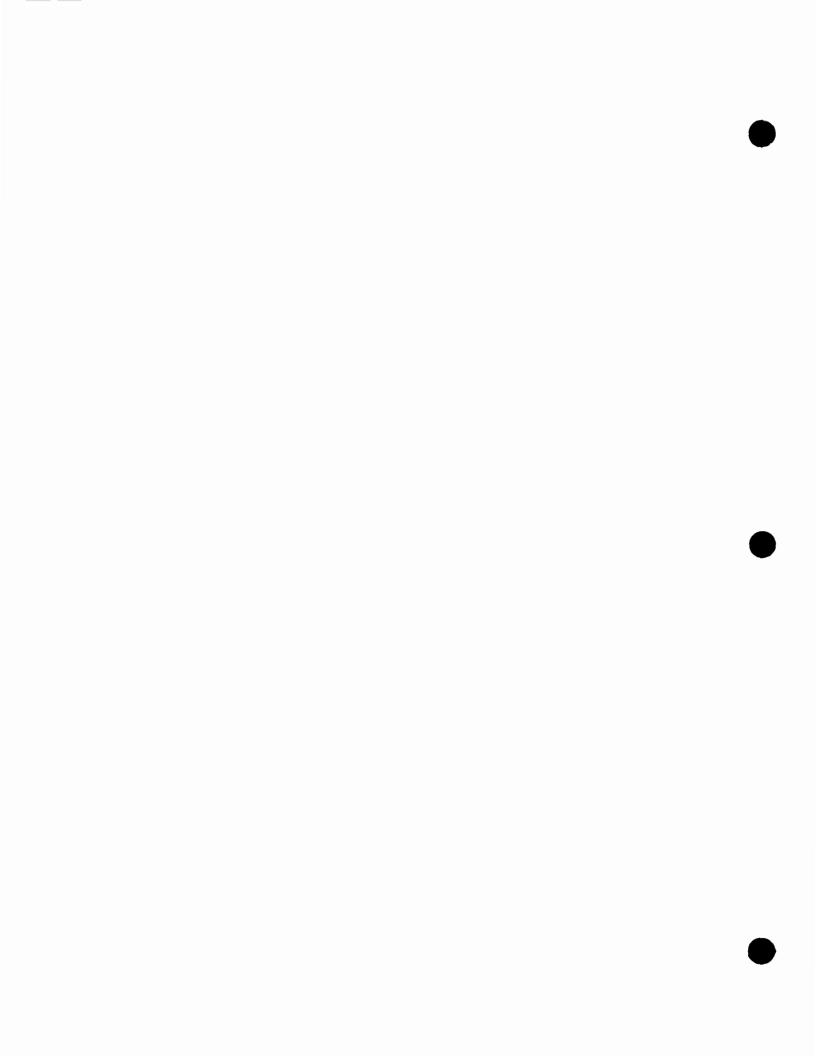
Presentations - UNC GILLINGS SCHOOL OF GLOBAL PUBLIC HEALTH STAFF

- Barbara K. Rimer, DrPH, MPH, Dean and Alumni Distinguished Professor
- Wizdom Powell, PhD, Associate Professor, Health Behavior
- Mark Holmes, PhD, Associate Professor, Health Policy and Management
- Chris Ringwalt, DrPH, Adjunct Professor, Health Behavior; Senior Scientist, UNC Injury Prevention Research Center

Questions From Members

Other Business

Adjournment





BIO-SKETCHES, GILLINGS VISITORS

Barbara K. Rimer, DrPH, MPH

Dean and Alumni Distinguished Professor

Dean Rimer received her DrPH in health education from the Johns Hopkins School of Public Health. Prior to becoming dean, she served as professor of health behavior and deputy director of UNC's Lineberger Comprehensive Cancer Center. She is the author of over 265 peer-reviewed articles. Her research has explored multiple areas, especially motivating people to be screened for cancer and enhancing their informed decision making regarding health services. Dean Rimer is the first woman and behavioral scientist to chair the National Cancer Institute's National Cancer Advisory Board. She was elected to the Institute of Medicine in 2008 and appointed by President Obama to chair the President's Cancer Panel in 2011. In 2013, she was awarded the American Cancer Society's Medal of Honor for her cancer control research.



RESEARCHERS

Mark Holmes, PhD

Associate Professor, Health Policy and Management

Director, Cecil G. Sheps Center for Health Services Research

Dr. Holmes received his PhD in Economics from the University of North Carolina, Chapel Hill. His research interests include hospital finance, rural health, health policy and patient-centered outcomes research. In 2015 the National Rural Health Association named him Outstanding Researcher in recognition of his high impact research in the field rural health. Currently, Dr. Holmes also serves as Director of the Cecil G. Sheps Center for Health Services Research, which aims to improve the health of individuals, families, and populations by increasing our understanding of the problems, issues and alternatives in the design and delivery of health care services.



Wizdom Powell, PhD

Associate Professor, Health Behavior

Dr. Powell received her PhD from the University of Michigan, Ann Arbor, in Clinical Psychology and is a trained population health disparities research scientist. Her research focuses on investigating psychosocial determinants of African American men's mental and physical health across the life-course. Her work is nationally recognized and is essential to the training of psychologists & public health professionals. As a result of her impactful research, Dr. Powell recently received the prestigious Aspen Institute Health Innovator Fellowship and a Rockefeller Foundation Academic Writing Residency.



Chris Ringwalt, DrPH

Adjunct Professor, Health Behavior; Senior Scientist, UNC

Injury Prevention Research Center

Dr. Ringwalt received his DrPH from the University of North Carolina, Chapel Hill. He has over 25 years of experience in the design, development, analysis and reporting of epidemiological, etiological, and evaluation studies relating to public health issues. His research has primarily focused on the prevention of adolescent and adult risk behaviors, particularly alcohol, tobacco and other drug use. As senior scientist for the UNC Injury Prevention Reseach Center, Dr. Ringwalt leads the research area focused on prescription ug overdose. He has served on multiple NIH review committees and has published over publications in peer-reviewed journals based on his research.



GILLINGS VISITORS



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and Engineering
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Lecturer, Health Behavior
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Anna Schenck, PhD
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Institute for Public Health; Professor of
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Clayton Somers, JD Vice Chancellor for Public Affairs 919-962-6331 clayton@unc.edu



Kristin Voltzke, MPH Co-President, SPH Student Government; PhD Candidate, Epidemiology krisv@email.unc.edu

UNC Gillings School of Global Public Health



Our Mission:

Improve public health, promote individual well-being, and eliminate health inequities across North Carolina and around the world.

A student's story

"If you could tell prospective students one thing about the Gillings School, what would you say?"

When asked this question, master's student Camille McGirt said: "Gillings provides an environment that surrounds students with the resources, instruction, infrastructure and personnel to allow dreams for a healthier world to actually transpire. Our school provides us with exceptional opportunities to think global and act local — and the zeal for creating a culture of health in our communities of choice is palpable."

Born in Durham, NC, Ms. McGirt (BSPH 2013, health policy and management, UNC) is a Hatch-Barnhill scholar in Health Behavior, working on childhood obesity reduction for adolescent girls in North Carolina. She founded and is now co-executive director of Healthy Girls Save the World, a nonprofit that provides NC girls a positive space to foster a healthy diet, physical activity, and healthy mental and physical lifestyle.

Camille exemplifies how the <u>School's mission</u> drives action and impact in research, teaching, practice, and service.

High ranking

Founded in 1940, UNC Gillings has been a topranked school of public health for many years.

- #I public school of public health in U.S.
- #2 school of public health overall (tied with Harvard) (U.S. News & World Report, 2015)
- Great programs
 - # #1 Nutrition PhD program
 - #1 Executive master's program, Health Policy and Management
 - Other top programs

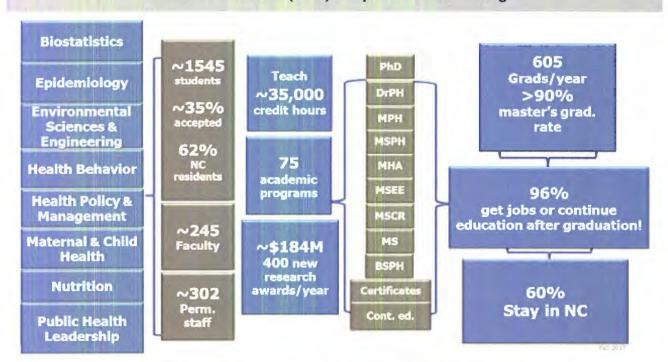


HB master's student Camille McGirt (right) Appeared on "The Dr. Oz show" on Nov. 28 to describe her work promoting teen health.

Academics at UNC Gillings (2016 - 2017)

Undergraduate (n=214) | master's (n=659) | doctoral-level (n=571)

Online certificates (n=74) and post-doctoral training



Teaching and learning at UNC Gillings

75 degree and program areas; recent additions include:

- Certificate and MPH in Health Informatics
- Dual MPH with Pharmacy
- MPH with concentration in Veterinary Epidemiology, with North Carolina State University
- New classrooms and collaboration spaces for 21st century learning

Highly sought-after grads

Almost 75% of Gillings graduates are employed in public health, health care and related positions within six months after graduation; 24% continue their educations; 60% who graduate with doctoral degrees stay in North Carolina.

A sampling of places our grads go after graduation



Students make an impact across NC

- Our students received 7 of 17 Impact Awards from the Graduate School in 2016; ~1/3 of all Impact Awards since inception in 2003
- 96 courses across Gillings had students working with partners in the field, practitioners in the classroom, or both in 2015
- 50.488: Student service hours in 2016
- Over \$1.1 million: Value of student service in 2016 (\$23.07/hour)



6 to 7

of full-time employees
this amounts to
agencies annually

> \$385,000 Value to North Carolina each year

The North Carolina Institute for Public Health (NCIPH) is the Gillings School's outreach arm. They improve public health practice, making North Carolina a healthier place. Every year, staff and faculty within NCIPH:

- Train the public health workforce in all 100 NC counties and beyond.
- Offer technical assistance, research and evaluation to NC partners.
- Get research into practice across NC.
- Disseminate practice-based research.
- Link students to research projects, service activities and practica.

Serving the people of NC for over 75 years

We conduct research, education, service and outreach in all 100 NC counties.

Research to practice: Gillings makes an impact on NC



We're in all 100 NC counties; discover more with our interactive maps: sph.unc.edu/research/maps



Reaching across NC

Gillings faculty Drs. Nab Dasgupta, Michele Jonsson Funk, Steve Marshall, Chris Ringwalt (project lead), Meghan Shanahan, all affiliates of the UNC Injury Prevention Research Center, tackle the opioid abuse crisis, from overdose prevention, to pain management, to addiction treatment and more. Innovative solutions developed by this team have been adopted across NC and nationwide.



Guilford County

Drs. Geni Eng and Alexandra Lightfoot, faculty members in Health Behavior, partner with the Greensboro Health Disparities Collaborative and two NC cancer care centers to promote equity in cancer care.



Granville and Nash Counties

Dr. Carmen Samuel Hodge, faculty member in Nutrition, is embedded in Granville Nash Public Health, a rural district health department, where she brings latest strategies in chronic disease prevention, nutrition, and physical activity interventions. She helped bring over \$1.7 million in funding to the district.



Buncombe and Lenoir Counties

Dr. Alice Ammerman, faculty member in Nutrition and director of the UNC Center for Health Promotion and Disease Prevention, evaluates strategies to increase access to fresh fruits and vegetables for low-income families with children.

We anticipate problems and accelerate public health solutions.

Deliver solutions faster

- Accelerate implementation of effective public health practices, programs and policies to improve health and well- being.
- Save lives of mothers and children by assuring that effective programs reach all corners of the world.
- Increase the pace of clinical trials so effective drugs benefit people faster.

Promote healthy lives at every age.

- Promote healthy aging.
- Create a culture of health in NC, U.S. and globally by promoting good nutrition and food access, preventing and treating obesity, and preventing use of tobacco products.
- Prevent violence against women.
- Prevent injuries.

Promote health, prevent disease & improve care.

- Prevent emerging infectious diseases.
- Prevent global non-communicable diseases, such as cancer, heart disease and diabetes.
- Develop more effective treatments for diseases, like diabetes and hypertension.
- Improve survivorship for cancer and other diseases.
- Improve mental health.
- Lead in population health and education for population health.
- Examine issues regarding access to, cost, and quality of health care: deliver solutions.

Enable a healthy planet and healthy people.

- Improve access to clean water and sanitation in NC, US and worldwide.
- Protect air and water resources.
- Prepare for natural and man-made disasters.
- Mitigate climate effects.

Harness big data for health and well-being.

- Use big data to uncover causes and consequences of disease. Potential for prevention.
- Create innovations in data visualization and analytics for health.
- Assure that all Gillings graduates are big data literate

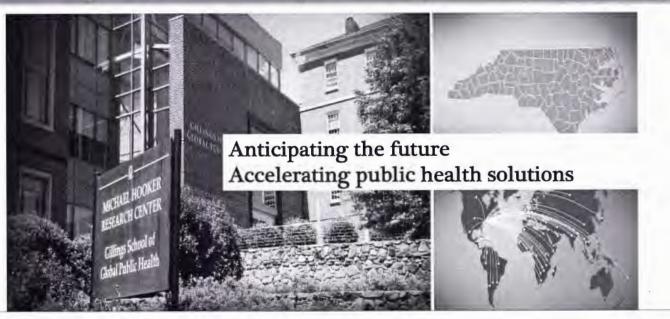
UNC Gillings School of Global Public Health 170 Rosenau Hall, Campus Box 7400 135 Dauer Drive, Chapel Hill, NC 27599

Elizabeth French, MA
Assistant Dean for Strategic Initiatives
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JNC Gillings School of Global Public Health #1 public school of public health in the U.S.



"He brought the university to communities."*



*Reverend Campbell, January 28, 2017

What Is Public Health?

"...preventing disease,
prolonging life and promoting
health through organized efforts
& informed choices of society,
organizations, public and private,
individuals and communities."



A. Winslow, 1920

Public Health: Many Roles





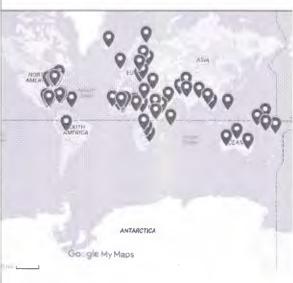
Our Mission

Improve public health, promote individual well-being, and eliminate health inequities across North Carolina and around the world.









In every NC county & 82 countries on 6 continents!



Our Mission



- Educate next generation of public health leaders.
- Discover, test, translate and implement solutions to health threats and problems.
- Serve North Carolina and beyond.

Our Mission and Values



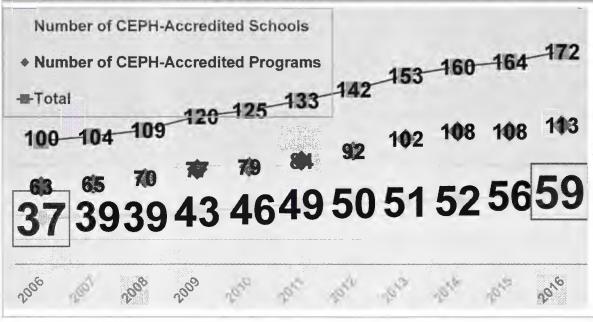
More Than 75 Years Strong!

Leading *public* school of public health (tied with Harvard for #2 overall) in the United States...

- ☐Groundbreaking research
- ☐ Exceptional teaching
- ☐ Dedicated service



Growth Of CEPH-Accredited Schools And Programs Of Public Health



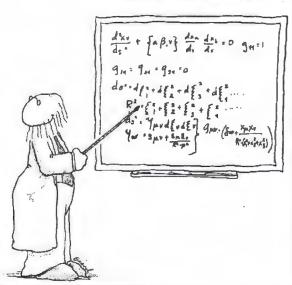
More competition for students, faculty & resources



Today's Presentations...

- Solving real world problems in communities through practical research that is applied
- Developing affordable, acceptable, scalable and sustainable solutions







Today's Presentations...

- How our research gets used...
 - ✓ Identify what strategies would be most effective in reducing deaths from colorectal cancers at reasonable cost.
 - ✓Improve men's health.
 - ✓ Apply solutions for opioid overdoses.
 - √Work with rural hospitals to thrive.







Solving The World's Greatest Public Health Threats & Problems

North Carolina
Service Programs

Products Research

Global Dissemination

Companies Policies Practice

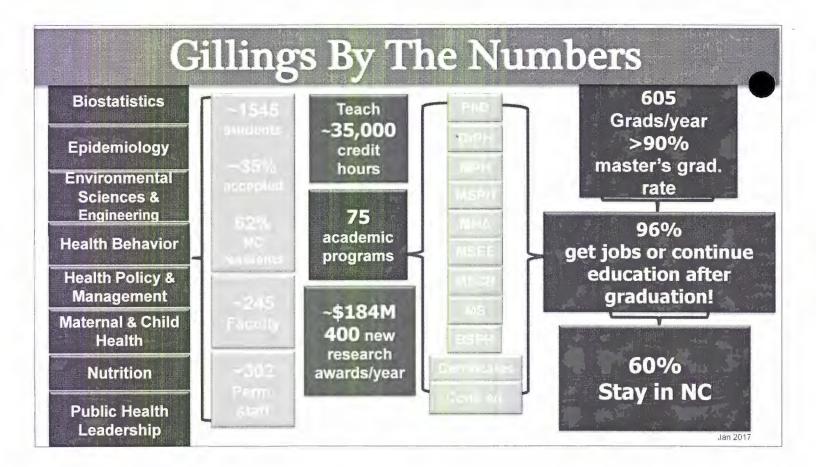
Leadinship

Education



Practical Idealists





Gillings Grads

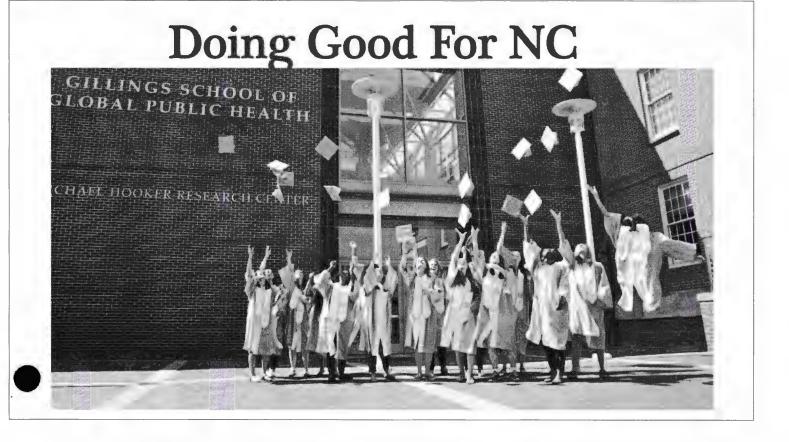
Gillings' grads get great jobs!





Gillings' Grads Get Great Jobs! **Duke**Medicine Johnson-Johnson University 24% >96% of QUINTILES' recent grads Industry ■ NOVANT 46% get jobs (or continue COASTAL CAROLINAS GVL. WakeMed 🕄 their education) ALLERGAN Dur pursuit, Life's pe Non-Other **MAYO CLINIC** 3% Profit/NGO BlueCross BlueShield **World Health** National Institutes Association Organization

Jan 2017





Solving The World's Greatest Public Health Threats & Problems

North Carolina

Education

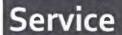
Research

Dissemination

Global Policies

Companies

Leadeschip



Practice

Programs

Products



Exceptional Value To NC

Health Behavior's Year-Long Capstone Course

~50

Students/ year

6 to 7

of full-time employees this amounts to 350

Minimum # of hours per student

17,500

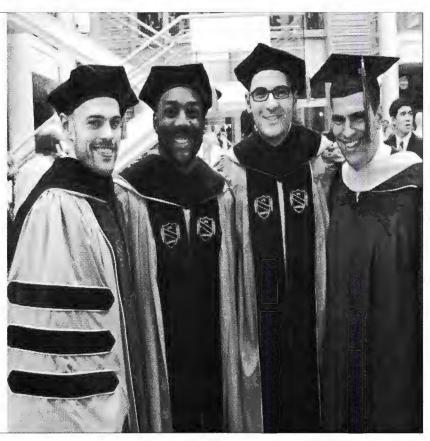
Total hours given to NC agencies annually

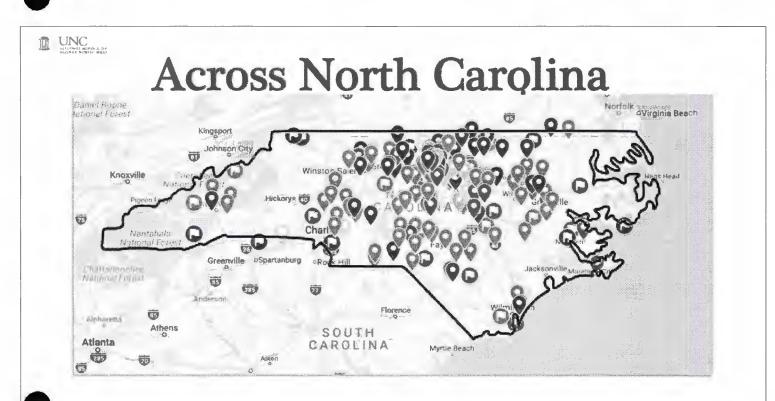
> \$385,000

Value to North Carolina each year

7/17

UNC Graduate
School
2016 Impact
Awards to
Gillings School
students





Gillings School: An Asset For NC

We partner with community organizations, health systems & others to create provide training of health professionals and create useful tools.



North Carolina Institute for Public Health



Technical

Assistance

- 8 community needs assessments
- 358 public health law consults



Training

- 428 programs
- 33,730 training completion
- 11,186 NC participants



Student

engagement

- 5 Team Epi Aid responses
- 267 student practica
- 50,000 hours of student service





Innovation Thrives



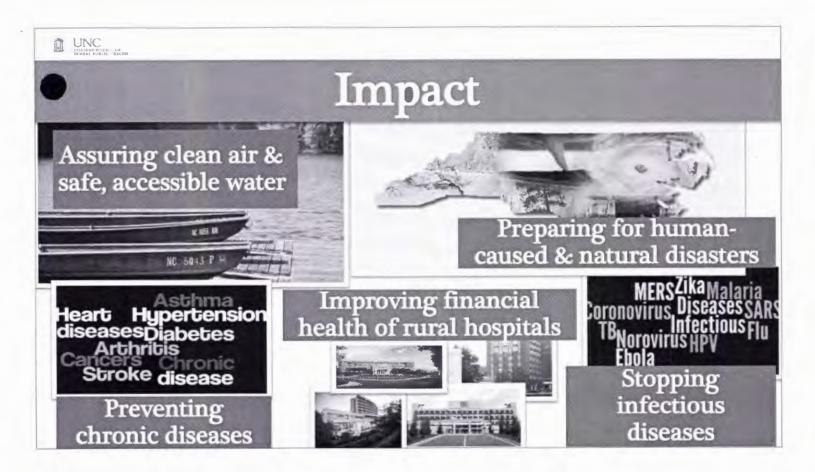


Gillings School: An Asset For NC

Faculty & students start companies and create value for NC (Quintiles, Rho, Symetrica, Aquagenx).











Average
\$/Gillings Pls in
FY16 = \$1.2
million
Highest average at
UNC-Chapel Hill

Economic Impact: Research Awards Create Jobs

■Total Awards Jobs Resulting from Awards

6613 jobs

\$184M

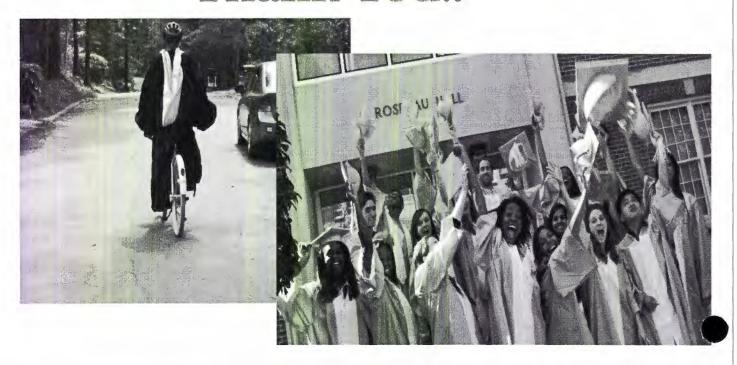
5851 jobs

\$163M

FY15

FY16

Thank You!!







GILLINGS SCHOOL OF GLOBAL PUBLIC HEALTH

Eliminating Health Disparities in Vulnerable Boys and Men in NC







Wizdom Powell, PhD, MPH February 8, 2017



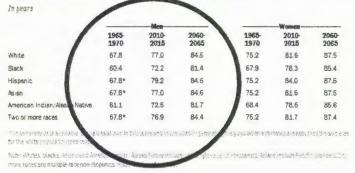


Women get Sicker, Men Die Quicker

Gender Disparities in Life-Expectancy

TABLE A2

Life Expectancy at Birth for Population Estimates and Projections, by Race-Hispanic Origin and Sex: 1965-1970, $20\underline{15-2020}$ and 2060-2065



Source: Based on United States Life Tables 1959-51, U.S. Decendial Life Tables for 1969-71, United States Life Tables 2010 (National Center for Health Spatistics) and 2014 National Projections (V.S. Census Sureavi)

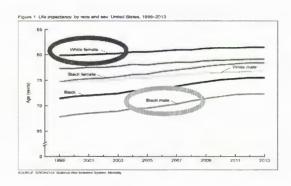
PEW RESEARCH CENTER

Males in the U.S. continue to live shorter lives than women and have consistently lived shorter lives than their global peers since 1980.





Some Groups of Boys and Men are more Vulnerable Disparities in Life-Expectancy



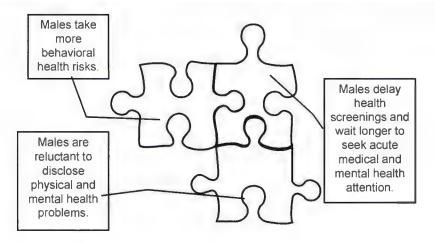
BUT, Non-Hispanic Black males live the shortest lives of all individuals in U.S. society and NC.





Why Do Male Health Disparities Exist?

Common Behavioral Explanations







Why Do Male Health Disparities Exist?

Missing Piece of the Puzzle

The role played by inequitable distribution of power, opportunity, and neighborhood conditions that uniquely disadvantage the health of socially vulnerable boys and men.



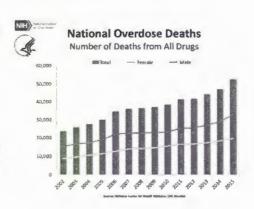


Disparities in Male Life-Expectancy

The Contribution of Substance Abuse

Many male premature deaths in the U.S. are attributable to substance abuse/misuse.

Males in the U.S. and NC are more vulnerable to illicit drug use and substance abuse mortality than women.







The Shared Costs of Male Health Disparities Disparities

- \$24.2 billion of excess costs in direct medical expenditures for Black men were attributed to health disparities.
- Indirect costs of Black male health disparities to the U.S. economy were at \$317.6 billion.
- Estimates indicate that we spent over \$160 million in North Carolina on the public system of adult substance abuse treatment.
- Additional costs to families, particularly, women and children.



IN UNC

Research Highlight: The MANHOODS Study

Masculinity, Affect
Negotiation,
Neighborhoods, Health
Outcomes, and
Opportunities for
Development Study.

Systematic Observation of Durham County Neighborhoods

7-day "Real-Time" Assessment of Stress, Violence Exposure, and Substance Use

> Development of a "Real-Time" Stress Reduction and Substance Abuse Prevention Intervention



Funded by the NIH-National Institutes of Drug Abuse (Grant#1K01 DA032611-01A1)



Why Durham Neighborhoods?

Race & Gender Disparities in Substance Abuse Outcomes

- Males constitute 75% of deaths from toxins compared to 25% of females.
- Blacks in Durham county represent 63% of individuals arrested for substance use-related crimes.
- Across and 8 year period, 40% of deaths related to substance use were among Black men.





Source: Evans et al. (2014).Substance use and abuse in Durham County. Retrieved from: http://childandfamilypolicy.duke.edu/wp-content/uploads/2013/09/Substance-Use-and-Abuse-in-Durham-County_Feb_2014_web_version.pdf



How We Observe Durham Neighborhoods

We developed a smartphone application for rural-urban settings to assess:

- · Adult/Youth Activity
- Physical Disorder
- Social Disorder
- Violence, Alcohol, and Other Drug Indicators







"Real-time" Assessments of Stress Exposure and Substance Use



- Recruit Black males between the ages of 18-29 from neighborhoods with high and moderate violence, alcohol, and other drug activity.
- Use mobile devices to assess stress, violence exposure, and drug use in real-time across a 7-day period.
- Measure stress hormones and use wearable devices to assess other physiologic measures (e.g., heartrate variability).



I UNC

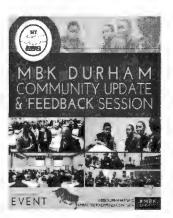
How We are Translating Evidence Into Local Action

Sample MBK Milestones, Strategies, & Recommendations



RECOMMENDATIONS

Revitatize North Carolina Men's rieelth Report Card and ar pand data collection to individe statistics foryounger males and other radial leithnic minority groups (e.g., 19spenic / Leiho males and Native Armsican males).







How We are Translating Evidence Into National Action 2016 Congressional Briefing



Government relations/public policy update

PI Government Relations Office collaborates on congressional briefing: "Eliminating Health Disparities Among Boys and Men."

On Tuesday, May 24, in collaboration with Rep. Donald M. Payne Jr., N.J.-10, and Rep. Markwayne Mullin, Okla.-02, the Government Relations Office of the APA Public Interest Directorate presented a congressional briefing on "Eliminating Health Disparities Among Boys and Men".





Policy-Level Solutions for Eliminating Male Health Disparities

- Support research and programs focusing on men's health disparities and key social determinants of male health.
- Stimulate public-private partnerships to address neighborhood conditions that increase substance abuse risk.
- Strengthen efforts to reform mental health systems to address male help-seeking barriers.
- Increase access to interventions that assist vulnerable men in substance abuse recovery in the criminal justice system, during the transition from incarceration, and as they reintegrate their communities and families.





THANK YOU



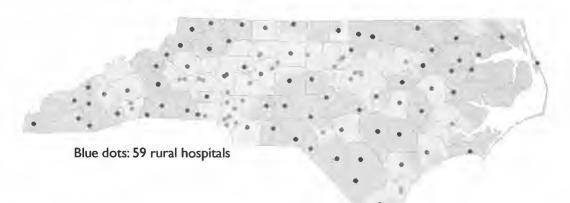






GILLINGS SCHOOL OF GLOBAL PUBLIC HEALTH

Improving Rural Health: North Carolina and Beyond

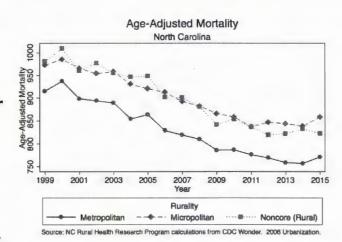


Mark Holmes, PhD
Associate Professor, Health Policy and Management, UNC Gillings School of Global Public Health
Director, Cecil G. Sheps Center for Health Services Research, UNC
mark_holmes@unc.edu; 919-966-7100
February 08, 2017



Rural Health at a Glance

- Rural areas poorer health on almost every measure
 - Older, poorer, more isolated
 - Persistently higher mortality
- Less healthcare infrastructure
 - Fewer docs, smaller hospitals
 - Half of rural hospitals lose money
- 120 rural hospital closures since 2005

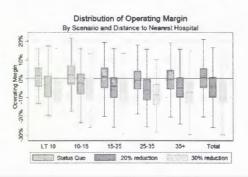




Examples of Research/Evaluation

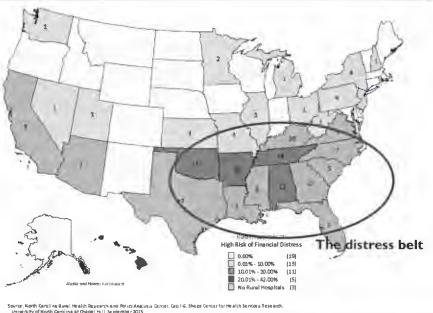
- Rural hospital closures
- Technical assistance to rural hospitals on their finance
- Develop and disseminate models for post-closure systems of care (e.g. Freestanding emergency departments)
- Policy analysis and model effects of federal reimbursement / rule changes





Spotlight on Rural Hospitals: Distress

- · Developed a model of financial distress
- Allows policymakers / admins to target at-risk hospitals, model policy changes



UNC

Spotlight on Rural Hospitals: Closures

- Increase in last five years in rate of rural hospital closures
- · Causes multifactorial
- Closure of only hospital in community decreased percapita income by ~\$1300
 - (e.g. in county of 25K, total effect of \$32m

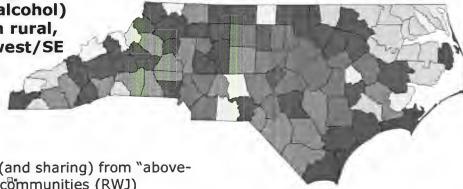


120 rural hospital closures in U.S. since 2005; most in South



Other Rural Health Work

Mortality from "poisoning" (drugs, alcohol) higher in rural, esp. in west/SE



· Learning (and sharing) from "aboveaverage" communities (RWJ)

- Medicaid/Medicare payment policy: value and effectiveness
- HIT/telemedicine
- · Health professional supply, policy, migration...

Source: CDC Wonder 2010-2015



GILLINGS SCHOOL OF GLOBAL PUBLIC HEALTH

Research using North Carolina's Controlled Substances Reporting System (CSRS)

Chris Ringwalt, DrPH
Injury Prevention Research Center
University of North Carolina at Chapel Hill

North Carolina State Legislature February 8, 2017

BRIEF DESCRIPTION

- Database of all prescriptions for controlled substances filled in North Carolina
- · Includes linked information on:
 - Prescriptions filled (e.g. dose & duration)
 - Patients
 - Prescribers
 - Dispensers (i.e., pharmacies)
- Designed primarily as a clinical tool
- 47,000 active practitioners currently registered
- · Also intended as a research tool:
 - "Inform the public...of the use and abuse trends related to prescription drugs...The Department may provide data to public or private entities for statistical or research purposes"

KEY FINDS FROM OUR CSRS STUDIES

- Prescribers and dispensers are grateful for the CSRS and the ability to consult their patients' histories of controlled substances
- Would like to increase ease of access
 - CSRS has established delegate accounts
 - CSRS is working with us now to create an interface between specific patients' prescription history and their electronic health records

NC MEDICAL BOARD STUDY

- Using the CSRS, we developed metrics to identify prescribers with "unusual and uncustomary" prescribing practices
- NC Medical Board has based its investigation policies on our metrics
- Upcoming, we will use the CSRS to:
 - Evaluate the effects of the policy on "high flying" prescribers' behaviors
 - Examine trends in prescribers who may be prematurely terminating or precipitously "tapering" their chronic pain patients

CONCLUDING REMARKS ABOUT THE CSRS

- Great potential to use the CSRS to support the State's response to the opioid epidemic
- Challenges
 - Time and effort required to secure de-identified data are considerable
- · Potential solution:
 - Establish a research liaison to review and process data requests in a timely fashion
- Working together, we can make a difference!

GOOD NEWS ABOUT NALOXONE AVAILABILITY

- Naloxone, tradename "Narcan", is a life-saving agent that can reverse an opioid overdose
- SB724, signed into law on June 20th 2016, allows anyone in NC to get naloxone without a prescription, provided they go to a pharmacy participating a statewide "Naloxone standing order" program

EFFECT OF NALOXONE STANDING ORDER BILL

Pharmacies in NC providing Naloxone under the new statewide standing orders as of:

May 2016



SB724, signed June 20, 2016, allows anyone in NC to get naloxone at pharmacies via a statewide "standing order"

Source: naloxonesaves.org

EFFECT OF NALOXONE STANDING ORDER BILL

Pharmacies in NC providing Naloxone under the new statewide standing orders as of:

June 21, 2016



SB724, signed June 20, 2016, allows anyone in NC to get naloxone at pharmacies via a statewide "standing order"

Source: naloxonesaves.org

EFFECT OF NALOXONE STANDING ORDER BILL

Pharmacies in NC providing Naloxone under the new statewide standing orders as of:

June 30, 2016 (includes Rite Aid)



SB724, signed June 20, 2016, allows anyone in NC to get naloxone at pharmacies via a statewide "standing order"

Source: naloxonesaves.org

EFFECT OF NALOXONE STANDING ORDER BILL

Pharmacies in NC providing Naloxone under the new statewide standing orders as of:

July 14, 2016 (includes Harris Teeter)



SB724, signed June 20, 2016, allows anyone in NC to get naloxone at pharmacies via a statewide "standing order"

Source: naloxonesaves.org

EFFECT OF NALOXONE STANDING ORDER BILL

Pharmacies in NC providing Naloxone under the new statewide standing orders as of:

August 14, 2016 (includes Walgreens)



SB724, signed June 20, 2016, allows anyone in NC to get naloxone at pharmacies via a statewide "standing order"

Source: naloxonesaves.org

EFFECT OF NALOXONE STANDING ORDER BILL

Pharmacies in NC providing Naloxone under the new statewide standing orders as of:

Feb 1, 2017 (includes BI-Lo)



SB724, signed June 20, 2016, allows anyone in NC to get naloxone at pharmacies via a statewide "standing order"

Source: naloxonesaves.org

Thank you!



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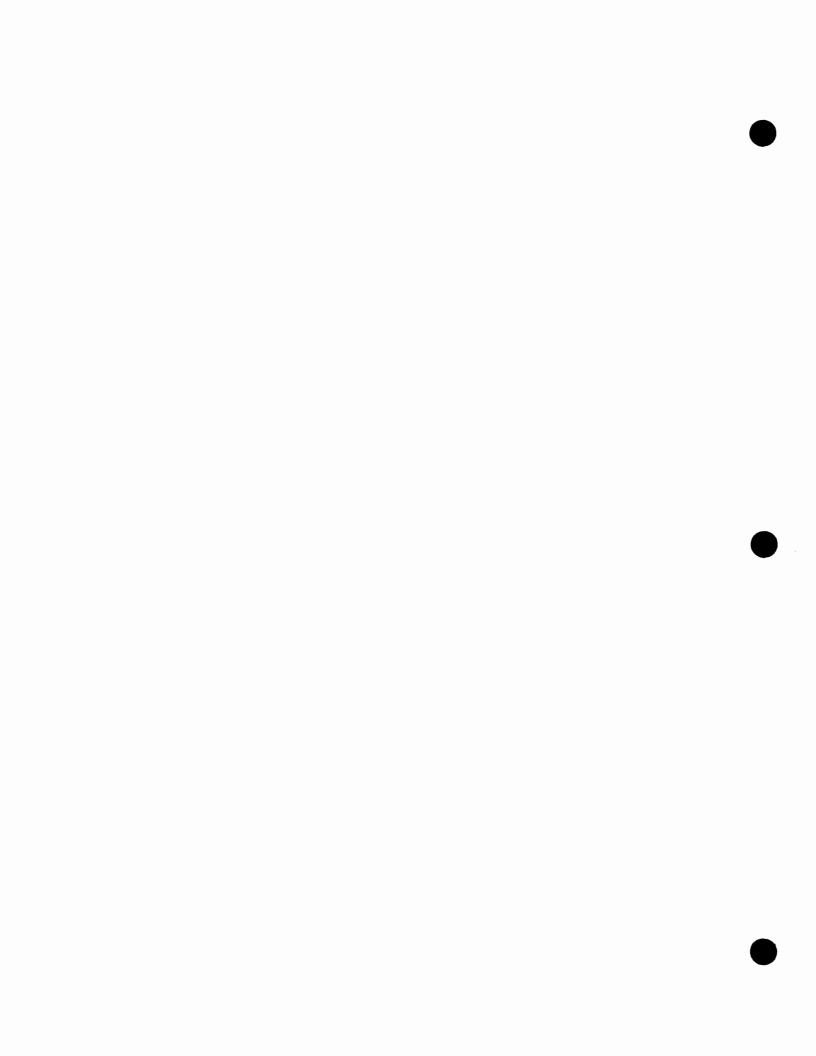
Committee Sergeants at Arms

NAME OF COMMITTEE HOL	use Committee on Health
DATE:2/8/2017	
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	House Sgt-At Arms:
1. Name: Warren Hawkins	# 1 No. 100 100 100 100 100 100 100 100 100 10
2. Name: Doug Harris	
3. Malachi McCullough, Jr	
4. Name: Bill Moore	
5. Name:	
	Senate Sgt-At Arms:
. Name:	
Name:	
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l c:	

House Pages Assignments Wednesday, February 08, 2017

Session: 1:00 PM

Committee	Room	Time	Pages	Member
Health	643	11:00 AM	John Frey	Rep. Larry Yarborough
			Anna Lee	Rep. Gregory F. Murphy,
				M.D.
			Min Lee	Rep. Chris Malone
			Grace Tippett	Rep. Susi Hamilton



House Committee on Health	2/8/2017	 www.pappinaentellites van 1.4 japp
Name of Committee	Date	

NAME	FIRM OR AGENCY AND ADDRESS
Jonatha Babalas	Enlate + Assoc.
Gerry Collan	Msm Mullins
JOEL MATHARES	GPM - ROSEDE
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Peter Daniel	C. (
SCOTT LASTER	4 GANC
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TJBughee	NP.
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Will Culpepper	MVA

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House Committee on Health	2/8/2017	reserving a party
Name of Committee	Date	

NAME	FIRM OR AGENCY AND ADDRESS
Danny Staley	Public Health-DHHS
Tin Byca	Normas
Ellen Essick	NCDPI
Susanne Schmal	NCOPI
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James Whalen	Rop. Cynthia Ball
Hary Dyster	NCDS
Alec Brker	NC Deutal Society

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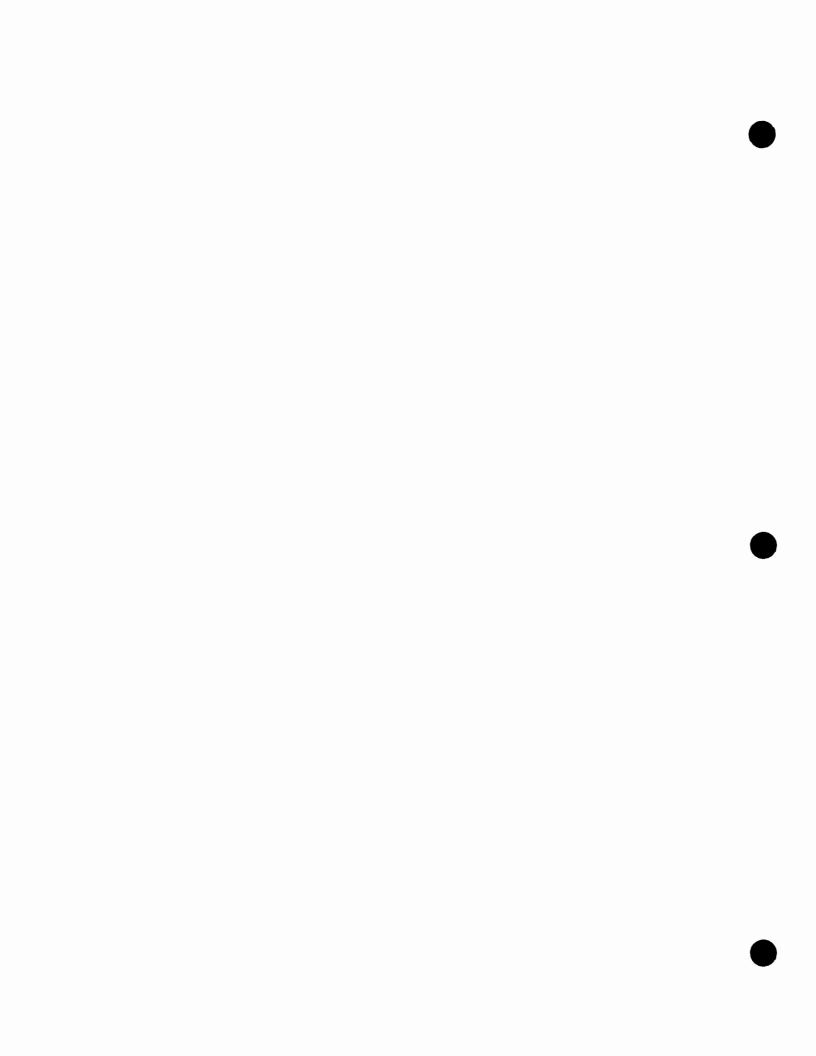
House Committee on Health	2/8/2017	
Name of Committee	Date	

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House Committee on Health 2/8/2017 Name of Committee Name of Committee

NAME	FIRM OR AGENCY AND ADDRESS
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DANIEL VAN LIERE	Vinit
Chris McCh	(DP
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VISITOR REGISTRATION SHEET

House Committee - HEALTH 2/8/2017

Name of Committee Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME

FIRM OR AGENCY AND ADDRESS

PACY GLVAPD	AHHE
Andy Chase	KMA
Jowy Elle	R. WA Assoc
Che McDonn	275
Zane Stilnell	156
Julia Lodans Scheunch	Oak City GR 116
Leslie Young	Word and Swift, P.A.
Joe Parrish	None
Drew Moreh	UNCGA
David Powers	UNCBOG
Hugh Johnson	NCPC

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VISITOR REGISTRATION SHEET

House Committee on Health	2/8/2017
Name of Committee	Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

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Emily Ziegler	UNC Rox
Lisa Ward	NC Dental Society
Shelly Dates	NC Dertal Society
Stephanie Whatum	MXC
SarahWolfe	MWC.
Carli Acror	UNC School of Dentistry
Mathew Graham Berkelham	ner UNC School of Dentistry
Prichard Greene Danielle Grough Jon Hartley	ECU School of Dental Medicine ECU School of Portal Medicine

ECU SOBM

Dew Morete David Pouretes Hugh Johnson

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VISITOR REGISTRATION SHEET

House Committee on Health	2/8/2017	
Name of Committee	Date	

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

CHRIS SIEVERS	FIRM OR AGENCY AND ADDRESS UNC SCHOOL OF DENTISIRY
Mary Morgan Bitter	UNCSchool of Pentistry
Fredrick Forms	
SCOTT PRUZSCHOLAB	en N= OtHS OPH
Kara Weishour	34
· Laura Gunter	NC810
Rivan Mewa 16	wm
Jessica Shamberger	ECH School of Dental Medicine
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Zaneta Carver	ECU School of Dental Medicine
Afex Green Fahim Talal Judes	ECU SODM UNC SOD Perk. Asan Law

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House Committee on Health Wednesday, February 15, 2017 at 11:00 AM Room 643 of the Legislative Office Building

MINUTES

The House Committee on Health met at 11:00 AM on February 15, 2017 in Room 643 of the Legislative Office Building. Representatives Adcock, Ball, Blackwell, Boswell, Brisson, Burr, Carney, Cunningham, Dobson, Dollar, Dulin, Earle, Farmer-Butterfield, Ford, Howard, Hunter, Bert Jones, Lambeth, Lucas, Murphy, Potts, Rogers, Setzer, Shepard, Szoka, White, Wray, Yarborough, and Zachary attended.

Representative Josh Dobson, Chair, presided.

The following bills were considered:

HB 57 Enact Physical Therapy Licensure Compact. (Representatives Szoka, G. Martin, Grange)

Representative Szoka presented the bill. Representative Burr offered an Amendment. The amendment passed. Rep. Jones motioned for a favorable report with a re-referral to Finance as amended and rolled into a PCS.

The meeting adjourned at 11:15am.

Representative Josh Dobson, Chair

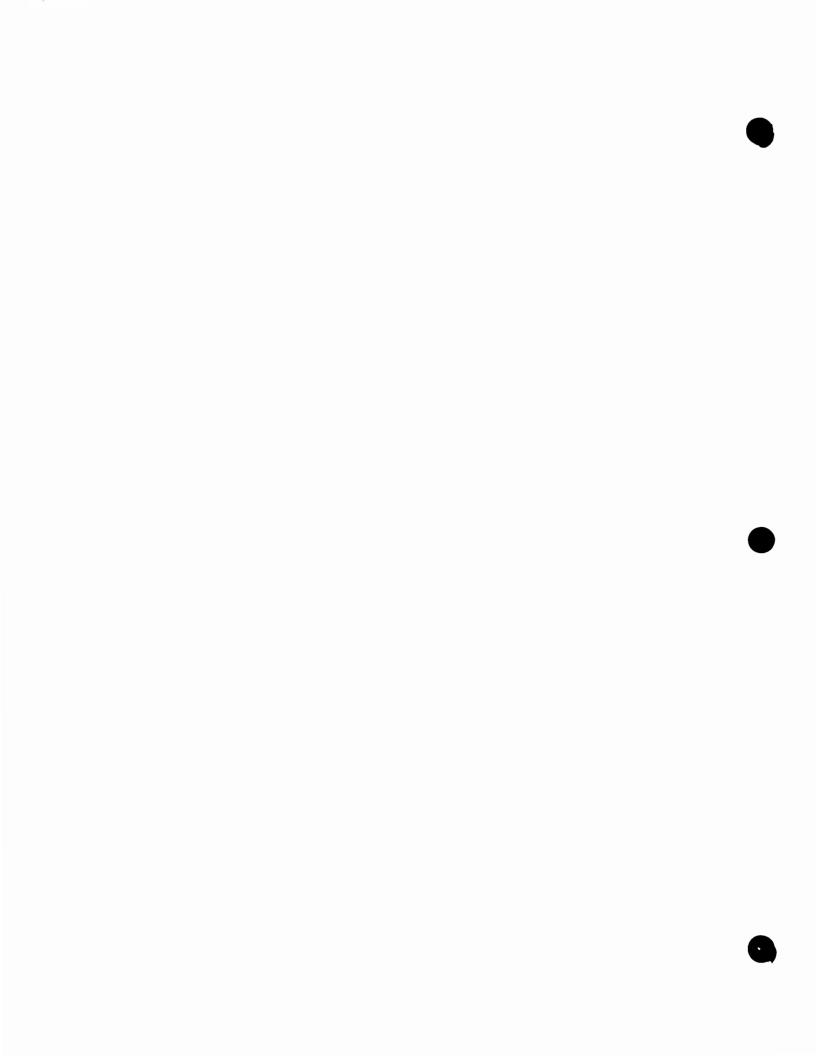
Presiding

Julie Ryan, Committee Clerk

NORTH CAROLINA HOUSE OF REPRESENTATIVES COMMITTEE MEETING NOTICE AND BILL SPONSOR NOTIFICATION 2017-2018 SESSION

You are hereby notified that the House Committee on Health will meet as follows:

DAY & DATTIME: LOCATION COMMENT	N :	Wednesday, February 15, 2 11:00 AM 643 LOB Representative Dobson w		ne meeting.
The following	ıg bil	ls will be considered:		
BILL NO. HB 57	Ena	ORT TITLE act Physical Therapy Licensu mpact.	ıre	SPONSOR Representative Szoka Representative G. Martin Representative Grange
			Respectfu	ılly,
			Represent Represent Represent	tative Justin P. Burr, Co-Chair tative Josh Dobson, Co-Chair tative Bert Jones, Co-Chair tative Donny Lambeth, Co-Chair tative Gregory F. Murphy, MD, Co-Chair
I hereby cert Tuesday, Feb			mmittee as	sistant at the following offices at 10:24 AM on
		Principal Clerk Reading Clerk – House Char	mber	
Brenda Olls	(Con	nmittee Assistant)		



House Committee on Health Wednesday, February 15, 2017, 11:00 AM 643 Legislative Office Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

BILL NO. SHORT TITLE

HB 57 Enact Physical Therapy Licensure

Compact.

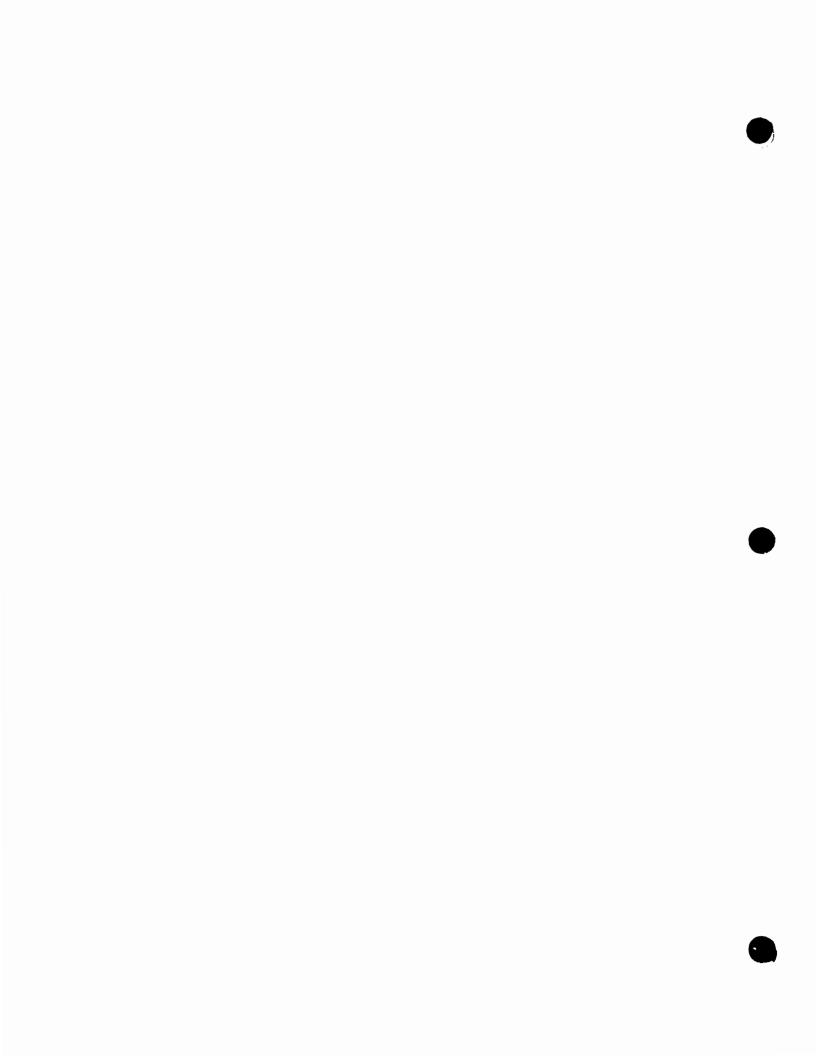
SPONSOR

Representative Szoka Representative G. Martin Representative Grange

Presentations

Other Business

Adjournment





HOUSE BILL 57: Enact Physical Therapy Licensure Compact.

2017-2018 General Assembly

Committee: House Health. If favorable, re-refer to Date: February 13, 2017

Finance

Introduced by: Reps. Szoka, G. Martin, Grange Prepared by: Jason Moran-Bates

Analysis of: First Edition Committee Co-Counsel

OVERVIEW: House Bill 57 would make North Carolina a member of the Physical Therapy Licensure Compact. Membership in the compact would allow physical therapists who hold licenses in good standing in any other Compact state to practice physical therapy in North Carolina. Likewise, physical therapists holding a valid license in North Carolina would be able to practice physical therapy in any of other the Compact member states.

CURRENT LAW: Under current law, individuals who hold a license to practice physical therapy in another state must go through the process to be licensed by endorsement before being allowed to practice in North Carolina. This process involves submitting an application and application fee, verifying licensure in the other state, and verifying a score of at least 600 or higher on the National Physical Therapy Exam. Once the North Carolina license is granted, the physical therapist must comply with all of North Carolina's requirements in order to maintain the license, in addition to complying with the requirements to maintain a license in any other state in which the therapist is licensed.

BILL ANALYSIS:

Section 1 of the bill recodifies Article 18B of Chapter 90 of the General Statutes, the current Physical Therapy Practice Act, as Article 18E of Chapter 90 of the General Statutes.

Section 2 of the bill creates Article 18F in Chapter 90 of the General Statutes, enacting the Physical Therapy Licensure Compact. In broad terms, physical therapists licensed in a Compact state would hold and maintain a license in their home state and be licensed to practice physical therapy in any Compact member state. The home state's laws and regulations would govern the therapist's maintenance of the license in the therapist's home state. If the therapist lost the license held in the home state, the therapist would no longer be licensed to practice in any of the Compact member states. Any therapist practicing in North Carolina under the terms of the Compact would be bound by North Carolina laws and regulations.

G.S. 90-270.120 sets forth the purpose of the Physical Therapist Licensure Compact.

G.S. 90-270.121 lists the definitions to be used in Article 18F.

G.S. 90-270.122 would require states participating in the Compact to: 1) participate fully in the Compact's data system, 2) have a mechanism to receive and investigate complaints about licensees, 3) notify the Compact Commission of any disciplinary action taken against a licensee, 4) fully implement a criminal background check requirement, 5) comply with the rules promulgated by the Compact Commission, 6) use a nationally recognized exam as a basis for licensure, and 7) establish continuing competence requirements. In addition, member states would have the authority to collect biometric data from each license applicant and to charge a fee for granting a compact privilege.





Legislative Analysis Division 919-733-2578

House Bill 57

Page 2

G.S. 90-270.123 would require individuals licensed under the Compact to: 1) hold a license in their home state, 2) not have encumbrances on any license in any state, 3) be eligible for Compact privileges in accordance with Article 18F, 4) not had adverse action against any license in the last two years, 5) notify the Commission the applicant is seeking privileges within another state, 6) pay applicable fees, 7) meet any jurisprudence requirements of the remote state, and 8) report adverse action taken against the licensee to the Commission within 30 days. G.S. 90-270.123 also states that the Compact privilege is valid only as long as the individual's license in the home state is valid. Licensees are required to follow all the laws, regulations, and regulatory authority of the remote state when practicing in the remote state. The process for restoring lost Compact privileges is also set forth.

G.S. 90-270.124 would allow active duty military members or their spouses to designate their home state as either their home of record, their Permanent Change of Station location, or their state of residence.

G.S. 270.125 states that although the home state has the exclusive authority to take adverse action against a home state license, it may take action based on the recommendations and investigations of a remote state. Remote states have the power to investigate complaints and initiate adverse action against licensees in the remote state. Member states may also jointly investigate complaints.

G.S. 90-270.126 would establish the Physical Therapy Compact Commission, which is the governing body of the Compact. The Commission is comprised of one delegate from each Compact state and must meet regularly, in public, to carry out the business of the Compact. It does not have the power to change the laws and regulations of the member states. G.S. 90-270.126 also establishes the Executive Board, which has the power to act on behalf of the Commission. The Board is comprised of seven voting members selected from the current membership of the Commission and two non-voting mebers from physical therapy organizations. The members of the Executive Board are immune from suit against them personally for their official actions.

G.S. 90-270.127 would establish a data system to be shared among the member states. This system can be accessed by any member state. Each member state must submit the following information on licensees to the system: 1) identifying information, 2) licensure data, 3) adverse actions, 4) non-confidential information related to alternative program participation, 5) information on denials of applications for licensure, and 6) other information determined by the Commission. Member states may designate certain information that will remain confidential. The Commission is required to notify all member states of any adverse action taken against a licensee.

G.S. 90-270.128 would set forth the Commission's authority to make rules for the Compact and the process to promulgate those rules. The Commission does not have any authority to change individual states' rules of practice for physical therapists. Prospective Commission rules are subject to a notice and comment period before being voted on by the Commission at a regular or special meeting. A public hearing will be held if requested by at least 25 people, a state or federal government agency, or an association of at least 25 members. If a majority of the legislatures of the Compact member states reject a rule by enactment of a statute or resolution, the rule will have no further effect in any member state.

<u>G.S. 90-270.129</u> would provide for enforcement of the Compact by all three branches of state government. It would allow the Commission to be an intervening party in any suit affecting the powers, responsibilities, or actions of the Commission. The Commission may terminate a member state from the Compact if it determines the member state is in default of its obligations under the Compact. Termination will be undertaken only as a last resort if no other method of securing compliance with the Compact has been effective. Disputes between member and non-member states relating to the Compact will be resolved by the Commission.

House Bill 57

Page 3

<u>G.S. 90-270.130</u> states the Compact will come into effect on the date the tenth member state enacts it into law. Member states can withdraw from the Compact by enacting a statute repealing the original enacting statute. Amendments to the Compact may be enacted by member states, but amendments will not be effective until they have been enacted into law by all the member states.

<u>G.S. 90-270.131</u> states that the provisions of the Compact are severable, and any provisions not specifically struck down by a court will remain in effect.

EFFECTIVE DATE: This act would be effective October 1, 2017.

BACKGROUND: This act streamlines the process for physical therapists licensed in other states to become eligible to practice in North Carolina. It is similar in structure and effect to the Nurse Licensure Compact (Article 9G of Chapter 90), which was enacted in 1999. As of February 14, 2017, the Compact had been enacted in Arizona, Missouri, Oregon, and Tennessee, and legislation had been introduced in Colorado, Kentucky, Mississippi, Montana, New Hampshire, New Jersey, North Dakota, and Washington.

GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2017

H

HOUSE BILL 57

Short Title:	Enact Physical Therapy Licensure Compact. (Public)
Sponsors:	Representatives Szoka, G. Martin, and Grange (Primary Sponsors).
P	For a complete list of sponsors, refer to the North Carolina General Assembly web site.
Referred to:	Health, if favorable, Finance
	February 8, 2017
	1.0014417 0, 2017
	A BILL TO BE ENTITLED
	ESTABLISHING A PHYSICAL THERAPY LICENSURE COMPACT TO
	ATE THE INTERSTATE PRACTICE OF PHYSICAL THERAPY. Assembly of North Carolina enacts:
	ECTION 1. Article 18B of Chapter 90 of the General Statutes, G.S. 90-270.24
	90-270.44, is recodified as Article 18E of Chapter 90 of the General Statutes,
	90 through G.S. 90-270.110.
	ECTION 2. Chapter 90 of the General Statutes is amended by adding a new Article
to read:	
	"Article 18F.
	"Physical Therapy Licensure Compact.
" <u>§ 90-270.12</u>	
	ose of this Compact is to facilitate the interstate practice of physical therapy with the oving public access to physical therapy services. The practice of physical therapy
	state where the patient/client is located at the time of the patient/client encounter.
	t preserves the regulatory authority of states to protect public health and safety
	surrent system of state licensure. This Compact is designed to achieve the following
objectives:	
(1	
	recognition of other member state licenses.
<u>(2</u>	
<u>(3</u>	
(1	therapy practice. Support spouses of relocating military members.
<u>(4</u> (5	
(2	between member states.
(6	
	that state accountable to that state's practice standards.
" <u>§ 90-270.12</u>	1. Definitions.
	n this Compact, and except as otherwise provided, the following definitions apply:
<u>(1</u>	
	the United States, including members of the National Guard and Reserve on



active duty orders pursuant to 10 U.S.C. Section 1209 and 1211.

To participate in the Compact, a state must do all of the following: 1 (a) Participate fully in the Commission's data system, including using the 2 (1) 3 Commission's unique identifier as defined in rules. Have a mechanism in place for receiving and investigating complaints about 4 (2) 5 licensees. 6 Notify the Commission, in compliance with the terms of the Compact and rules, (3) of any adverse action or the availability of investigative information regarding a 7 8 licensee. 9 Fully implement a criminal background check requirement, within a time frame (4) established by rule, by receiving the results of the Federal Bureau of 10 Investigation record search on criminal background checks and use the results 11 12 in making licensure decisions in accordance with subsection (b) of this section. 13 Comply with the rules of the Commission. <u>(5)</u> Utilize a recognized national examination as a requirement for licensure 14 (6)15 pursuant to the rules of the Commission. Have continuing competence requirements as a condition for license renewal. 16 (7) Upon adoption of this statute, the member state shall have the authority to obtain 17 (b) biometric-based information from each physical therapy licensure applicant and submit this 18 information to the Federal Bureau of Investigation for a criminal background check in accordance 19 20 with 28 U.S.C. § 534 and 42 U.S.C. § 14616. 21 A member state shall grant the compact privilege to a licensee holding a valid (c) 22 unencumbered license in another member state in accordance with the terms of the Compact and 23 rules. 24 (d) Member states may charge a fee for granting a compact privilege. 25 "§ 90-270.123. Compact privilege. In order to exercise the compact privilege under the terms and provisions of the 26 27 Compact, the licensee shall meet all of the following qualifications: 28 Hold a license in the home state. (1) 29 (2) Have no encumbrance on any state license. Be eligible for a compact privilege in any member state in accordance with 30 (3) 31 subsections (d), (g) and (h) of this section. 32 Have not had any adverse action against any license or compact privilege (4) 33 within the previous two years. 34 <u>(5)</u> Notify the Commission that the licensee is seeking the compact privilege within 35 a remote state(s). Pay any applicable fees, including any state fee, for the compact privilege. 36 (6) 37 Meet any jurisprudence requirements established by the remote state(s) in (7) 38 which the licensee is seeking a compact privilege. 39 (8) Report to the Commission adverse action taken by any non-member state 40 within 30 days from the date the adverse action is taken. The compact privilege is valid until the expiration date of the home license. The 41 (b) 42 licensee must comply with the requirements of subsection (a) of this section to maintain the 43 compact privilege in the remote state. 44 A licensee providing physical therapy in a remote state under the compact privilege (c) 45 shall function within the laws and regulations of the remote state. 46 A licensee providing physical therapy in a remote state is subject to that state's 47 regulatory authority. A remote state may, in accordance with due process and that state's laws, 48 remove a licensee's compact privilege in the remote state for a specific period of time, impose 49 fines, and/or take any other necessary actions to protect the health and safety of its citizens. The licensee is not eligible for a compact privilege in any state until the specific time for removal has 50 51 passed and all fines are paid.

If a home state license is encumbered, the licensee shall lose the compact privilege in 1 2 any remote state until both of the following occur: 3 The home state license is no longer encumbered. (1) 4 Two years have elapsed from the date of the adverse action. (2) 5 Once an encumbered license in the home state is restored to good standing, the licensee (f) 6 must meet the requirements of subsection (a) of this section to obtain a compact privilege in any 7 remote state. 8 If a licensee's compact privilege in any remote state is removed, the individual shall (g) 9 lose the compact privilege in any remote state until all of the following occur: The specific period of time for which the compact privilege was removed has 10 (1)ended. 11 12 (2) All fines have been paid. Two years have elapsed from the date of the adverse action. 13 (3) Once the requirements of subsection (g) of this section have been met, the license must 14 15 meet the requirements in subsection (a) of this section to obtain a compact privilege in a remote 16 state. 17 "§ 90-270.124. Active duty military personnel or their spouses. 18 A licensee who is active duty military or is the spouse of an individual who is active duty 19 military may designate one of the following as the home state: 20 (1) Home of record. 21 Permanent Change of Station (PCS). (2) 22 (3) State of current residence if it is different than the PCS state or home of record. "§ 90-270.125. Adverse actions. 23 24 A home state shall have exclusive power to impose adverse action against a license (a) 25 issued by the home state. 26 A home state may take adverse action based on the investigative information of a (b) 27 remote state, so long as the home state follows its own procedures for imposing adverse action. 28 Nothing in this Compact shall override a member state's decision that participation in an alternative program may be used in lieu of adverse action and that such participation shall 29 remain non-public if required by the member state's laws. Member states must require licensees 30 31 who enter any alternative programs in lieu of discipline to agree not to practice in any other 32 member state during the term of the alternative program without prior authorization from such 33 other member state. 34 Any member state may investigate actual or alleged violations of the statutes and rules 35 authorizing the practice of physical therapy in any other member state in which a physical therapist or physical therapist assistant holds a license or compact privilege. 36 A remote state shall have the authority to do all of the following: 37 (e) Take adverse actions as set forth in subsection (d) of G.S. 90-270.123 against a 38 (1) licensee's compact privilege in the state. 39 Issue subpoenas for both hearings and investigations that require the attendance 40 (2) and testimony of witnesses, and the production of evidence. Subpoenas issued 41 by a physical therapy licensing board in a party state for the attendance and 42 testimony of witnesses, and/or the production of evidence from another party 43 state, shall be enforced in the latter state by any court of competent jurisdiction. 44 according to the practice and procedure of that court applicable to subpoenas 45 issued in proceedings pending before it. The issuing authority shall pay any 46 witness fees, travel expenses, mileage, and other fees required by the service 47 statutes of the state where the witnesses and/or evidence are located. 48

If otherwise permitted by state law, recover from the licensee the costs of

investigations and disposition of cases resulting from any adverse action taken

(3)

against that licensee.

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Purchase and maintain insurance and bonds.

Borrow, accept, or contract for services of personnel, including employees of a

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member state.

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- <u>f.</u> Establish additional committees as necessary.
- g. Other duties as provided in rules or bylaws.
- (e) Meetings of the Commission.
 - (1) 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 G.S. 90-270.128.
 - (2) The Commission or the Executive Board or other committees of the Commission may convene in a closed, non-public meeting if the Commission or Executive Board or other committees of the Commission must discuss any of the following:
 - a. Non-compliance of a member state with its obligations under the Compact.
 - b. The employment, compensation, discipline or other 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.
 - d. Negotiation of contracts for the purchase, lease, or sale of goods, services, or real estate.
 - e. Accusing any person of a crime or formally censuring any person.
 - <u>f.</u> <u>Disclosure of trade secrets or commercial or financial information that is privileged or confidential.</u>
 - g. Disclosure of information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy.
 - h. Disclosure of investigative records compiled for law enforcement purposes.
 - i. Disclosure of information related to any investigative reports prepared by or on behalf of or for use of the Commission or other committee charged with responsibility of investigation or determination of compliance issues pursuant to the Compact.
 - j. Matters specifically exempted from disclosure by federal or member state statute.
 - (3) 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 that fully and clearly describe all matters discussed in a meeting and shall provide a full and accurate summary of actions taken, 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 by a majority vote of the Commission or order of a court of competent jurisdiction.
- (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 member 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 1 2 shall promulgate a rule binding upon all member states. The Commission shall not incur obligations of any kind prior to securing the 3 (4) funds adequate to meet the same; nor shall the Commission pledge the credit of 4 5 any of the member states, except by and with the authority of the member state. The Commission shall keep accurate accounts of all receipts and disbursements. 6 (5) 7 The receipts and disbursements of the Commission shall be subject to the audit 8 and accounting procedures established under its bylaws. However, all receipts 9 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 10 included in and become part of the annual report of the Commission. 11 Qualified Immunity, Defense, and Indemnification. -12 (g) The members, officers, executive director, employees and representatives of the 13 Commission shall be immune from suit and liability, either personally or in 14 their official capacity, for any claim for damage to or loss of property or 15 16 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 17 18 claim is made had a reasonable basis for believing occurred within the scope of 19 Commission employment, duties or responsibilities; provided that nothing in 20 this paragraph 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 21 22 willful or wanton misconduct of that person. The Commission shall defend any member, officer, executive director, 23 (2) employee or representative of the Commission in any civil action seeking to 24 impose liability arising out of any actual or alleged act, error, or omission that 25 occurred within the scope of Commission employment, duties, or 26 27 responsibilities, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission 28 29 employment, duties, or responsibilities; provided that nothing herein shall be construed to prohibit that person from retaining his or her own counsel; and 30 31 provided further, that the actual or alleged act, error, or omission did not result from that person's intentional or willful or wanton misconduct. 32 The Commission shall indemnify and hold harmless any member, officer, 33 (3) executive director, employee, or representative of the Commission for the 34 amount of any settlement or judgment obtained against that person arising out 35 of any actual or alleged act, error or omission that occurred within the scope of 36 Commission employment, duties, or responsibilities, or that such person had a 37 38 reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities, provided that the actual or alleged act, 39 40 error, or omission did not result from the intentional or willful or wanton misconduct of that person. 41 42 "§ 90-270.127. Data system. 43 The Commission shall provide for the development, maintenance, and utilization of a 44 coordinated database and reporting system containing licensure, adverse action, and investigative information on all licensed individuals in member states. 45 Notwithstanding any other provision of state law to the contrary, a member state shall 46
 - as required by the rules of the Commission, including all of the following:

 (1) Identifying information.
 - (2) Licensure data.
 - (3) Adverse actions against a license or compact privilege.

submit a uniform data set to the data system on all individuals to whom this Compact is applicable

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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

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appear and testify at the hearing not less than five business days before the 1 2 scheduled date of the hearing. 3 Hearings shall be conducted in a manner providing each person who wishes to (2)comment a fair and reasonable opportunity to comment orally or in writing. 4 5 All hearings will be recorded. A copy of the recording will be made available (3) 6 on request. 7 <u>(4)</u> Nothing in this section shall be construed as requiring a separate hearing on 8 each rule. Rules may be grouped for the convenience of the Commission at 9 hearings required by this section. Following the scheduled hearing date, or by the close of business on the scheduled 10 (i) hearing date if the hearing was not held, the Commission shall consider all written and oral 11 12 comments received. If no written notice of intent to attend the public hearing by interested parties is 13 (i) received, the Commission may proceed with promulgation of the proposed rule without a public 14 15 hearing. 16 (k) 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 17 18 record and the full text of the rule. 19 Upon determination that an emergency exists, the Commission may consider and adopt (1) 20 an emergency rule without prior notice, opportunity for comment, or hearing, provided that the 21 usual rule-making procedures provided in the Compact and in this section shall be retroactively 22 applied to the rule as soon as reasonably possible, in no event later than 90 days after the effective 23 date of the rule. For the purposes of this provision, an emergency rule is one that must be adopted 24 immediately in order to do any of the following: 25 Meet an imminent threat to public health, safety, or welfare. (1) 26 (2) Prevent a loss of Commission or member state funds. 27 (3) Meet a deadline for the promulgation of an administrative rule that is 28 established by federal law or rule. 29 (4) Protect public health and safety. The Commission or an authorized committee of the Commission may direct revisions 30 31 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 32 33 posted on the website 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 34 revision results in a material change to a rule. A challenge shall be made in writing, and delivered 35 to the chair of the Commission prior to the end of the notice period. If no challenge is made, the 36 37 revision will take effect without further action. If the revision is challenged, the revision may not 38 take effect without the approval of the Commission. 39 "§ 90-270.129. Oversight, dispute resolution, and enforcement. 40 (a) Oversight. -41 The executive, legislative, and judicial branches of state government in each (1) member state shall enforce this Compact and take all actions necessary and 42 43 appropriate to effectuate the Compact's purposes and intent. The provisions of this Compact and the rules promulgated hereunder shall have standing as 44 45 statutory law. All courts shall take judicial notice of the Compact and the rules in any judicial 46 (2) 47 or administrative proceeding in a member state pertaining to the subject matter 48 of this Compact which may affect the powers, responsibilities or actions of the 49 Commission. The Commission shall be entitled to receive service of process in any such 50 (3)

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 member state has defaulted in the performance of its obligations or responsibilities under this Compact or the promulgated rules, the Commission shall do all of the following:
 - a. Provide written notice to the defaulting state and other member states of the nature of the default, the proposed means of curing the default and/or any other action to be taken by the Commission.
 - b. Provide remedial training and specific technical assistance regarding the default.
 - (2) If a state in default fails to cure the default, the defaulting state may be terminated from the Compact upon an affirmative vote of a majority of the member states, and all rights, privileges and benefits conferred by this Compact may be terminated on the effective date of termination. A cure 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 given by the Commission to the governor, the majority and minority leaders of the defaulting state's legislature, and each of the member states.
 - A state that has been terminated is responsible for all assessments, obligations, and liabilities incurred through the effective date of termination, including obligations that extend beyond the effective date of termination.
 - (5) The Commission shall not bear any costs related to a state that is found to be in default or that 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 District of Columbia or the federal district where the Commission has its principal offices. The prevailing member shall be awarded all costs of such litigation, including reasonable attorney's fees.
- (c) Dispute Resolution. -
 - (1) Upon request by a member state, the Commission shall attempt to resolve disputes related to the Compact that arise among member states and between member and non-member states.
 - (2) The Commission shall promulgate a rule providing for both mediation and binding dispute resolution for disputes as appropriate.
- (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 District of Columbia or the federal district where the Commission has its principal offices against a member 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 attorney's fees.

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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.

"§ 90-270.130. Date of implementation of the interstate Commission for Physical Therapy Practice and associated rules, withdrawal and amendment.

- (a) The Compact shall come into effect on the date on which the Compact statute is enacted into law in the tenth member 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 that 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 that 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 member state may withdraw from this Compact by enacting a statute repealing the same.
 - (1) A member state's withdrawal shall not take effect until six months after enactment of the repealing statute.
 - Withdrawal shall not affect the continuing requirement of the withdrawing state's physical therapy licensing board 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 physical therapy licensure agreement or other cooperative arrangement between a member state and a non-member state that does not conflict with the provisions of this Compact.
- (e) This Compact may be amended by the member states. No amendment to this Compact shall become effective and binding upon any member state until it is enacted into the laws of all member states.

"§ 90-270.131. Construction and severability.

This Compact shall be liberally construed so as to effectuate the purposes thereof. The provisions of this Compact shall be severable and if any phrase, clause, sentence or provision of this Compact is declared to be contrary to the constitution of any party state or of the United States or the applicability thereof to any government, agency, person or circumstance is held invalid, the validity of the remainder of this Compact and the applicability thereof to any government, agency, person or circumstance shall not be affected thereby. If this Compact shall be held contrary to the constitution of any party state, the Compact shall remain in full force and effect as to the remaining party states and in full force and effect as to the party state affected as to all severable matters."

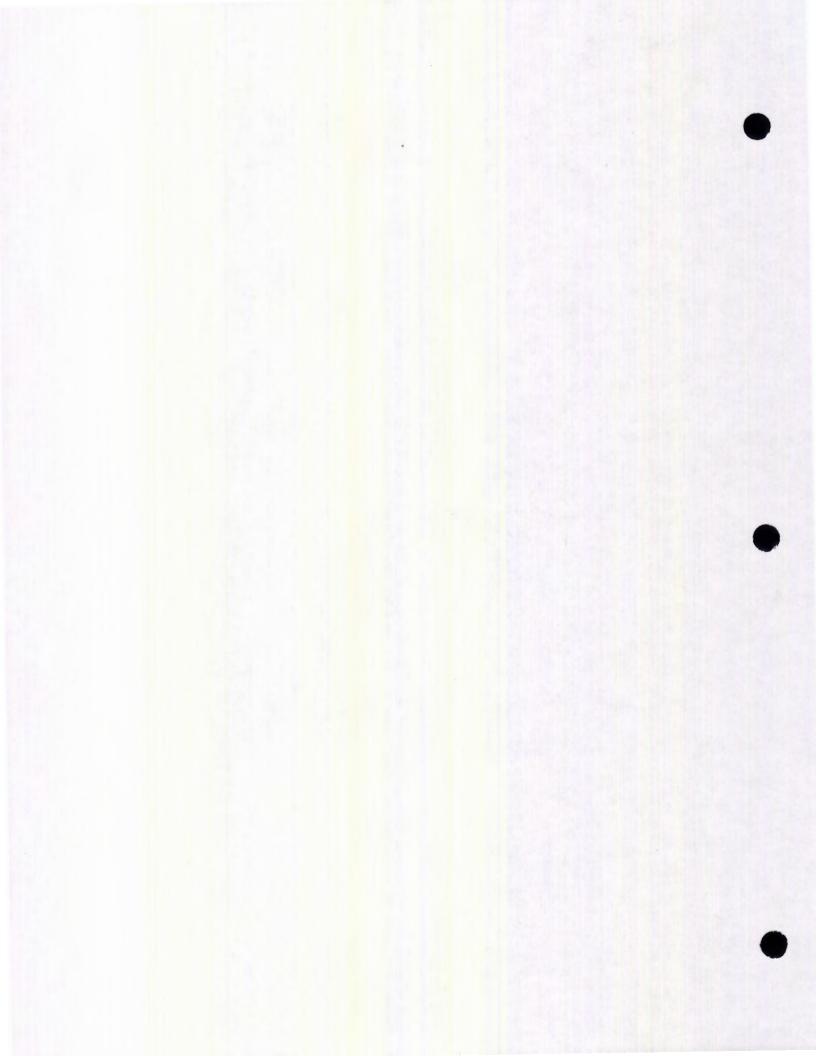
SECTION 2. This act becomes effective October 1, 2017.



NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT House Bill 57

H57-ABC-1 [v.3]	AMENDMENT No (to be filled in by Principal Clerk)	0
		Page 1 of 1
Amends Title [NO] First Edition	Date 2-15	,2017
Representative Burr		
	ecomes effective October 1, 2017. The Nor report to the Revisor of Statutes when the	
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	ate Committee Amendment	
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NORTH CAROLINA GENERAL ASSEMBLY HOUSE OF REPRESENTATIVES

HEALTH COMMITTEE REPORT

Representative Justin P. Burr, Co-Chair Representative Josh Dobson, Co-Chair Representative Bert Jones, Co-Chair Representative Donny Lambeth, Co-Chair Representative Gregory F. Murphy, MD, Co-Chair

FAVORABLE COM SUB, UNFAVORABLE ORIGINAL BILL AND RE-REFERRED

HB 57 Enact Physical Therapy Licensure Compact.

Draft Number:

H57-PCS30065-BCf-1

Serial Referral: FINANCE Recommended Referral: None

Long Title Amended:

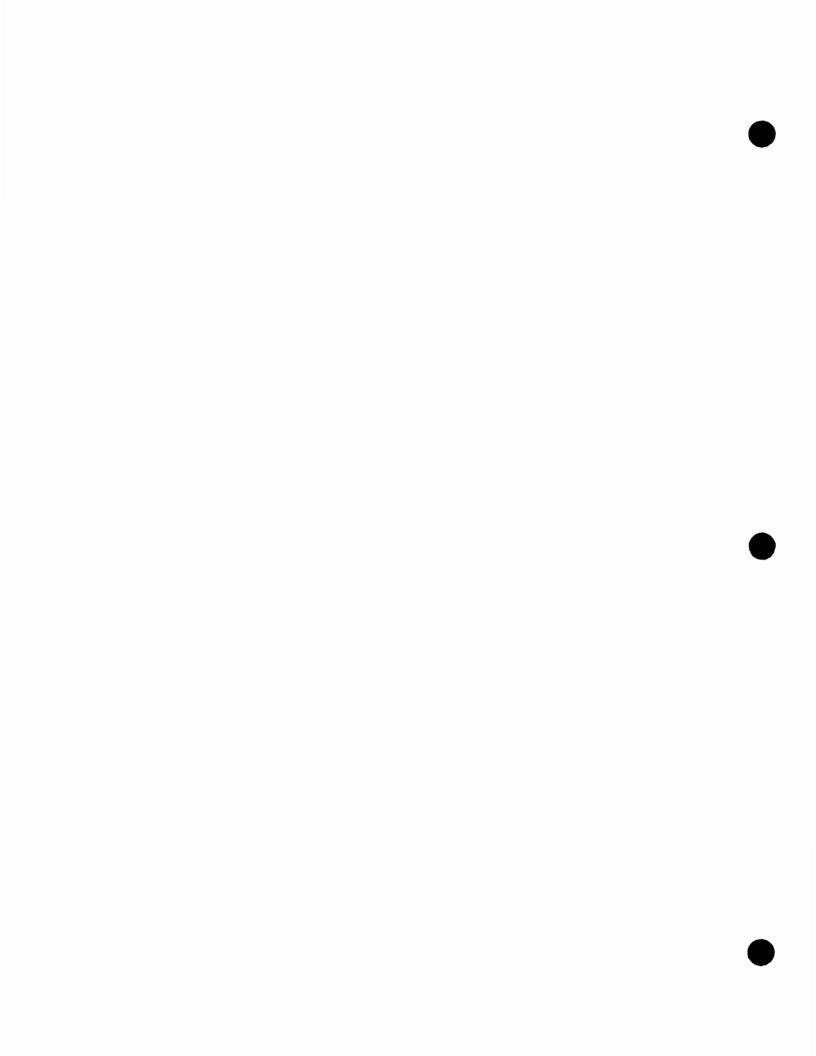
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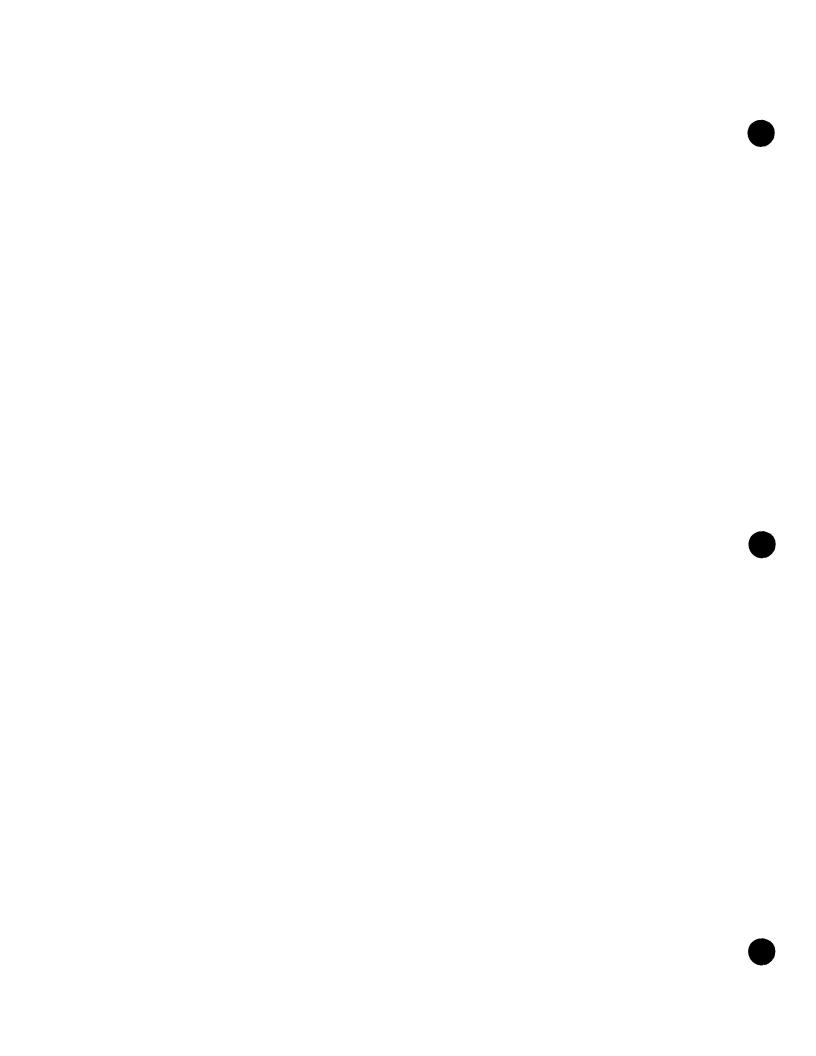
TOTAL REPORTED: 1





Committee Sergeants at Arms

NAME OF COMMITTEE _	House Comm.	on Health
DATE: 02/15/17	Room:	643
	House Sgt-At Arms:	
1. Name: Young Bae		-
2. Name: Jim Moran	\$ V \$	
3. Nunc: Dean Mars	hbourne	
4. Name: Terry McCI	raw	-
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VISITOR REGISTRATION SHEET

House Comm. on Health

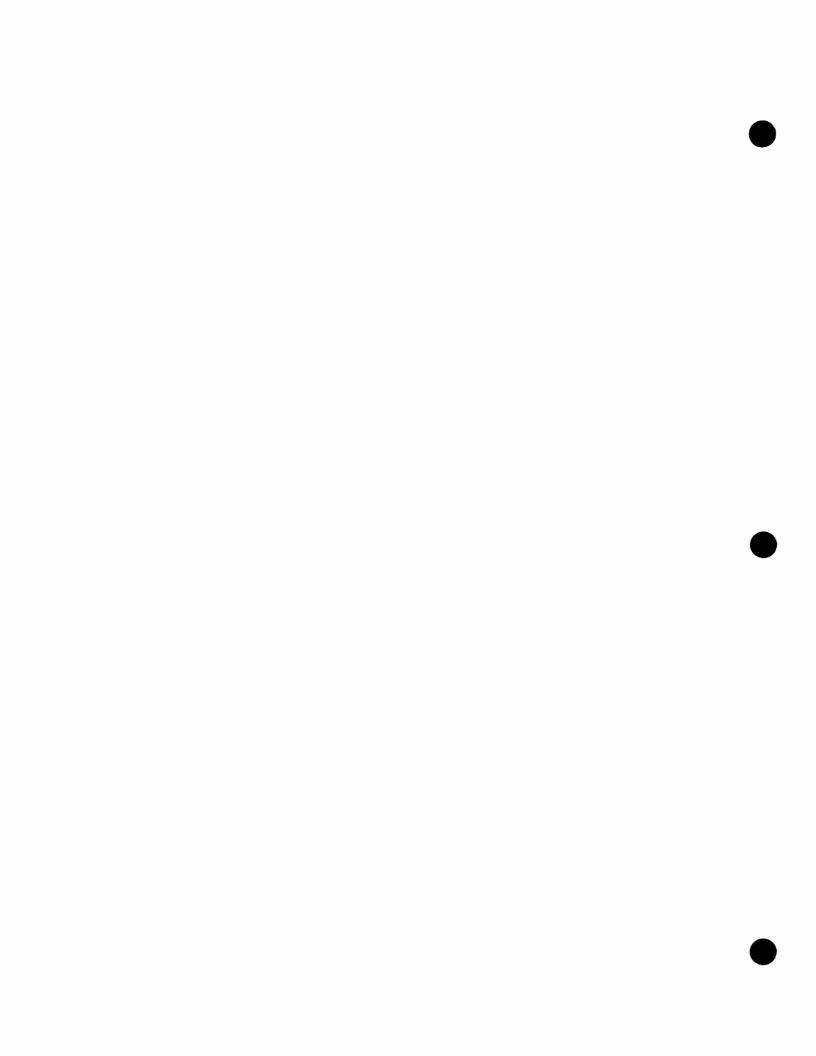
02/15/17

Name of Committee

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

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NC Board of NURSING



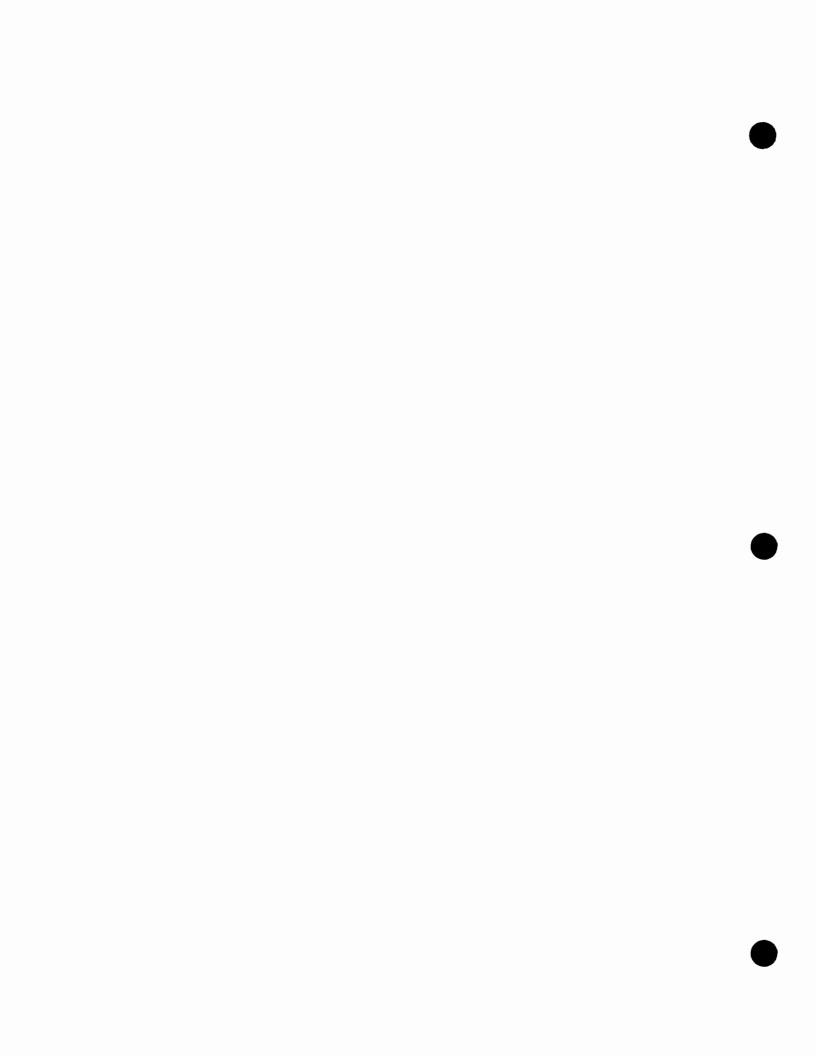
House Comm. on Health

02/15/17

Name of Committee

Date

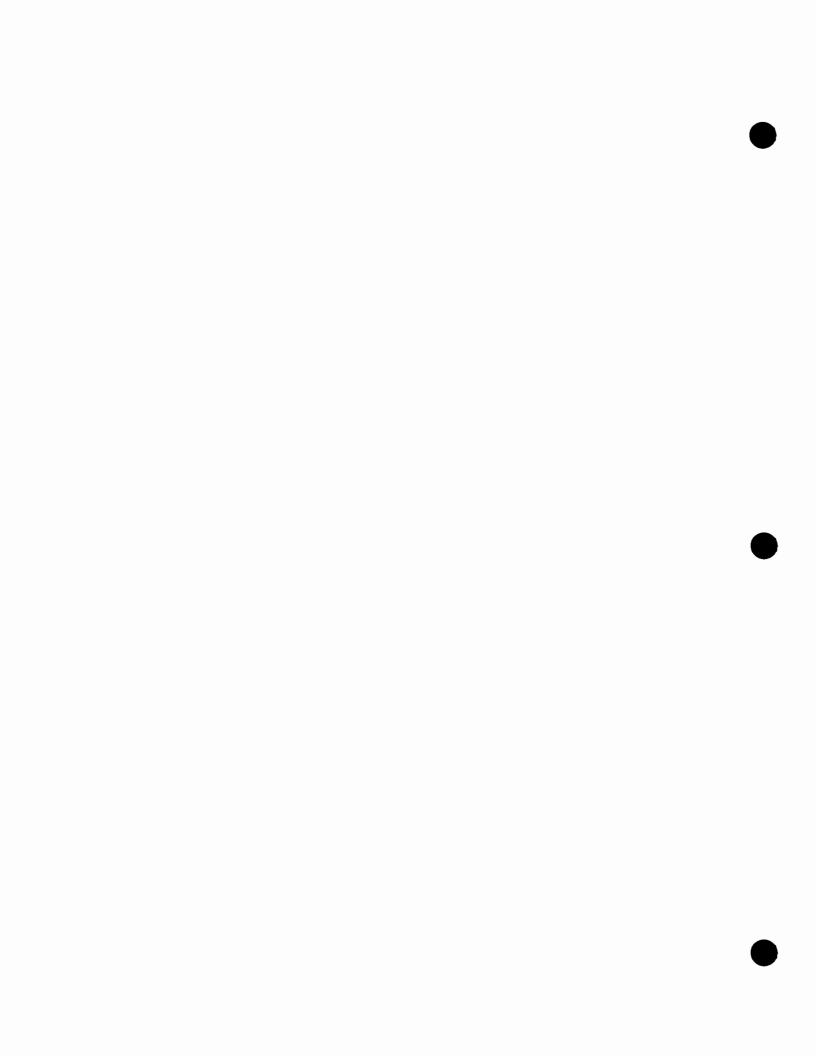
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Stephen Kouba	KMA
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David Reed	NC Board of PT Examiners
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House Comm. on Health

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NAME	FIRM OR AGENCY AND ADDRESS
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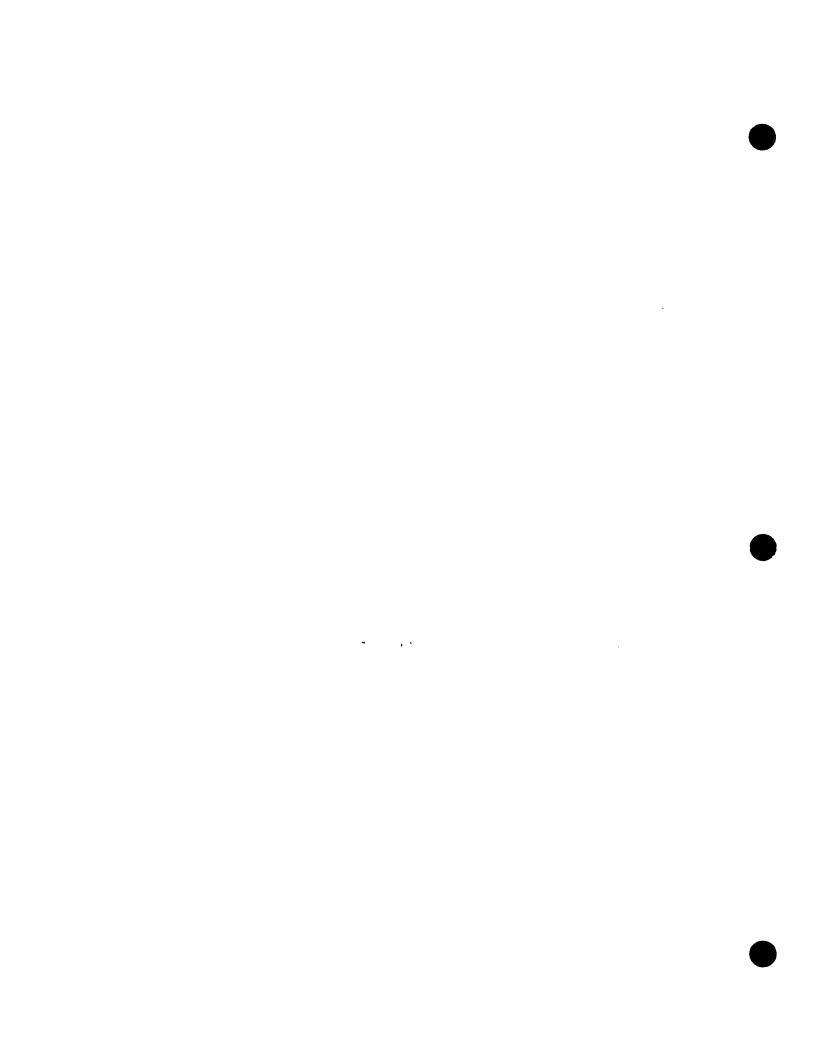
House Comm. on Health

02/15/17

Name of Committee

Date

NAME	FIRM OR AGENCY AND ADDRESS
Ben Popken	DHHS
Daylon	63 C 5 T P
Words Kelly	Focus carolina
TIBURE	NP
Chris Doughton	· MWC
GONTON SINS	NCVC
Danny A. Crotti	NCVC
Jeri I. Graham	NC Veteraus Council
BARRY J COYLE	MOAA SENC CHAPTER
Brenda Brubatu	Vietnam Veterans el apresia
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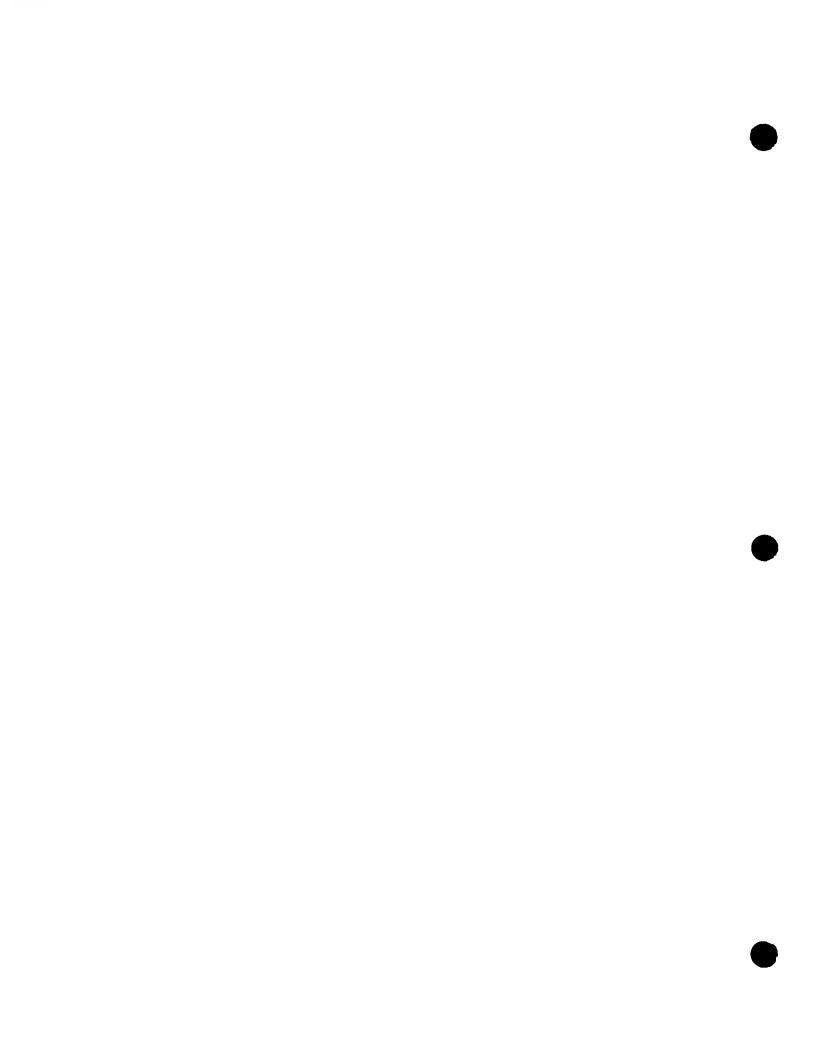
House Comm. on Health

02/15/17

Name of Committee

Date

NAME	FIRM OR AGENCY AND ADDRESS
Brooke Davis	Disabled American Veterans - Dept of Ne 1025 New Bern Ave. Rakigh, NC
ROGER SHEARIN	Marine Corps LEague of NC 389 GEROA LN, Clayton NC 37527
Bre Hager	CaroMont



House Committee on Health Wednesday, March 1, 2017 at 11:00 AM Room 643 of the Legislative Office Building

MINUTES

The House Committee on Health met at 11:00 AM on March 1, 2017 in Room 643 of the Legislative Office Building. Representatives Adcock, Ball, Blackwell, Boswell, Brisson, Burr, Carney, Cunningham, Dobson, Dollar, Dulin, Earle, Farmer-Butterfield, Ford, Howard, Hunter, Insko, Jackson, Bert Jones, Lambeth, Lucas, Malone, Murphy, Potts, Rogers, Setzer, Shepard, Szoka, White, Wray, Yarborough, and Zachary attended.

Representative Bert Jones, Chair, presided.

The following bills were considered:

HB 36 Enact Enhanced Access to Eye Care Act. (Representatives Burr, Collins, Dobson, Howard)

The meeting was FOR DISCUSSION ONLY. Representative Burr explained HB 36, which has a PCS. Supporters of the bill and opponents of the bill each had a total of 15 minutes to speak.

After the speakers concluded, members of the committee responded with questions for the bill supporters and opponents.

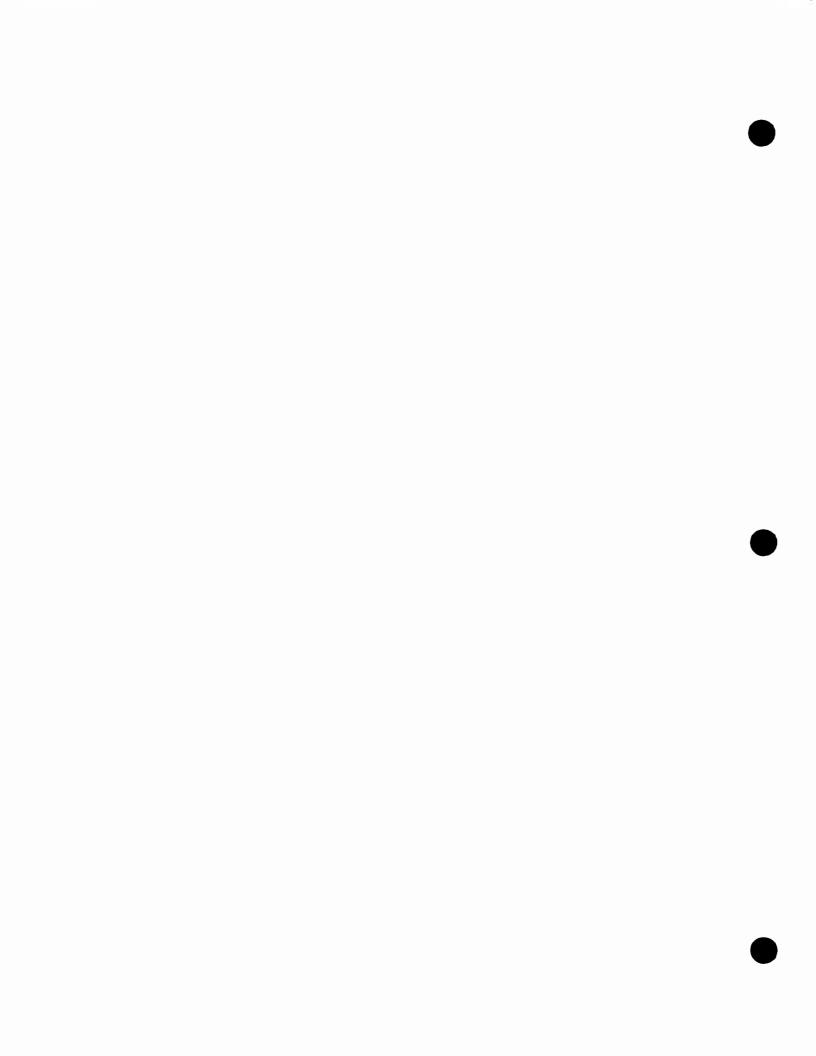
Speaker names and handouts are included with these Minutes.

The meeting adjourned at 12:00.

Representative Bert Jones, Chair

Presiding

Brenda Olls, Committee Clerk



NORTH CAROLINA HOUSE OF REPRESENTATIVES COMMITTEE MEETING NOTICE AND BILL SPONSOR NOTIFICATION 2017-2018 SESSION

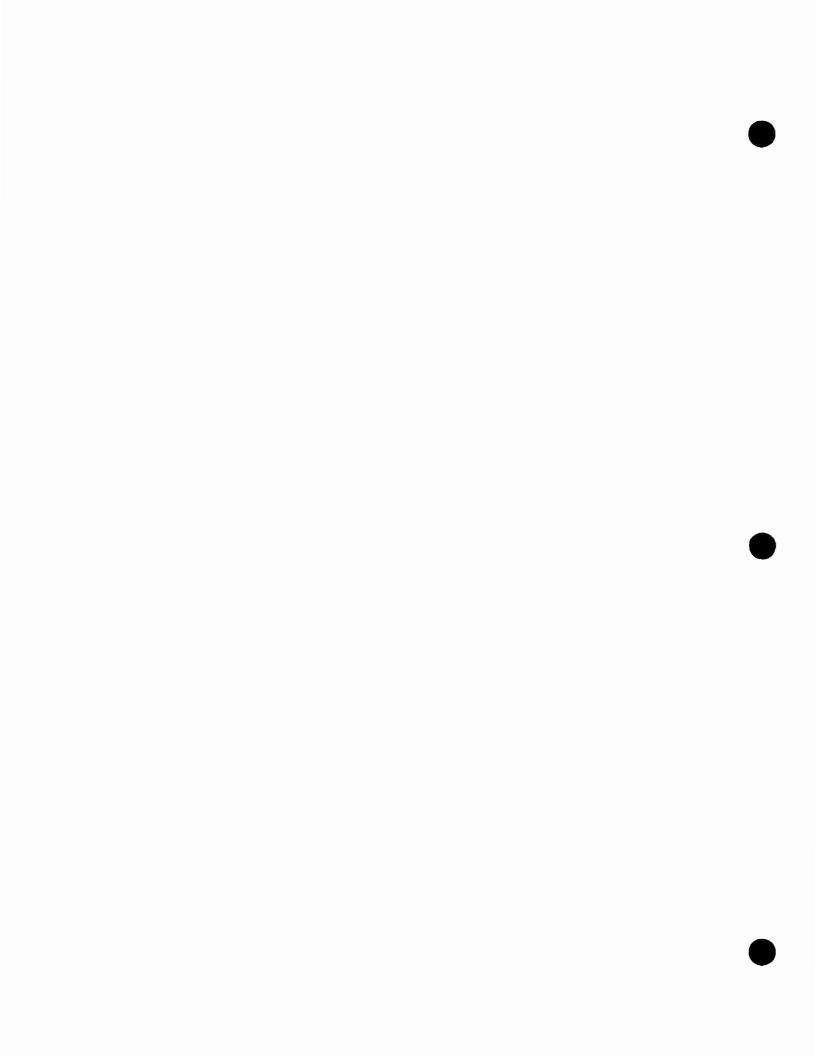
You are hereby notified that the House Committee on Health will meet as follows:

DAY & DATE: Wednesday, March 1, 2017

11:00 AM

TIME:

LOCATION COMMENT		643 LOB Representative Bert Jones	will be p	residing.
The following	ıg bil	lls will be considered:		
BILL NO. HB 36	Ena Act	ORT TITLE act Enhanced Access to Eye Ca c. cussion Only	are	SPONSOR Representative Burr Representative Collins Representative Dobson Representative Howard
		I	Respectfu	lly,
		F F	Represent Represent Represent	ative Justin P. Burr, Co-Chair ative Josh Dobson, Co-Chair ative Bert Jones, Co-Chair ative Donny Lambeth, Co-Chair ative Gregory F. Murphy, MD, Co-Chair
I hereby cert Thursday, Fe	•	•	mittee as	sistant at the following offices at 1:25 PM or
		Principal Clerk Reading Clerk – House Cham	ber	
Brenda Olls	(Con	nmittee Assistant)		



House Committee on Health Wednesday, March 1, 2017, 11:00 AM 643 Legislative Office Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

BILL NO. SHORT TITLE

HB 36 Act.

Enact Enhanced Access to Eye Care

Discussion Only

SPONSOR

Representative Burr

Representative Collins Representative Dobson Representative Howard

Presentations

The meeting will be FOR DISCUSSION ONLY with each side having a total of 15 minutes to express their support or opposition to the bill.

Other Business

Adjournment

			_
			_

H 36 Enact Enhanced Access to Eye Care Act for Discussion Only

The House Health Co-Chairs agreed to allow each side a total of 15 minutes to express their support or opposition to the bill. The 15 minutes for each side will be broken down as follows:

10 minutes for the supporters of the bill (list provided by Angel Sams)

- Steve Eyler
- Jim Fanelli
- Galen Grayson
- Chris Wroten

10 minutes for the opponents of the bill (list provided by Laurie Onorio)

• Dr Sue Burden who will have the presentation. (She plans to only use 8 min...)

Susan K. Burden, MD Associate Professor Department of Ophthalmology Wake Forest University

• **Dr Paul Cunningham, MD** (Remainder of the 10 minutes)

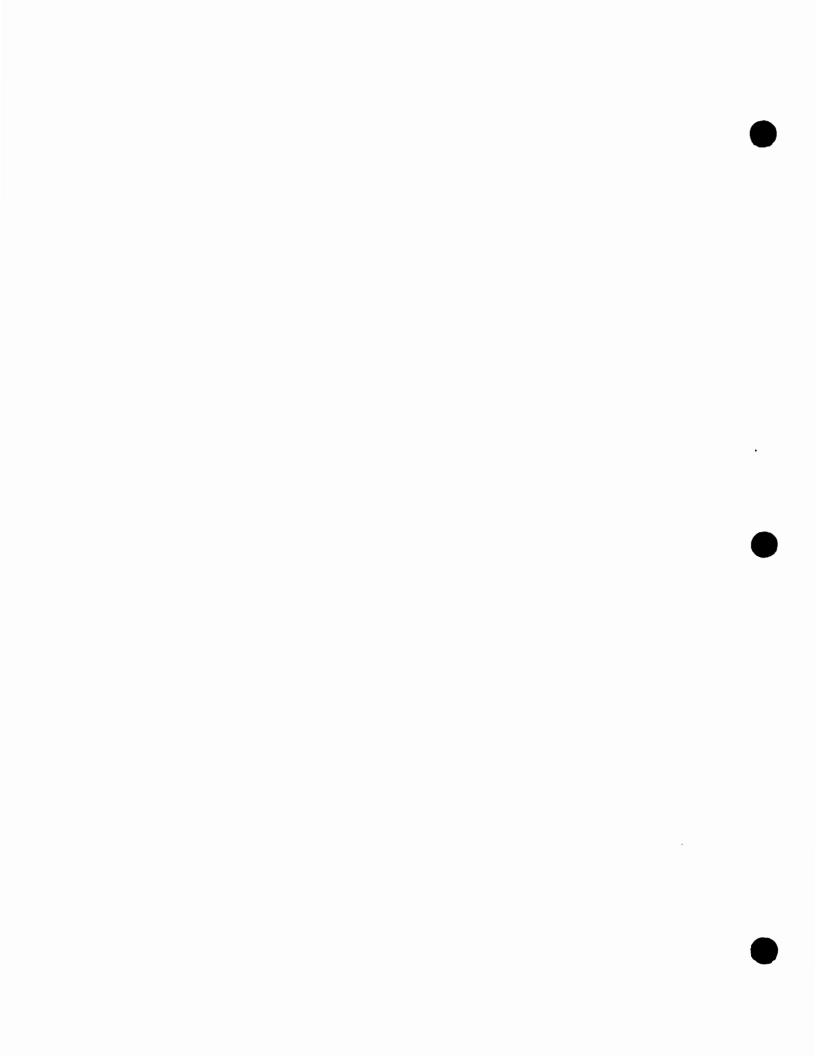
5 minutes for supporters of the bill

David Cockrell

5 minutes for opponents of the bill

• **Tom Fetzer** will speak as an ophthalmology patient. He is also one of our registered lobbyists.

Both sides have handouts





HOUSE BILL 36: Enact Enhanced Access to Eye Care Act.

2017-2018 General Assembly

Committee: House Health. If favorable, re-refer to Date:

Insurance. If favorable, re-refer to

Appropriations

Introduced by: Reps. Burr, Collins, Dobson, Howard

Analysis of: PCS to First Edition

H36-CSBC-4

Prepared by: Jason Moran-Bates

Staff Attorney

February 28, 2017

OVERVIEW: House Bill 36 would remove the general prohibition against surgery contained in the optometry scope of practice and replace it with a list of specifically prohibited surgical procedures.

CURRENT LAW: Under current law, the practice of optometry is defined in G.S. 90-114. It includes the examination of the eye by any method, other than surgery, to diagnose or treat any abnormal condition of the eye; the employment of instruments, devices, pharmaceutical agents and procedures, other than surgery, to examine, diagnose treat, or correct vision defects; and the prescribing or application of glasses, contacts, and other devices to treat abnormal conditions of the eye.

BILL ANALYSIS:

Section 1 of House Bill 36 would amend G.S. 90-114 by removing the general prohibition on surgery from the scope of practice of optometry and replace with a list of surgical procedures which are excluded from the definition of the practice of optometry. These procedures include:

- Retina laser procedures, LASIK, and PRK.
- Non-laser surgery related to eye removal.
- Non-laser surgery requiring full thickness incision or excision of the cornea.
- Corneal transplants or lamellar keratoplasty.
- Non-laser surgery requiring incision of the iris and ciliary body, vitreous, or retina.
- Non-laser surgical extraction of the crystalline lens.
- Non-laser surgical intraocular implants.
- Non-laser surgery of the extraocular muscles.
- Non-laser surgery of the eyelid for eyelid malignancies or repair of blepharochalasis, ptosis, or tarsorraphy.
- Non-laser surgery of the bony orbit.
- Non-laser surgery of the lacrimal system, other probing procedures.
- Non-laser surgery requiring full-thickness conjunctivoplasty.
- Any other non-laser procedure that does not correct and relieve ocular abnormalities.
- Injection into the posterior chamber of the eye to treat macular or retinal disease.
- Administration of, or procedures performed under, general anesthesia.

Section 2 of House Bill 36 would amend G.S. 90-118 to add a new subsection requiring the Board of Optometry to identify procedures, techniques, or treatment modalities which require additional





Legislative Analysis Division 919-733-2578

House PCS 36

Page 2

education, training, or experience. No optometrist would be permitted to perform those procedures, techniques, or treatment modalities without meeting all requirements the Board sets to perform those identified procedures, techniques, or treatment modalities.

Section 3 of House Bill 36 would allow the Board to appoint a committee comprised of optometrists and ophthalmologists to establish requirements which must be met by optometrists before they are allowed to perform the procedures, techniques, or treatment modalities identified by the Board pursuant to Section 2.

EFFECTIVE DATE: Section 1 of this act would become effective January 1, 2018. The remainder of the act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2017

H HOUSE BILL 36

Short Title:	Enact Enhanced Access to Eye Care Act. (F	Public)
Sponsors:	Representatives Burr, Collins, Dobson, and Howard (Primary Sponsors). For a complete list of sponsors, refer to the North Carolina General Assembly web site.	
Referred to:	Health, if favorable, Insurance, if favorable, Appropriations	

February 2, 2017

A BILL TO BE ENTITLED

AN ACT AMENDING THE SCOPE OF PRACTICE OF OPTOMETRY IN ORDER TO ENHANCE ACCESS TO EYE CARE IN NORTH CAROLINA.

The General Assembly of North Carolina enacts:

Whereas, the provision of eye care is rapidly evolving through advances in technology, pharmacology, and biotechnology; and

Whereas, the health care profession of optometry is dedicated to providing patient-centered eye care of the highest quality; and

Whereas, 1180 licensed Doctors of Optometry now provide the majority of primary eye care in North Carolina due to widespread geographic distribution and excellence in practice; and

Whereas, Doctors of Optometry provide eye care in 98 North Carolina counties, with primary office locations in 88 counties; and

Whereas, the wide availability of practicing Doctors of Optometry in North Carolina provides access to high quality eye care throughout the State; and

Whereas, the optometric profession has steadily evolved in expansion of practice while maintaining an exemplary record of safety and care since being first statutorily defined in 1909; and

Whereas, the statutes governing the practice of optometry have not been substantively updated to acknowledge advances in technology since 1977; and

Whereas, the continued expansion of optometric services in North Carolina will greatly improve access and affordability of eye care to the citizens of North Carolina; Now, therefore, The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-114 reads as written:

"§ 90-114. Optometry defined.

- (a) Any one or any combination of the following practices shall constitute the practice of optometry:
 - (1) The examination of the human eye by any method, exther than surgery, method to diagnose, to treat, or to refer for consultation or treatment any abnormal condition of the human eye and its adnexa; or
 - (2) The employment of instruments, devices, pharmaceutical agents and procedures, other than surgery, procedures intended for the purposes of investigating, examining, treating, diagnosing or correcting visual defects or abnormal conditions of the human eye or its adnexa; or



Laser or nonlaser injection into the posterior chamber of the eye to treat any

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macular or retinal disease.

The administration of general anesthesia.

SECTION 2. This act becomes effective January 1, 2018.

Procedures performed under general anesthesia."

GENERAL ASSEMBLY OF NORTH CAROLINA **SESSION 2017**

H D

HOUSE BILL 36 PROPOSED COMMITTEE SUBSTITUTE H36-CSBC-4 [v.2]

02/28/2017 07:27:43 PM

Short Title:	Enact Enhanced Access to Eye Care Act.	(Public)
Sponsors:		
Referred to:		

February 2, 2017

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A BILL TO BE ENTITLED

AN ACT AMENDING THE SCOPE OF PRACTICE OF OPTOMETRY IN ORDER TO ENHANCE ACCESS TO EYE CARE IN NORTH CAROLINA.

The General Assembly of North Carolina enacts:

Whereas, the provision of eye care is rapidly evolving through advances in technology, pharmacology, and biotechnology; and

Whereas, the health care profession of optometry is dedicated to providing patient-centered eye care of the highest quality; and

Whereas, 1180 licensed Doctors of Optometry now provide the majority of primary eye care in North Carolina due to widespread geographic distribution and excellence in practice; and

Whereas, Doctors of Optometry provide eye care in 98 North Carolina counties, with primary office locations in 88 counties; and

Whereas, the wide availability of practicing Doctors of Optometry in North Carolina provides access to high quality eye care throughout the State; and

Whereas, the optometric profession has steadily evolved in expansion of practice while maintaining an exemplary record of safety and care since being first statutorily defined in 1909; and

Whereas, the statutes governing the practice of optometry have not been substantively updated to acknowledge advances in technology since 1977; and

Whereas, the continued expansion of optometric services in North Carolina will greatly improve access and affordability of eye care to the citizens of North Carolina; Now, therefore, The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-114 reads as written:

"§ 90-114. Optometry defined.

- Any one or any combination of the following practices shall constitute the practice of optometry:
 - (1)The examination of the human eye by any method, other than surgery, method to diagnose, to treat, or to refer for consultation or treatment any abnormal condition of the human eve and its adnexa; or
 - The employment of instruments, devices, pharmaceutical agents and (2) procedures, other than surgery, procedures intended for the purposes of investigating, examining, treating, diagnosing or correcting visual defects or abnormal conditions of the human eye or its adnexa; or
 - (3) The prescribing and application of lenses, devices containing lenses, prisms, contact lenses, orthoptics, vision training, pharmaceutical agents, and prosthetic



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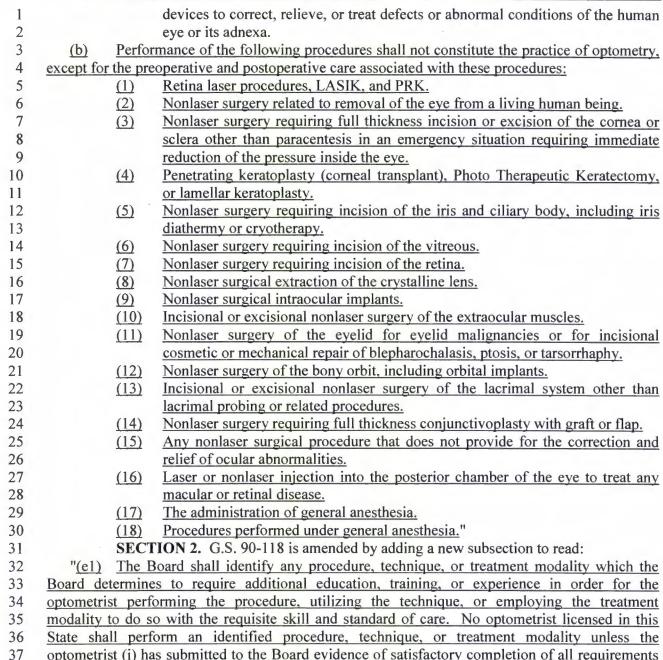
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optometrist (i) has submitted to the Board evidence of satisfactory completion of all requirements established by the Board to perform the identified procedure, technique, or treatment modality, and (ii) has been certified by the Board as qualified to perform the identified procedure, technique, or treatment modality."

SECTION 3. A committee appointed by the Optometry Board, consisting of five licensed optometrists and five licensed ophthalmologists, shall recommend to the Board by July 31, 2017, education, training, or other requirements to perform any procedure, technique, or treatment modality identified by the Board under G.S. 90-118(e1). The Board, after consideration of the committee's recommendations, shall establish appropriate protocols and criteria for the certification of optometrists to perform each procedure, technique, or treatment modality identified by the Board. The Board may appoint additional committees as it deems appropriate in the future to recommend modifying or establishing requirements for certification by the Board under G.S. 90-118(e1).

SECTION 4. Section 1 of this act becomes effective January 1, 2018; the remainder of this act is effective when it becomes law.

H36-CSBC-4 [v.2] House Bill 36 Page 2



House Health Committee

North Carolina General Assembly Legislative Building 16 West Jones Street Raleigh, NC 27601 February 5, 2017

To the Honorable Members of the North Carolina General Assembly,

As a comprehensive ophthalmologist in practice for over two decades, I am totally embarrassed by an NC ophthalmologist's recent comment which was circulated within the North Carolina Legislative body via an email, referring to North Carolina doctors of optometry as mere "glasses doctors." As an ophthalmologist, I am embarrassed that some of my colleagues are resorting to deride optometry in this fashion. Optometry is a learned profession with over 150 years of humanitarian service to the American public. Optometry is an independent health care profession which has grown out of and evolved (alongside other medical professions), nurtured and empowered by the same great American cultural drive and experience which has propelled all of our collective industry, from the childhood lemonade stand to our largest conglomerates. Where would the medical profession and consequently healthcare in this nation be today if outside groups had meddled or attempted to interfere with the growth and evolution of the medical profession in the same way that we now see outside groups trying to interfere with the independent advancement of the optometric profession?

Referring to an optometrist as a "glasses doctor," in the state of North Carolina, where optometry is practiced with such high standards, is akin to calling an attorney nothing more than a "parking ticket fixer," or a dentist a "teeth cleaner," or a teacher a mere "babysitter." North Carolina is home to some of optometry's most iconic and highly regarded practitioners. It is insulting, condescending, demeaning, and as someone who also proudly holds a doctorate in optometry (OD) alongside my osteopathic medical degree (DO), I take personal offense to this label. This type of unprofessional "spin" is arrogant, completely inappropriate and, in my opinion, demonstrates a lack of respect for the members of the NC General Assembly. Mockingly throwing this dispersion your way, as if NC legislators are not sophisticated enough to understand the high standards and rigorous educational process that young and aspiring NC students in the year 2017 must go through to become licensed optometric professionals.

Following college, Optometrists complete a comprehensive and robust 4-year professional program which, like medical school, includes didactic instruction in the basic and clinical sciences. Similar to an ophthalmology residency, the professional optometry program includes years of supervised clinical practice. Many optometrists take on an additional 1 or 2 years of post-graduate work. Comparing optometry programs with ophthalmology residencies side by side reveals that doctors of optometry acquire more accredited graduate college level

<u>coursework</u> dealing specifically with the eye, the physiology and anomalies of vision, and disorders of the eye than their ophthalmology-resident counterparts.

As an example, at Northeastern State University's Oklahoma College of Optometry, professional OD students must complete 172 formally-vetted, graduate-level semester credit hours over 4 years, approved by, the college, the University, the American Council on Optometric Education (ACOE), and accredited by the state's Board of Regents for Higher Education. In addition to this, candidates for state licensure must pass a comprehensive series of national and state written and practical examinations before being granted the privilege of a license to practice.

By comparison, many ophthalmologists (including myself) earn no equivalent accredited graduate level credit/coursework during their residency, which is where we learn to be eye doctors. One does NOT learn to be an eye doctor in medical school, where instruction in eye care is scarce to non-existent. There is no comparison here, to the experience and depth of training acquired in the first few years of optometry school. The fact *is* that there is little to no instruction in ophthalmology or eye care in medical school.

I refer you to an excerpt from a published article written by Peter J. McDonnell, MD, ophthalmologist, and the highly regarded director of the Wilmer Eye Institute of John Hopkins University, perhaps the premier Ophthalmology program in the world. Published in *Ophthalmology Times*, March 15, 2005, it is freely available online for all to see. The author highlights the fact that the vast majority of medical schools in this country do not even require an eye care rotation:

"Let me explain. Each year, the Association of University Professors of Ophthalmology (https://mww.dupo.org) convenes in some lovely setting. The attendees are largely department chairpersons and residency program directors from about 125 departments across the United States. The idea is to have a forum where academic leaders can learn from each other about how best to teach their residents and fellows, survive the changes in the healthcare system, strengthen their research programs, etc. For a new chairperson, it represents an opportunity to seek out advice from the most successful chairpersons and to learn some of the things about the position that were taught in medical school. At this most recent meeting, I learned there is something else they don't teach you in medical school, and it's called ophthalmology. A speaker at the podium asked for a show of hands of those departments where the medical curriculum had a required rotation in ophthalmology. About one-fifth of the hands went up, including my own. No required rotation in ophthalmology and about 80% went up.

So as to not think that this is taken out of context, please reference the complete *Ophthalmology Times*, March 15, 2005 article at:

http://ophthalmologytimes.modernmedicine.com/ophthalmologytimes/content/ophthalomology-who-needs-learn

With regards to the argument that optometrists do not go to medical school and somehow that makes their training inferior, I again refer you to another published article by Dr. McDonnell, and *Ophthalmology Times*, this time 2 years later, January 15, 2007:

"They say that we are better educated than our parents' generation. What they mean is that we go to school longer. They are not the same thing."

—Douglas Yates

The president of my university, William Brody, MD, PhD, says we take too long to train the current generation of physicians and biomedical scientists. I agree. Some will perceive this view as anti-intellectual, but I think we spend years of student-physicians' lives teaching them things they don't need to know and making them do things that will not be germane to their future careers. Some examples:

A couple of decades ago, the American Board of Ophthalmology
mandated a clinical internship for those, like me, seeking to become
board-eligible in ophthalmology. This ruling immediately added a year's
time to that needed to become an ophthalmologist in the United States.

No evidence exists that this additional requirement elevated the quality of ophthalmologists practicing in the United States compared with those who came before us. Rather, we learned to use drugs with names primarily of historic interest today to treat diseases we no longer managed once our internships were completed.

 Despite completing the requirements for majors in both biochemistry and chemistry in college, I spent much of the first 2 years of medical school taking additional courses in these subjects. Memorizing the small bones of the hand was a challenge, and I can recall that the trapezium is the small bone supporting the thumb.

Trust me when I tell you that most of what I was taught and required to memorize in medical school has been iong forgotten and never used in the practice of my profession."

Please take a moment to reflect on this last sentence! Again, this is the director of one of, if not the most prestigious ophthalmology program in the world saying this. Again, I invite you to go right to the published source:

http://ophthalmologytimes.modernmedicine.com/ophthalmologytimes/news/clinical/ophthalmology/shortened-training-would-offer-advantages

Compared to years of formally accredited graduate level coursework completed in optometry school, the didactic curriculum in many ophthalmology residencies revolves around a 7-week course offered yearly at a few sites across the nation called the Basic and Clinical Science course (ref: The Lancaster Course in Ophthalmology or similar). That and a set of home-study books (also referred to as the Basic and Clinical Science Course) constitutes the bulk of the didactic program in many ophthalmology residency programs. I am in no way implying there is anything wrong with an ophthalmologists education and training, or the time-honored methods employed. It accomplishes the intended purpose. Modern <u>optometric</u> educational paradigms, though structured in a more conventional manner from the viewpoint of university-based education, are equally efficient and achieve the prescribed goal and purpose of providing qualified eye doctors for our communities.

In the year 2017, our nation's Optometrists are clinicians, educators, and accomplished researchers. They are our caring neighbors, friends, family, and prominent members of what constitute the fabric of our society. They are mature, knowledgeable, and skilled, professionals who approach their purpose with all the sincerity, devotion, and compassion of any other health care provider who has received and accepted this life's calling.

Respectfully,

Richard E. Castillo, OD, DO

Ophthalmologist/Optometric Physician

Professor & Assistant Dean The Oklahoma College of Optometry Tahlequah, OK 74464 castillo@nsuok.edu

Chair

The National Commission on Vision and Health www.visionandhealth.org



References:

McDonnell, PJ. Ophthalmology?!-Who needs to learn that? Medical schools need to emphasize ophthalmology in their curricula. *Ophthalmology Times*, March 15, 2005.

McDonnell, PJ. Shortened training would offer advantages. *Ophthalmology Times*, January 15, 2007.

Piedmont Eye Surgical and Laser Center, P.L.L.C.

TIMOTHY BEVIS, M.D., FAAO

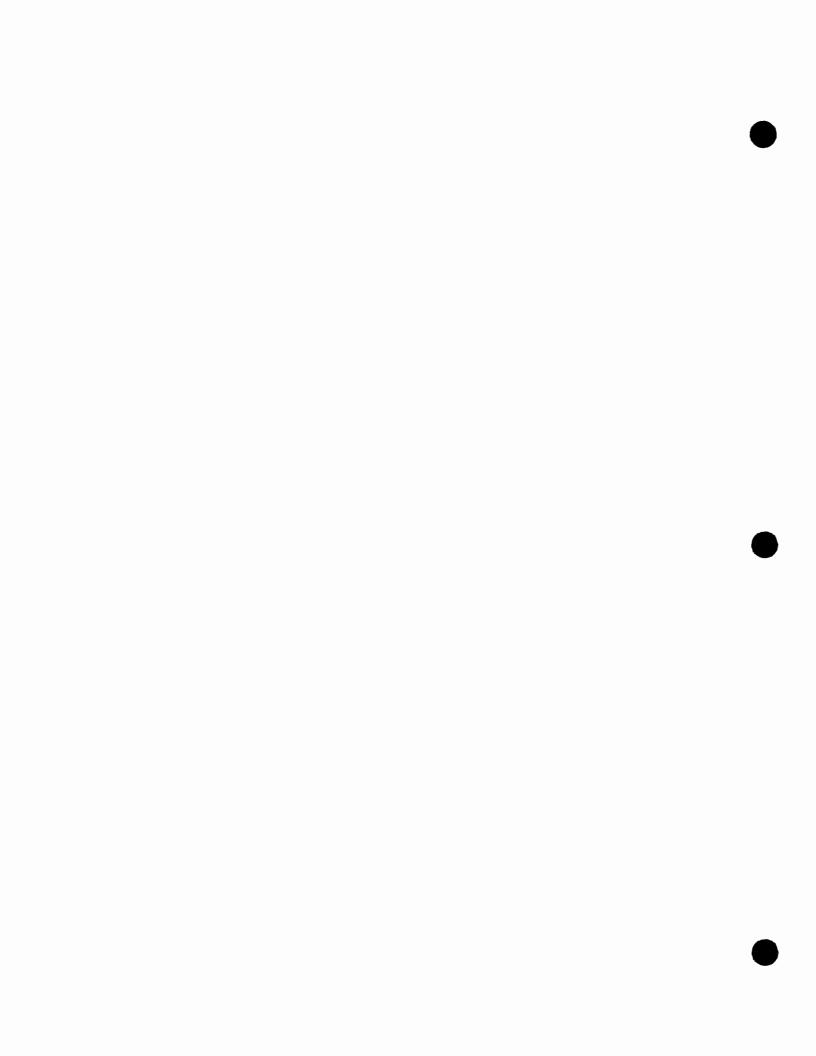
Glaucoma Treatment • Cataract Surgery

To Whom It May Concern:

My name is Timothy Bevis and I am an Ophthalmologist practicing in North Carolina. I am writing in regards to the Optometric legislation HB 36. This legislation helps to define the Optometrist scope of practice. I have been in North Carolina for 10 years and have had the pleasure to work with over 50 referring Optometrist. Together we care for individuals with a wide variety of ocular issues. I have the utmost confidence in the Optometrist I work with, and have had an excellent rapport with them. The new bill does allow for an increase in the optometric scope of practice. This increase has already been approved in a few other states. These states required additional training for the added privileges, and from my understanding North Carolina would implement this as well. Optometrist are the Primary Care Providers of eye care in the United States. The extension of services provided by Optometrists would provide more efficient access to the growing number of patients who need primary eye care. Based on the wealth of knowledge of the optometrist that I have had the privilege of working with. I have no reservations with their ability to incorporate these changes into their practice. I look forward to continuing to work alongside my colleagues to provide the best care possible for our patients.

Sincerely,

Timothy Bevis M.D.





February 13, 2017

To Members of the North Carolina General Assembly:

My name is Briggs Cook and I am an Ophthalmologist practicing in Huntersville North Carolina. I graduated from Johns Hopkins University School of Medicine and graduated in 1995. I completed my internship and residency in Ophthalmology at the Mayo Clinic in Rochester, Minnesota and then completed a two-year fellowship in Eye and Facial Plastic Surgery at the University of Wisconsin Madison. I came to the Charlotte area in 2001 and have been practicing in this area since that time.

My practice focus has always been Eye and Facial Plastic Surgery along with General Ophthalmology. I have worked extensively with Optometrists during my entire career both and Charlotte and the Lake Norman Region of North Carolina. As I gradually began to form collegial alliances with Optometrists in the Charlotte and Lake Norman areas, I have continued to be impressed with their level of training and devotion to patient care. In some respects, I have always felt that their level of training was superior to what I received during my training in Ophthalmology, as Optometry training has always been exceptionally patient-focused.

I have lectured several times to the Piedmont Optometric Society as well as the Catawba Valley Optometric Society. In the past I have given lectures as well on minor surgical procedures and how to perform them safely as Optometrists. I have always found the audience to be attentive and engaged. I maintain a very close relationship with my Optometry colleagues and they are always welcome to contact me at any time during the day or night, as I know I can as well. Just as my Optometry colleagues refer patients to me, I refer patients to them when I feel I need a more in-depth examination.

I value my relationship with optometrist in the area and have full faith and confidence in their abilities and knowledge. My Optometry colleagues are conscientious and very attentive to patients. I know that concerns have been expressed that the Optometric level of knowledge is not sufficient to warrant granting privileges to perform certain procedures, and I wholeheartedly disagree. In fact, as I mentioned, I routinely refer patients for in-depth exams to my Optometric colleagues. I also know that there are concerns that Optometrists will use this bill as a "stepping-stone" to perform more-advanced procedures in the future. What I have seen and experienced is contrary to that. Optometrists have taken a very slow, cautious and methodical approach to enlarging their scope of practice. Optometrists will never put patient safety at risk. Just as I have expanded my scope of practice over the years by learning new techniques and slowly introducing them into my practice, I have no doubts that Optometrists will take the same approach.



As an Ophthalmologist, I wholeheartedly and fully support HB 36. Rather than being divisive and competitive, I have chosen to work closely with my Optometric colleagues, for they truly are colleagues and not "the enemy." I am not sure why there is such rancor among Ophthalmologists regarding procedures performed by Optometrists, but it is upsetting when I have worked so closely with them for almost 20 years. It is certainly not in the favor of either Ophthalmologists or Optometrists to continue to fight, and most definitely not in the best interests of patients. In contrast, as I said, I believe we should work together and support each other through continued collegiality. I would be happy to continue to support the Optometric Academy through the implementation process.

It is my pleasure to lend my support to HB 36 and the Optometric community. Please do not hesitate to contact me with questions. I can be reached via cell phone at 704-604-2950 or via email at <u>briggscook ayahoo.com</u>.

Respectfully.

Briggs E. Cook, Jr., MD

Galen Grayson, MD

453 Lyttleton Drive, Charlotte, NC 28211

1/13/2017

Dear North Carolina General Assembly Members,

I write this letter in support of the Enhanced Access to Eye Care Act (House Bill 36). I have practiced ophthalmology in North Carolina since 1996 after completing my residency at the University of Southern California. I attended Harvard Medical School and served as a US Navy Medical Officer. Currently, I am the Medical Director at CHS Ophthalmology Care in Charlotte, NC.

I have an extensive history of co-managing patients with optometrists. Of those with whom I have worked, I am particularly impressed with the high degree of clinical acumen, the outstanding quality of care and the sound judgment used when referrals to both primary care physicians and ophthalmologists are indicated

Optometrists go through 4 years of professional school after college and many undergo an additional year of residency. I believe that the skill set developed by optometrists is greatly underutilized. Furthermore, I feel that with proper training and certification, there are additional procedures that can be safely performed by optometrists. For example, the laser used to clear a cloudy membrane, which can form after cataract surgery, results in rapid visual improvement in an outpatient setting. This procedure has minimal risk and has a very short learning curve, especially in the hands a professional who is already trained to examine the eye such as an optometrist.

As long as proper training and certification are achieved by optometrists for certain procedures, I feel the needs of the community will be enhanced. This will be achieved by the avoidance of unnecessary referrals in order to safely meet the needs of the community. In addition, cost savings will be realized by patients, insurance companies and the State of North Carolina as well as the Federal Government. I ask that you vote in favor of the Enhanced Access to Eye Care Act (House Bill 36).

Very Sincerely,

Galen Grayson, M.D.



PHYSICIANS PROTOCOL/LASER DEFINED VISION

1002 North Church Street, Suite 101, Greensboro, NC 27408

I know that there are multiple rumors, fears, and innuendo surrounding the topic of HB 36 which is Optometric legislation surrounding the Optometrists scope of practice. I am only interested in the facts as I've seen them through my eyes and my experiences dealing with these very issues.

I went to medical school and grew up in Oklahoma, I did my ophthalmology training at Tulane University, and did my corneal fellowship in Oklahoma. I have been practicing Ophthalmology in North Carolina since 1991 with patients routinely referred from Tennessee, West Virginia, Virginia and South Carolina. During that time, I have had referral relationships with over 300 different optometrists taking care of well over 50,000-75,000 patients and procedures. I give these statistics only to point out that I have a significant sample size, as well as, I have been in states which can perform the increased scope of practice that the optometrists are seeking with HB36. In each of these states additional training was required for optometrists to expand their scope of practice and I understand these same measures would be required with optometrists in North Carolina so not just anyone could start treating patients without appropriate additional training.

We are seeing an increased need in basic primary care which currently is not being met by the medical community as I see it. More physician assistants, emergency room physicians and family practitioners are being asked to meet unmet primary eye care in North Carolina. However, their training in eye care is limited. Optometrists provide a large majority of the primary eye care in North Carolina. In fact, a recent optometric study showed that 85% of all comprehensive eye exams are performed by optometrist with a significant number of all vision correction devices prescriptions written by optometrists. (1) There are a little over 24,000 Ophthalmologists in the United States and slightly over 40,000 Optometrists in the United States. The need for basic eye care continues to grow and the ability to get an appointment a basic eye exam continues to grow in the state of North Carolina and in my practice despite recently adding a new physician to our practice.

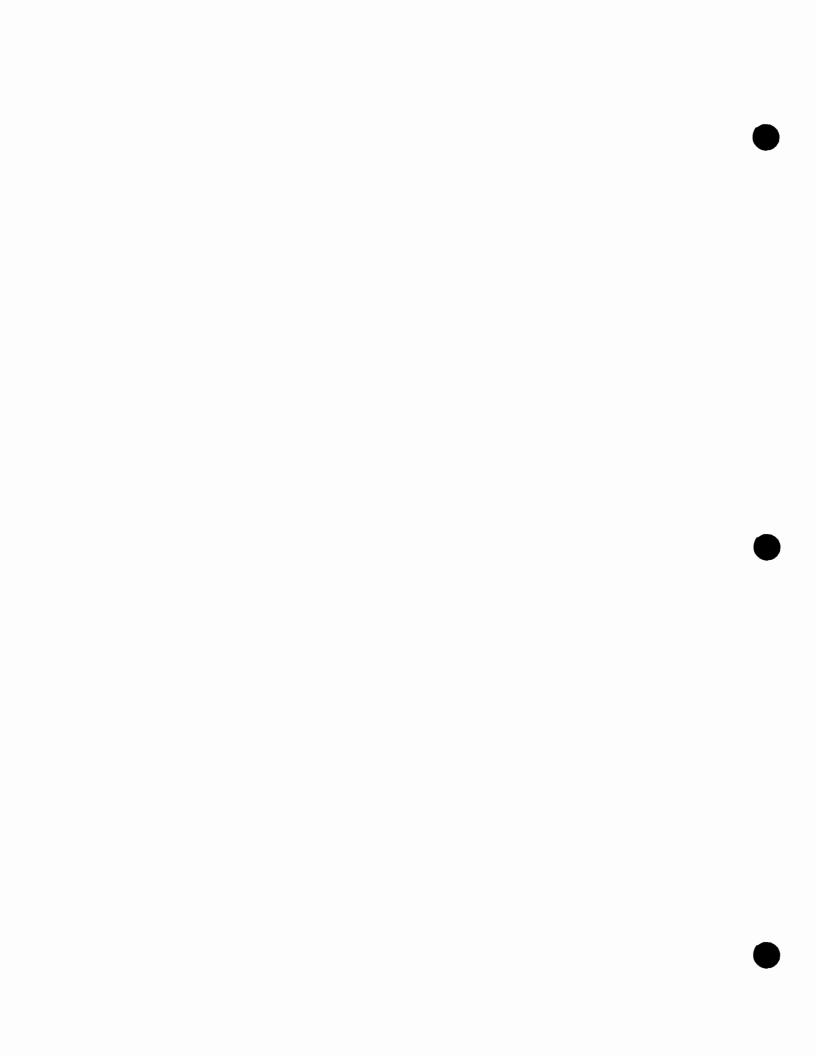
Like myself, the Optometrists I work with take a patient centered approach to the care of their and my patients that we share. Even though I can't speak for all the optometrists themselves, I have witnessed that like myself they are interested in what provides the best outcomes for their patients in their professional decisions not their scope of practice. During the previous expansions of Optometry's scope of practice in 1977 (I was in high school then) and in 1998 which I actively participated in the same predictions of poor ocular outcomes and the potential for loss of life was being discussed. These consequences have not been witnessed by me in my practice and my co-management of patients. Remember the Optometrist has at least 4 years of ocular training with many now going on to residencies. The optometrists in my practice note that their malpractice premiums have remained stable over several years at \$500-600.00 per year. I would think if patients were being injured there would be an increase in premiums related to poor outcomes.

One important point is that I currently work with many companies in key opinion roles and in fact Ophthalmologists and Optometrists are not adversaries as some would like to have you believe but we are colleagues and teammates working for the same objectives to improve patient care, medical outcomes, and surgical outcomes. I have really enjoyed over the last 25 years providing specialty eye care for the patients I share and manage with my fellow optometrists. Optometrists have sent their family to me for surgical eye care and I have sent my family to them for intervention as well. I look forward to teaming with their primary eye care talents to continue to provide the citizens of our state all levels of eye care that is the envy of every other state.

Karl Stonecipher, MD

1. The American Optometric Association. An Action-Oriented Analysis of the State of Optometric Profession, 2013

ttp://www.visionmonday.com/latest-news/article/the-state-of-the-optometric-profession-2013-identifies-trendssues-41615/)





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KITTY HAWK 3524 N. Crosten Hwy. North Ceroline 27949 (252) 441-3163

EDENTON 222 D Virginia Road North Carolina 27932 (252) 482-5444 Dear Sir:

I am writing in support of HB 36. My name is Jitendra Swarup. I am a surgical Ophthalmologist and the owner of Albemarle Eye Center and Precision Eye Care. We have offices in Elizabeth City, Kitty Hawk, Edenton, and Washington, North Carolina. In the 20-years that I have practiced Ophthalmology in our great state of North Carolina, I have worked with numerous extremely talented Optometrists. I have seen not only an excellent skill set in these doctors but also a high level of understanding with regard to treatment of ocular diseases. The knowledge that I have seen these individuals possess, allows me to feel very comfortable with the provisions that HB 36 proposes for expanding the scope of Optometry in the state of North Carolina.

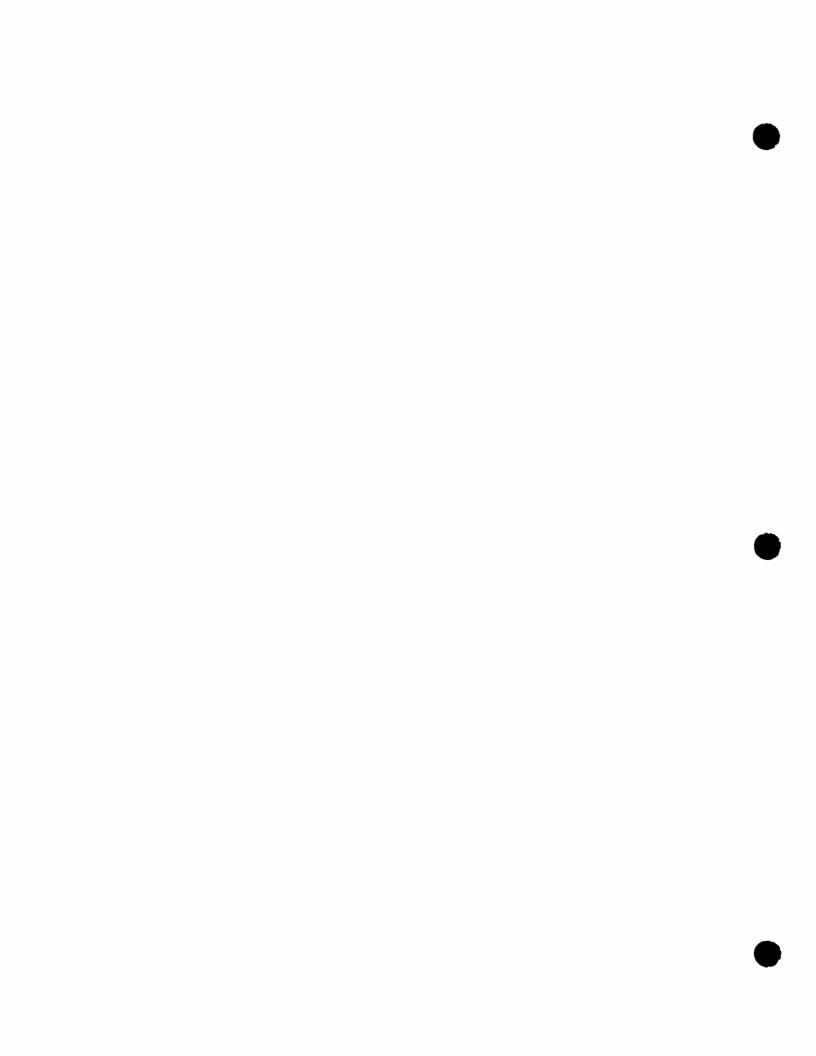
I feel the procedures highlighted in HB 36 will not put patients at risk as the Optometrists performing these procedures will most certainly have the approval and oversight from the North Carolina Board of Optometry; this board is the strictest in the entire country. I also feel confident that patients will have better access to treatment by the passing of this bill, especially in the numerous rural areas of North Carolina.

If I can be of any further assistance regarding this matter please feel free to contact me.

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Sincerely,

Jitendra Swarup, M.D.



Concerned North Carolina Medical Educators

Comments on HB 36

February 27, 2017

To: Members of the NC Senate and NC House of Representatives

We are writing to you today as North Carolina citizens and leaders in medical education, not on behalf of our respective institutions, to express our serious concerns about HB 36.

This legislation would permit optometrists, who are non-physician practitioners, who have neither completed medical school nor surgical residency, to perform scalpel and laser surgery on and around the eye. We strongly feel that this legislation compromises the safety and quality of surgical care for North Carolina eye patients by removing the current standards of medical, clinical and surgical training required to perform eye surgery. These safeguards currently ensure that citizens of North Carolina have access to the safest and highest quality of surgical eye care. For these reasons, we strongly urge you to oppose HB 36.

Optometrists are our friends and colleagues. We appreciate their valuable addition to the eye care team. Many, if not most, ophthalmologists work in concert with optometrists. The American Academy of Ophthalmology and the American Optometric Association have worked together to provide guidance to ophthalmologists and optometrists in the proper sharing of care. However, granting optometrists surgical privileges for which they have not been adequately trained is not acceptable.

HB 36 seeks to remove the statutory restriction on optometrists performing surgery. Eye tissue is extremely delicate. Once it is damaged, it is often impossible to fix. Among surgeons, eye surgery is considered one of the most difficult and delicate surgeries that are performed. Despite this, optometrists are seeking a carve-out exception for certain laser and scalpel procedures, based on the idea that these procedures are generally low risk. While some procedures are higher risk than others, no procedures are without risk.

In 2016, similar legislation was attempted in six states and Puerto Rico. All of these states rejected the legislation. A recent study showed that for optometry-performed laser treatments (laser trabeculoplasty) in Oklahoma, when compared to ophthalmologists, patients required more retreatments, leading to an increased time and cost burden to patients and the medical system as a whole.

North Carolina has three of the best ophthalmology training programs in the country. These institutions must adhere to the national education criteria set by the Accreditation Council for Graduate Medical Education (ACGME). The ACGME sets the minimum standards for becoming a qualified surgeon. Optometry training is not subject to ACGME educational standards, which include four years of undergraduate education, four years of medical education, one year of internship seeing complex medical and surgical patients, and a three year ophthalmology residency.

In contrast, the current optometric curriculum includes only a small fraction of the educational fundamentals established by the ACGME. Optometry school is in no way sufficient to qualify them to become surgeons.

HB 36 states that optometric privileges have not increased since 1977. This is an inaccurate statement. The scope of optometric practice in North Carolina was expanded in 1997 through a consent agreement of multiple parties including the NC Medical Board, the NC State Board of Optometric Examiners, the NC Medical Society, the NC Society of Ophthalmology and the NC State Optometric Society. Further, optometrists have also been granted prescribing privileges by the General Assembly and were approved to perform injection procedures since 1977. It is also important to note that the scope of necessary medical knowledge has expanded exponentially over the last forty years, not decreased. The number of medications and their interactions has increased enormously. The number of possible surgical approaches to the same eye disease has increased as well. To suggest that traditional medical and surgical training is no longer necessary to safely perform eye surgery strikes us as dangerously misguided.

One alarming impact of HB 36 is that the North Carolina State Board of Examiners in Optometry would decide whether an optometrist's education, training and experience is sufficient to protect patients who require eye surgery in North Carolina. Unlike the North Carolina Medical Board, the North Carolina Board of Optometry has no experience in determining qualifications to safely perform surgery.

The North Carolina ophthalmology training programs we chair have been responsible for training hundreds of ophthalmology residents and fellows to perform the types of surgery that optometrists would be authorized to perform if HB 36 were to be enacted. We are unanimously certain that the optometric surgical authority proposed in this bill will increase patient safety risks and lower the standards of surgical eye care. For these reasons, we urge you to oppose this dangerous legislation.

We appreciate your consideration of our concerns and would welcome any questions you may have regarding the complexity of surgical training and providing safe surgical eye care.

Respectfully,

Edward G. Buckley, MD

Professor and Chair Dept. of Ophthalmology

Duke University School of Medicine

Idenard G. Buckley

Donald L. Budenz, MD, MPH

Professor and Chairman Dept. of Ophthalmology

UNC Chapel Hill School of Medicine Wake Forest School of Medicine

Craig M. Greven, MD

Professor and Chair

Dept. of Ophthalmology

Cian Greven MD



One of these moles is harmless. One of them is a life-threatening melanoma.*

Dermatologists train for more than a decade to know the difference.

Melanoma is curable if it is caught early—so a correct diagnosis is literally the difference between life and death.

HB36 (Enact Enhanced Access to Eye Care Act) and SB73 and HB88 (Modernize Nursing Practice Act) would allow optometrists and nurses to diagnose skin cancer without back-up from a supervising dermatologist.

For a patient with melanoma, that could be the mistake of a lifetime.

*In the above example, the larger mole is benign. The smaller one is cancerous.



NORTH CAROLINA DERMATOLOGY ASSOCIATION

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Original Investigation

Comparison of Outcomes of Laser Trabeculoplasty Performed by Optometrists vs Ophthalmologists in Oklahoma

Joshua D. Stein, MD, MS; Peter Y. Zhao, MD; Chris Andrews, PhD; Gregory L. Skuta, MD

IMPORTANCE Oklahoma is one of the few states where optometrists have surgical privileges to perform laser trabeculoplasty (LTP). Optometrists in other states are lobbying to obtain privileges to perform LTP and other laser procedures. Little is known whether outcomes of patients undergoing this procedure by optometrists are similar to those undergoing LTP by ophthalmologists.

OBJECTIVE To compare outcomes of LTPs performed by ophthalmologists with those performed by optometrists to determine whether differences exist in the need for additional LTPs.

DESIGN, SETTING, AND PARTICIPANTS This retrospective longitudinal cohort study used a health care claims database containing more than 1000 eyes of Medicare enrollees with glaucoma who underwent LTP in Oklahoma from January 1, 2008, through December 31, 2013. For each procedure, the data specify the type of eye care professional who performed the LTP. The rate of LTPs performed by ophthalmologists that required 1 or more additional LTPs in the same eye was compared with the rate of LTPs performed by optometrists. Regression models determined factors affecting risk of undergoing more than 1 LTP in the same eye.

MAIN OUTCOMES AND MEASURES Proportion of enrollees requiring additional LTPs, hazard ratio with 95% CIs of undergoing additional LTPs.

RESULTS A total of 1384 eyes of 891 eligible patients underwent LTP from January 1, 2008, through December 31, 2013. There were 1150 eyes that received LTP (83.1%) by an ophthalmologist and 234 eyes (16.9%) that had the procedure performed by an optometrist. The mean (SD) age at the initial LTP was 77.7 (7.5) years for enrollees with ophthalmologist-performed LTP and 77.6 (8.0) years for those with optometrist-performed LTP (P = .89). Among the 1384 eyes receiving LTP, 258 (18.6%) underwent more than 1 LTP in the same eye. The proportion of eyes undergoing LTP by an optometrist requiring 1 or more subsequent LTP session (35.9%) was more than double the proportion of eyes that received this procedure by an ophthalmologist (15.1%). Medicare beneficiaries undergoing LTP by optometrists had a 189% increased hazard of requiring additional LTPs in the same eye compared with those receiving LTP by ophthalmologists (hazard ratio, 2.89; 95% CI, 2.00-4.17; P < .001) after adjusting for potential confounders.

CONCLUSIONS AND RELEVANCE Considerable differences exist among the proportions of patients requiring additional LTPs comparing those who were initially treated by ophthalmologists with those initially treated by optometrists. Health policy makers should be cautious about approving laser privileges for optometrists practicing in other states until the reasons for these differences are better understood.

Invited Commentaries

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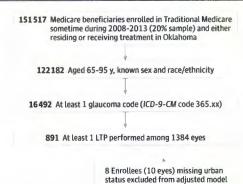
JAMA Ophthalmol. doi:10.1001/jamaophthalmol.2016.2495 Published online July 28, 2016.

aser trabeculoplasty (LTP) is a common procedure that can effectively decrease intraocular pressure in patients with primary and some secondary forms of openangle glaucoma. It can augment the ability to lower intraocular pressure in patients who are already taking glaucoma medications and is useful in patients who have difficulty administering eye drops or with medication adherence. In fact, LTP may be a more cost-effective option for treating glaucoma than medication, especially for patients who have difficulty with adherence. 1.2 The advent of selective LTP contributed to a 46% increase in this procedure among Medicare beneficiaries from January 1, 2002, through December 31, 2009.3

Ophthalmologists have been performing LTP since 1979 when the procedure was first developed by Wise and Witter.4 Recently, optometrists have been lobbying state legislatures for expanded privileges so they may perform LTP. In Oklahoma, optometrists were given permission to perform LTP on patients with glaucoma in 1998.5 More recently, legislation was passed in Kentucky and Louisiana allowing optometrists to perform laser ocular surgical procedures. 6,7 Ophthalmologists learn how to perform LTP during residency training. The Accreditation Council for Graduate Medical Education mandates that graduating residents perform a minimum of 5 LTPs.8 Case logs show that the average ophthalmological resident performs 14 LTPs and 83 other laser procedures during residency training.9 In Oklahoma, training of optometrists to perform lasers involves a 2-day course, "Laser Therapy for the Anterior Segment," which is held at the Northeastern State University Oklahoma College of Optometry. This course consists of 9 hours of lectures and 4 hours of laboratory sessions, including gonioscopy, LTP, laser iridotomy, and capsulotomy.10

To our knowledge, there has never been a study comparing outcomes of LTP performed by ophthalmologists vs procedures performed by optometrists. Using a health care claims database containing more than 1000 eyes of Medicare beneficiaries with glaucoma who underwent LTP in Oklahoma, we compared outcomes of those receiving this procedure by oph-

Figure 1. STROBE Sample Selection Figure



Identification of beneficiaries eligible for current study from 20% Medicare claims database. ICD-9-CM indicates International Classification of Diseases, Ninth Revision, Clinical Modification: LTP, laser trabeculoplasty.

Key Points

Question Are there differences in the frequency and likelihood of undergoing additional laser trabeculoplasty among Medicare enrollees in Oklahoma who underwent this procedure by an ophthalmologist vs others who underwent the procedure by an optometrist?

Findings Among the 1384 eyes receiving laser trabeculoplasty, the proportion of eyes treated by optometrists requiring additional laser trabeculoplasty in the same eye (35.9%) was more than double the proportion of those treated by ophthalmologists (15.1%). Optometrist-treated eyes had a 189% increased risk of requiring additional laser trabeculoplasty.

Meaning Future work seems warranted to substantiate whether the differences identified affect clinical outcomes and costs.

thalmologists vs enrollees undergoing LTP by optometrists. These analyses may help guide health policy makers in other states who are trying to decide whether to give optometrists privileges to perform laser procedures.

Methods

Data Source

We used a 20% nationally representative sample of Medicare claims to identify beneficiaries undergoing LTP. The database contained information including International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)11 diagnosis codes, Current Procedural Terminology (CPT-4)12 procedure codes, National Provider Identifier numbers to identify specific eye care professionals, and service dates for all encounters. Claims data were merged with Medicare denominator files for information on enrollment dates in Medicare and demographic characteristics of the beneficiaries. Data were linked by a patient identifier, allowing longitudinal, person-specific analysis from January 1, 2008, through December 31, 2013. A similar data source was used previously to study patients with ocular diseases. 13,14 The University of Michigan institutional review board approved this study, which used deidentified claims data.

Study Sample

We identified all individuals with any form of glaucoma (*ICD9-CM* code 365.xx) who underwent 1 or more LTP (*CPT-4* code 65855) from January 1, 2008, through December 31, 2013, in Oklahoma (**Figure 1**). *Current Procedural Terminology* codes do not distinguish argon LTP, selective LTP, and micropulse LTP; therefore, beneficiaries who underwent any of these procedures were included. Individuals younger than 65 and older than 95 years were excluded as were enrollees in Medicare Advantage plans because our data source does not fully describe all care received by persons in such plans. Procedures that were submitted for payment but not paid and those missing eye laterality were also excluded. Each claim specifies whether an ophthalmologist or optometrist performed the LTP and whether it was performed on the right or left eye. Bilateral codes were counted as separate procedures for each eye.

Statistical Analysis

All analyses were performed using SAS software, version 9.4 (SAS Inc) and R, version 3.2.3 (R Foundation for Statistical Computing). Characteristics of the study population were summarized using means (SDs) for continuous variables and frequencies and percentages for categorical variables. For all inference procedures, P < .05 (Kaplan-Meier method, Wald test, and Cox proportional hazards regression model) was considered statistically significant.

Receipt of Additional LTPs

The primary outcome was receipt of additional LTPs in the same eye. This outcome was identified as another record of *CPT-4* code 65855 on a separate date on the same eye as the initial procedure. Subsequent LTPs could have been performed by the same eye care professional or an ophthalmologist or optometrist other than the health care professional who performed the initial procedure. The unit of observation was the eye, but a clustering term was included to allow for the correlation between eyes of the same beneficiary. ¹⁵ Observations were right censored at the end of eligibility.

We calculated product limit estimates (with robust SEs) of the time to the second LTP as a function of the type of initial eye care professional (ophthalmologist or optometrist). These estimates were compared at 6 months and 3 years with Wald tests. We used proportional hazards regression models (created by generalized estimating equations to allow for correlated observations) to determine a single estimate of the effect of the key predictor variable: type of eye care professional who performed the initial LTP. An additional model was created adjusting for age at initial LTP, sex, race/ethnicity, where the enrollee lived (urban, large rural, or small rural town), and year of the procedure. In a separate model, we studied whether an interaction between race/ethnicity (non-Hispanic white vs black, Hispanic, American Indian, and persons of other races/ ethnicities) and type of eye care professional performing the initial LTP affected the hazard of undergoing additional LTPs.

Receipt of Incisional Glaucoma Surgical Procedures After LTP

Finally, we determined the proportion of patients receiving LTP by each type of eye care professional who subsequently underwent incisional glaucoma surgery (trabeculectomy or glaucoma drainage-device insertion) during the follow-up.

Results

A total of 1384 eyes of 891 eligible patients underwent 1 or more LTPs in Oklahoma during the study period. There were 1150 eyes that received LTP (83.1%) by an ophthalmologist and 234 eyes (16.9%) that had the procedure performed by an optometrist. A total of 493 patients (55.3%) underwent LTP at least once in both eyes. The number of LTPs performed by ophthalmologists ranged from 1 to 277 procedures; 57 ophthalmologists performed this procedure at least once. Optometrists each performed from 1 to 38 LTP procedures; 23 optometrists performed LTP at least once. The most common *ICD-9-CM* glau-

coma diagnosis code listed on the date of the initial LTP was 365.11 (1206 [87.1%]) and was similar for both types of eye care professionals (975 [86.6%] of patients with an ophthalmologistperformed LTP and 231 [89.7%] with an optometristperformed procedure). All enrollees in both groups were observed for up to 72 months. The median time from study eligibility to the first LTP was 28.8 months for patients first treated by ophthalmologists and 20.0 months for patients first treated by optometrists. The median times from the first LTP to the end of follow-up were 31.3 and 42.4 months, respectively. The mean (SD) age at the initial LTP was 77.7 (7.5) years for enrollees with ophthalmologist-performed LTP and 77.6 (8.0) years for those with optometrist-performed LTP (P = .89). The proportions of white, black, and other patients receiving LTP by ophthalmologists vs optometrists were 85.2% vs 75.5% (P = .004), 8.2% vs 10.8% (P = .33), and 6.5% vs 13.7% (P = .004), respectively (Table 1). Twenty-five enrollees (2.8%) received bilateral LTP on the same day.

Among the 1150 eyes undergoing LTP by an ophthalmologist, 174 (15.1%) received 1 or more LTPs on the same eye during the follow-up. Of the 234 eyes treated with LTP by optometrists, 84 (35.9%) underwent 1 or more additional LTPs on the same eye during follow-up (P < .001). Figure 2 displays the distribution of time to second procedure. Second procedures within 6 months were much less common when the first procedure was performed by an ophthalmologist (3.9%) vs an optometrist (24.9%) (P < .001). The difference persisted with time, for example, 17.7% vs 34.3% at 3 years (P < .001).

We also studied the timing of the additional LTPs by the 2 eye care professional groups relative to the 10-day global period (ie, the immediate post-LTP period, when charges for normal postoperative care are included in the global surgical procedure fee). For patients first treated by ophthalmologists, no additional procedures occurred during the global period, and the probability of a subsequent LTP between 11 and 30 days was 1.1% (95% CI, 0.7%-1.9%). For patients first treated by optometrists, the probability of subsequent LTPs in the global period was 0.4% (95% CI, 0.1%-3.0%) and between days 11 and 30 was 10.3% (7.0%-15.0%).

For the 174 eyes that received LTP by ophthalmologists that required additional laser treatment, 155 (89.1%) received the subsequent LTP by the same ophthalmologist, 13 (7.5%) by a different ophthalmologist, and 6 (3.4%) by an optometrist. Among the 1150 eyes initially treated by ophthalmologists, 21 (1.8%) underwent 3 or more LTPs on the same eye. In comparison, for the 84 eyes that received LTP by optometrists that required additional LTPs, 73 (86.9%) received the subsequent LTP by the same optometrist, 5 (6.0%) by a different optometrist, and 6 (7.1%) by an ophthalmologist. Of the 234 eyes treated initially by optometrists, 11 (4.7%) underwent 3 or more LTPs on the same eye.

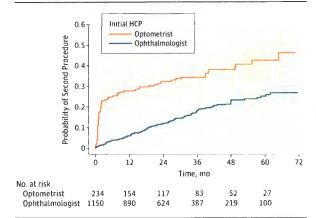
After adjustment for potential confounding factors, eyes that received LTP by optometrists had a 189% greater hazard for a subsequent LTP in the same eye during follow-up (hazard ratio, 2.89; 95% CI, 2.00-4.17; P < .001) compared with those undergoing LTP by an ophthalmologist. Female patients had a 43% increased hazard of undergoing a subsequent LTP in the same eye during follow-up (hazard ra-

Table 1. Demographics of Patients Receiving LTP I	by an Ophthalmologist or Optometrist
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Characteristic	Overall	LTP Initially by an Ophthalmologist	LTP Initially by an Optometrist	P Value
Individuals, No.	891	752	139	
Eyes, No.	1384	1150	234	
Patient age, mean (SD), y	77.7 (7.6)	77.7 (7.5)	77.6 (8.0)	.89
Sex, No. (%)				
Male	345 (39)	294 (39)	51 (37)	50
Female	546 (61)	458 (61)	88 (63)	.59
Race, No. (%)				
White	746 (84)	641 (85)	105 (76)	
Black	77 (9)	62 (8)	15 (11)	
Hispanic	7 (<1)	6 (<1)	1 (<1)	.02
Native	57 (6)	40 (5)	17 (12)	
Other	4 (<1)	3 (<1)	1 (<1)	
Year of first procedure, mean (SD) ^a	2010.3 (1.7)	2010.4 (1.7)	2009.9 (1.6)	.001
Year of first procedure, No. (%)				
2008	171 (19.2)	135 (18.0)	36 (26.0)	
2009	168 (18.9)	137 (18.2)	31 (22.3)	
2010	147 (16.5)	120 (16.0)	27 (19.4)	.04
2011	148 (16.6)	131 (17.4)	17 (12.2)	.04
2012	135 (15.2)	120 (16.0)	15 (10.8)	
2013	122 (13.7)	109 (14.4)	13 (9.4)	

Abbreviation: LTP, laser trabeculoplasty.

Figure 2. Time to Second Laser Trabeculoplasty in Same Eye for Beneficiaries Receiving Initial Treatment by Ophthalmologists and Optometrists



Kaplan-Meier estimates of cumulative incidence for each group. Data are clustered because of some beneficiaries having both eyes studied. The study lasted 72 months: follow-up began at the first laser trabeculoplasty. Therefore, there was none at risk at month 72. HCP indicates health care professional.

tio, 1.43; 95% CI, 1.02-2.01; P = .04). There was no association between age (hazard ratio, 1.04 per 10 years; 95% CI, 0.84-1.28) at initial LTP (P = .72), between black, Hispanic, or American Indian individuals, and persons of other races/ethnicities vs white (P = .79; hazard ratio, 1.06; 95% CI, 0.71-1.57), or between large rural vs urban residence of the patient ($P \ge .15$; hazard ratio, 0.75; 95% CI, 0.48-1.17) and between small rural vs urban residence of the patient ($P \ge .15$; hazard ratio, 0.73; 95% CI, 0.48-1.12) and the hazard of additional LTPs (Table 2). The

interaction model used to investigate whether race/ethnicity affected the hazard ratio of additional LTPs for ophthalmologist-performed vs optometrist-performed LTP was not statistically significant.

Among the 1150 eyes that underwent LTP by ophthalmologists, 49 (4.3%) subsequently underwent incisional glaucoma surgery. By comparison, of the 234 eyes that underwent LTP by an optometrist, 5 (2.1%) subsequently underwent such surgery.

Discussion

In this analysis of more than 1000 eyes of Medicare beneficiaries with glaucoma who underwent LTP in Oklahoma from January 1, 2008, through December 31, 2013, we note substantial differences in the receipt of additional LTPs by patients who underwent the procedure by an ophthalmologist compared with an optometrist. After adjustment for demographic and other factors, patients who underwent LTP by an optometrist had an approximate 2-fold higher likelihood of undergoing additional LTPs in the same eye compared with others who received this procedure by an ophthalmologist. Most additional LTPs performed by optometrists were done soon after the initial procedure and were performed by the same optometrist as the initial LTP.

Although this study highlights major differences in outcomes of patients undergoing subsequent LTPs after the initial procedure performed by ophthalmologists and procedures performed by optometrists, it is difficult with claims data to discern the reasons for the differences observed. Possible explanations include differences in the sociodemographic char-

^a The average of the 1384 dates of the initial LTP.

Table 2. Factors Affecting the Hazard of Requiring Additional Laser Trabeculoplasty^a

Factor	Model	Hazard Ratio (95% CI) ^b	P Value
Initial LTP by an OD vs initial LTP by an EyeMD	Crude	2.58 (1.84-3.61)	<.001
Initial LTP by an OD vs initial LTP by an EyeMD	Adjusted	2.89 (2.00-4.17)	<.001
Each year later LTP was initially performed (eg, 2013 vs 2012)	Adjusted	1.03 (0.92-1.16)	.57
Female vs male	Adjusted	1.43 (1.02-2.01)	.04
Other races vs white	Adjusted	1.06 (0.71-1.57)	.79
Each additional decade of age	Adjusted	1.04 (0.84-1.28)	.72
Large rural town vs urban	Adjusted	0.75 (0.48-1.17)	.20
Small rural town vs urban	Adjusted	0.73 (0.48-1.12)	.15

Abbreviations: EyeMD, ophthalmologist; LTP, laser trabeculoplasty; OD, optometrist.

requiring additional LTPs compared with those who had their initial LTP in 2012. This difference was not statistically significant. SEs were adjusted for clustering because of some beneficiaries having both eyes studied. P values and 95% CIs are from robust Wald procedures.

acteristics of ophthalmologists' vs optometrists' patients and how each group responds to LTP, differences in disease severity between the 2 groups, differences in selection of patients who are appropriate candidates for LTP between the 2 types of eye care professionals, and differences in how the LTP was performed, including the type of laser used, laser settings, amount of the drainage angle treated in one setting, or whether the procedure was performed properly. Unfortunately, without access to clinical data, such as the preoperative and postoperative intraocular pressure levels, gonioscopy findings, and records describing how the procedures were performed, it is impossible to identify which of these or other factors are contributing to the observed differences in receipt of subsequent LTPs between the groups.

Another possible explanation for differences observed may be that ophthalmologists can perform incisional surgery on patients with failed LTP, whereas optometrists, who cannot do so, may perform additional LTPs. Likewise, because incisional glaucoma surgery is reimbursed more than LTP, this could influence decision making. However, we doubt that this factor is contributing much to the differences observed because a subset of ophthalmologists routinely performs incisional glaucoma surgery, whereas most eye care professionals (optometrists and comprehensive ophthalmologists) would refer patients to glaucoma subspecialists for surgery and thus not benefit financially from recommending incisional surgery vs additional LTPs. Furthermore, few patients in both groups underwent incisional glaucoma surgery during the follow-up; therefore, it is unlikely that this is a major factor responsible for the differences in additional LTPs between the 2 groups.

Some of the patients undergoing LTP by optometrists may reside in communities where access to incisional glaucoma surgery is limited, which may explain some of the differences. Moreover, despite the fact that all the patients in this analysis had Medicare, patients of ophthalmologists may have been better able to make the copayments of incisional glaucoma surgery compared with those receiving care by optometrists. Additional research is needed to study these various potential explanations.

The success of LTP depends on various patient-related and health care professional-related factors. Laser trabeculoplasty has been most effective in patients with primary openangle glaucoma, exfoliation glaucoma, and pigmentary glaucoma. 16-18 Other glaucoma types, such as angle-closure and angle-recession glaucoma, usually respond poorly to LTP. The degree of angle pigmentation can also affect the success of the procedure and risk for intraocular pressure increases after LTP. 19,20 Experience and expertise of the eye care professional can also affect outcomes because the effectiveness of LTP requires proper identification of the angle structures to treat. Although, to our knowledge, this is the first study that directly compared LTP performed by ophthalmologists vs optometrists, Lowry et al21 showed that LTP performed by attending ophthalmologists was more effective than procedures performed by resident physicians, suggesting that experience in performing the procedure is important.

An interesting finding from these analyses is that many of the patients who underwent additional LTPs by optometrists did so soon after the initial LTP, whereas additional LTPs among patients treated by ophthalmologists tended to occur much later after the initial procedure. One can speculate the reasons for the differences observed. One possibility is that the optometrists performing this procedure may have been more cautious, scheduling the procedure into 2 or more sessions to try to limit postoperative inflammation or intraocular pressure increases. 22,23 Alternatively, to maximize reimbursement, some optometrists may schedule LTP into more than 1 session, with the timing of subsequent LTPs after the 10-day global period of the initial procedure. The large increase in additional LTPs for the patients undergoing the procedure by optometrists immediately after the global period suggests that this may be a contributing factor, although we are unaware of any reports indicating that optometrists systematically practice in this manner. A third possibility is that because the pressure-decreasing effect of LTP may take several weeks to months to occur, ophthalmologists may be more aware that it may take some time to observe the effect of the initial LTP before proceeding with additional LTPs. However, we know of no studies directly comparing the knowledge level about LTP of these

The adjusted model included all of the covariates listed in the table: whether the LTP was performed by an optometrist (vs an ophthalmologist), calendar year the LTP was performed, sex, race/ethnicity, age, and patient residence. The interpretation of the calendar year of the initial LTP is as follows: Persons who underwent their initial LTP in 2013 had a 3.4% increased hazard of

b Hazard ratios are calculated from crude and adjusted proportional hazards regression models for time to event (second procedure in same eye).

2 eye care professional groups. With claims data, we cannot tell whether any of these or other factors are responsible for the differences in performance of subsequent LTPs immediately after the global period.

Several studies have assessed the outcomes of additional LTPs.24 Feldman et al25 found a 35% success rate at 6 months with additional argon LTPs, which decreases to 11% after 24 months. Starita et al26 reported that 18% of patients who underwent additional argon LTPs had an intraocular pressure increase of more than 10 mm Hg. As a result, authorities often discourage the performance of additional argon LTPs. The success of additional selective LTPs has been more promising. Hong et al²⁷ described additional intraocular pressure reduction after additional selective LTPs. Durr and Harasymowycz²⁸ did as well. Others have shown that selective LTP can decrease intraocular pressure in eyes that have undergone argon LTP previously.29 Unfortunately, our data source lacks details regarding the amount of the angle treated and the type of laser used during the initial procedure to assess whether the subsequent LTPs performed by eye care professionals in both groups are consistent with recommended clinical practice guidelines.

To our knowledge, this is the first study to examine differences in outcomes of LTP between patients receiving care by ophthalmologists and those by optometrists. A strength of this study is its large diverse population of patients with glaucoma enrolled in Medicare throughout Oklahoma. We are not only including patients receiving care at one particular academic institution or by a small group of eye care professionals but are also including patients who underwent LTP performed by 57 ophthalmologists and 23 optometrists. We had longitudinal follow-up for several years after the initial LTP to compare the longer-term outcomes. Finally, the data come

from claims submitted by ophthalmologists and optometrists, and not from patient self-report, which may be less reliable.³⁰

Our study has several limitations. First, claims data lack clinical details, such as intraocular pressure levels before or after LTP, slitlamp and gonioscopy findings, or details of how the procedures were performed. Second, our study focused on Medicare beneficiaries. It is unclear whether the findings would be similar for younger patients or those with other forms of health insurance. Third, there may be systematic differences between the patients receiving care by ophthalmologists and those by optometrists, including differences in disease severity between the groups. Unfortunately, there were not enough eyes that were coded with the new glaucoma severity codes to assess for this difference. One would expect that patients with more severe glaucoma would be receiving their care by ophthalmologists and thus would be more, not less, likely to require additional LTPs. Although we adjusted our models for some confounding factors, including age and race/ethnicity, there are other unmeasured confounders not included in claims data.

Conclusions

Based on the findings of these analyses, we urge state legislatures and health policy makers to be cautious about giving optometrists privileges to perform LTP in other states until additional research is performed to better delineate the reasons for the differences in the use of additional LTP we are observing in Oklahoma. Furthermore, researchers should determine the effect that these differences have on costs of care and, most important, on clinical outcomes such as disease progression.

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Drafting of the manuscript: Stein, Zhao. Critical revision of the manuscript for important intellectual content: Zhao, Andrews, Skuta. Statistical analysis: Andrews.

Administrative, technical, or material support: Stein. Na additional contributions: Zhao, Skuta.

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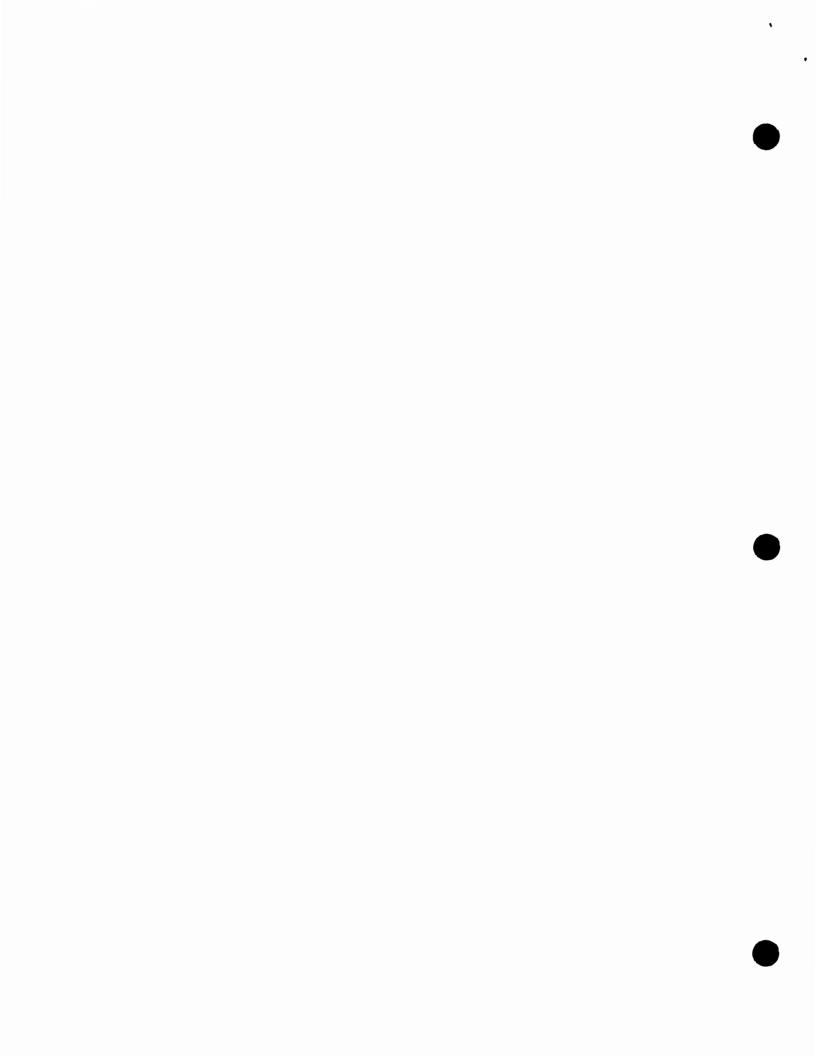
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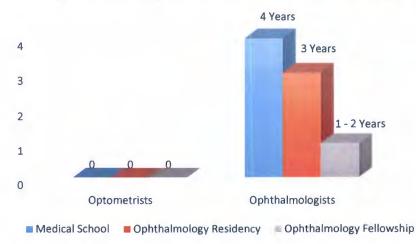
THE NORTH CAROLINA MEDICAL SOCIETY OPPOSES OPTOMETRISTS PERFORMING SURGERY

NC patients who need eye surgery deserve the best-trained doctors.

Only 3 states (Kentucky, Louisiana, Oklahoma) have an optometry law like HB 36. For good reason:

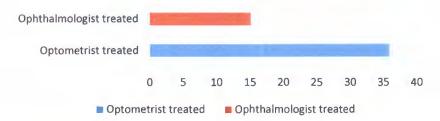
- o Optometry training is inadequate for performing surgery.
- o Ophthalmologists, by contrast, are trained medical doctors.

Ophthalmologists Get Much More Training



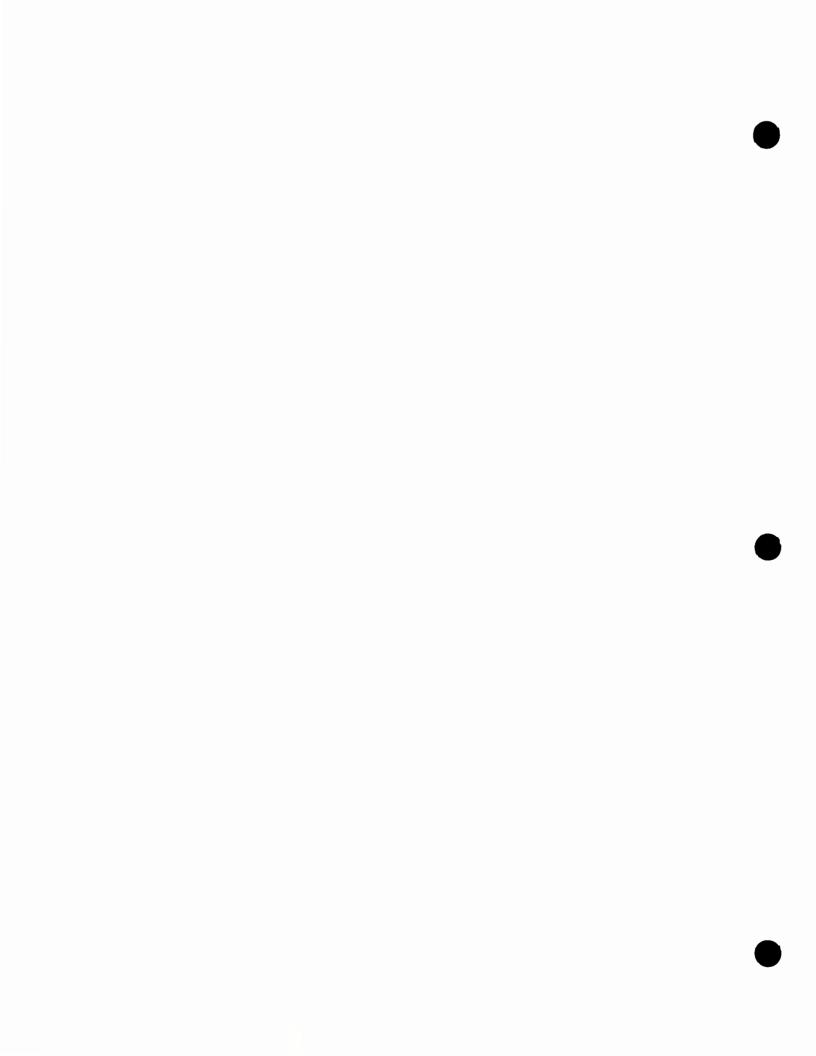
An Oklahoma study found that optometrist-treated eyes had a <u>189% increased risk</u> of requiring repeat laser surgery.

Oklahoma Study: Double rate of repeat laser with optometrist-treated eyes



The U.S. Department of Veterans Affairs <u>prohibits</u> laser surgery by optometrists.

Help protect North Carolina patients from unnecessary surgery.



-///

NCSEPS

Eye Physicians Oppose HB 36

Eye surgery is complex. It should be left to qualified eye surgeons.

Our state's medical community and the North Carolina Medical Society oppose HB 36.

There are no "uncomplicated" surgeries or procedures involving the eye. Every eye is unique and eye surgery requires a level of expertise that can only be gained through rigorous medical education, surgical training and clinical experience.

Ophthalmologists are the only physicians who are qualified to perform eye surgery and prepared to manage surgical complications that can, and do, occur.

Optometry Training

2,300 Hours

- At least three years of college
- 4 years of optometry school

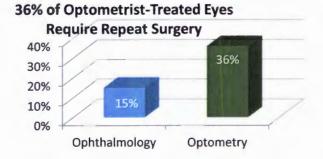
Ophthalmology Training

17,000+ Hours

- 4 years of college
- · 4 years of medical school
- 1 year hospital internship
- 3 years in surgical residency in a hospital

When it comes to eye surgery, training matters.

Oklahoma Study: More than double rate of repeat laser with optometrist-treated eye.



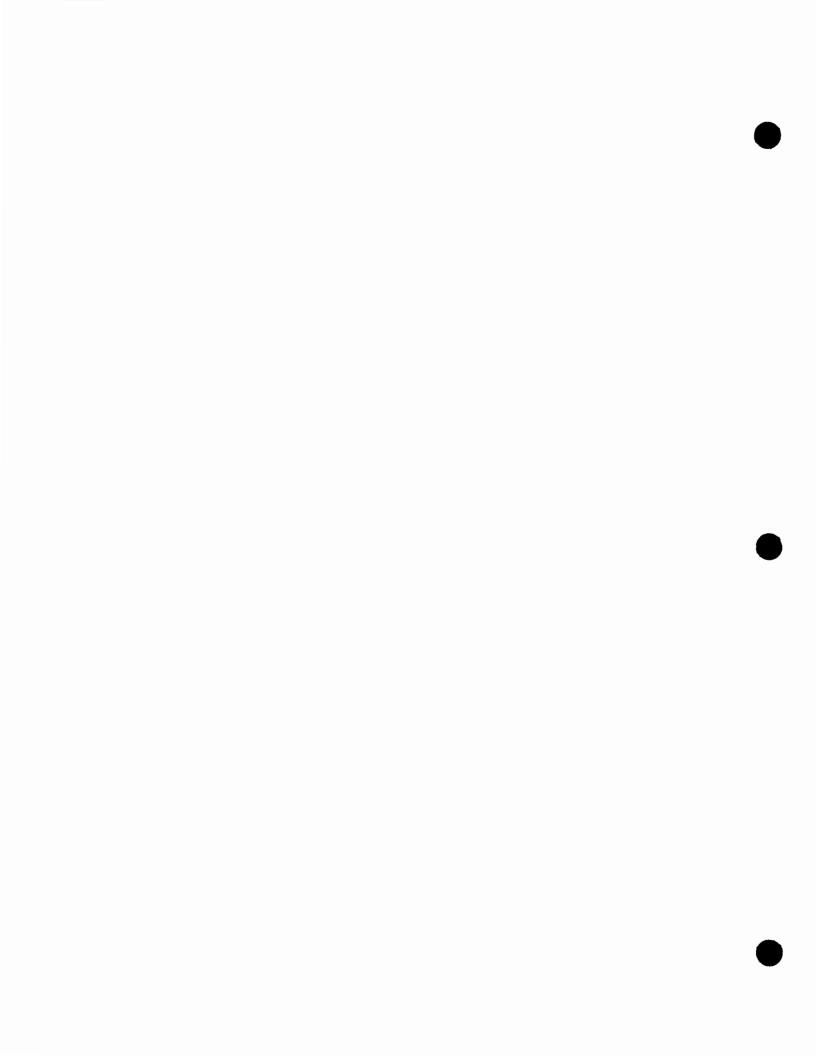
Optometrists are valued members of the eye care team with expertise in providing basic eye care services, such as eye exams and contact lens fitting. Optometrists are not surgeons.

Only three states have an optometry law like HB 36.

The U.S. Department of Veterans Affairs prohibits laser surgery by optometrists.

Preserve Patient Safety and Surgery by Surgeons in North Carolina.

The North Carolina Society of Eye Physicians and Surgeons (NCSEPS) | 919-833-3836 | www.nceyemd.org Contact: Laurie Onorio, tel: 919-412-9371, ljo@walkwest.com



GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2017

H

Short Title:

Sponsors:

Referred to:

HOUSE BILL 36

Enact Enhanced Access to Eye Care Act. (Public)

Representatives Burr, Collins, Dobson, and Howard (Primary Sponsors).

For a complete list of sponsors, refer to the North Carolina General Assembly web site.

Health, if favorable, Insurance, if favorable, Appropriations

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February 2, 2017

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A BILL TO BE ENTITLED

AN ACT AMENDING THE SCOPE OF PRACTICE OF OPTOMETRY IN ORDER TO ENHANCE ACCESS TO EYE CARE IN NORTH CAROLINA.

The General Assembly of North Carolina enacts:

Whereas, the provision of eye care is rapidly evolving through advances in technology, pharmacology, and biotechnology; and

Whereas, the health care profession of optometry is dedicated to providing patient-centered eye care of the highest quality; and

Whereas, 1180 licensed Doctors of Optometry now provide the majority of primary eye care in North Carolina due to widespread geographic distribution and excellence in practice; and

Whereas, Doctors of Optometry provide eye care in 98 North Carolina counties, with primary office locations in 88 counties; and

Whereas, the wide availability of practicing Doctors of Optometry in North Carolina provides access to high quality eye care throughout the State; and

Whereas, the optometric profession has steadily evolved in expansion of practice while maintaining an exemplary record of safety and care since being first statutorily defined in 1909; and

Whereas, the statutes governing the practice of optometry have not been substantively updated to acknowledge advances in technology since 1977; and

Whereas, the continued expansion of optometric services in North Carolina will greatly improve access and affordability of eye care to the citizens of North Carolina; Now, therefore, The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-114 reads as written:

"§ 90-114. Optometry defined.

- (a) Any one or any combination of the following practices shall constitute the practice of optometry:
 - (1) The examination of the human eye by any method, other than surgery, method to diagnose, to treat, or to refer for consultation or treatment any abnormal condition of the human eye and its adnexa; or
 - (2) The employment of instruments, devices, pharmaceutical agents and procedures, other than surgery, procedures intended for the purposes of investigating, examining, treating, diagnosing or correcting visual defects or abnormal conditions of the human eye or its adnexa; or



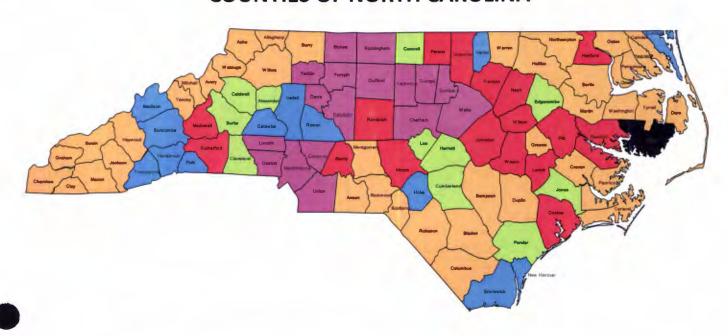
Genera	l Assemb	oly Of North Carolina Session 2017
	(3)	The prescribing and application of lenses, devices containing lenses, prisms, contact lenses, orthoptics, vision training, pharmaceutical agents, and prosthetic
		devices to correct, relieve, or treat defects or abnormal conditions of the human
		eye or its adnexa.
<u>(b)</u>		rmance of the following procedures shall not constitute the practice of optometry,
		eoperative and postoperative care associated with these procedures:
	(1)	Retina laser procedures, LASIK, and PRK.
	<u>(2)</u>	Nonlaser surgery related to removal of the eye from a living human being.
	<u>(3)</u>	Nonlaser surgery requiring full thickness incision or excision of the cornea or
		sclera other than paracentesis in an emergency situation requiring immediate
		reduction of the pressure inside the eye.
	<u>(4)</u>	Penetrating keratoplasty (corneal transplant), or lamellar keratoplasty.
	<u>(5)</u>	Nonlaser surgery requiring incision of the iris and ciliary body, including iris
		diathermy or cryotherapy.
	<u>(6)</u>	Nonlaser surgery requiring incision of the vitreous.
	(7)	Nonlaser surgery requiring incision of the retina.
	(8)	Nonlaser surgical extraction of the crystalline lens.
	(9)	Nonlaser surgical intraocular implants.
	<u>(10)</u>	Incisional or excisional nonlaser surgery of the extraocular muscles.
	(11)	Nonlaser surgery of the eyelid for eyelid malignancies or for incisional
		cosmetic or mechanical repair of blepharochalasis, ptosis, or tarsorrhaphy.
	(12)	Nonlaser surgery of the bony orbit, including orbital implants.
	(13)	Incisional or excisional nonlaser surgery of the lacrimal system other than
		lacrimal probing or related procedures.
	<u>(14)</u>	Nonlaser surgery requiring full thickness conjunctivoplasty with graft or flap.
	(15)	Any nonlaser surgical procedure that does not provide for the correction and
		relief of ocular abnormalities.
	(16)	Laser or nonlaser injection into the posterior chamber of the eye to treat any
		macular or retinal disease.
	(17)	The administration of general anesthesia.
	(18)	Procedures performed under general anesthesia."
	SEC	FION 2. This act becomes effective January 1, 2018.



North Carolina Society of Eye Physicians & Surgeons

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Ophthalmologists (Eye Physicians and Surgeons) Coverage COUNTIES OF NORTH CAROLINA



Number of ophthalmologists within 25 miles of the county seat and the percent of the NC population this represents:

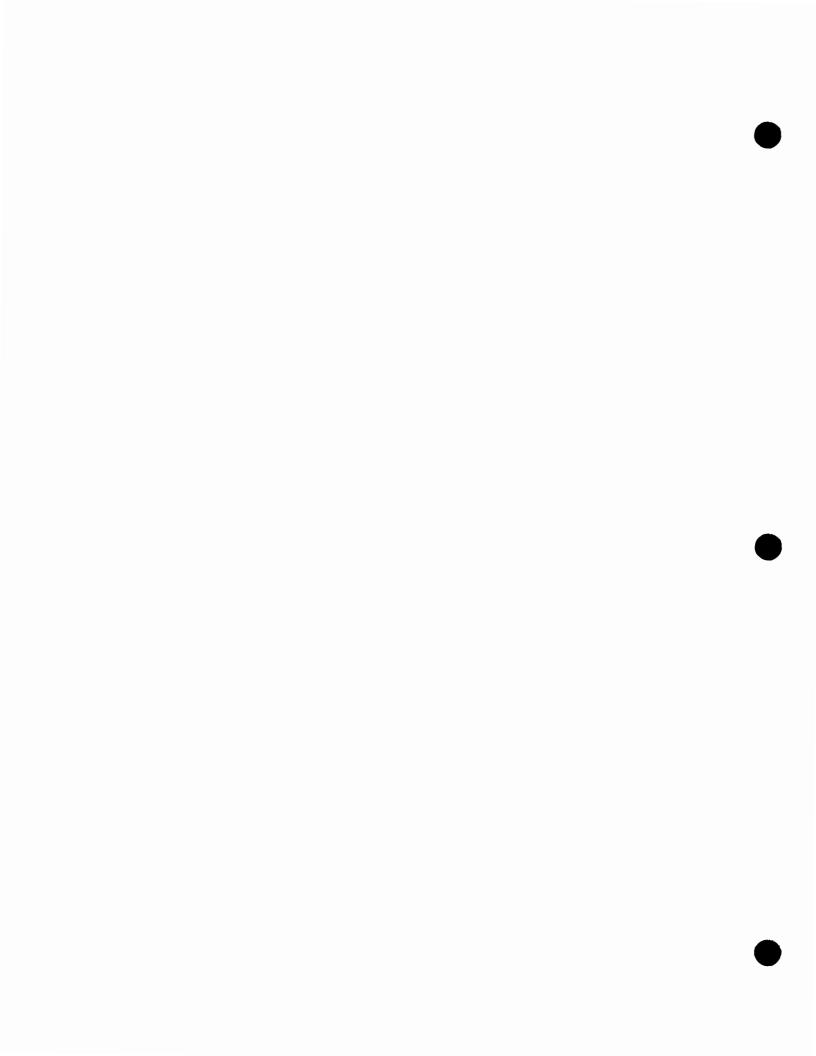
>50	48.0%	Alamance, Cabarrus, Chatham, Davidson, Davie, Durham, Forsyth, Gaston, Guilford, Lincoln, Mecklenburg, Orange, Rockingham, Stokes, Union, Wake, Yadkin
31 to 50	13.6%	Brunswick, Buncombe, Catawba, Currituck, Henderson, Hoke, Iredell, Madison, New
		Hanover, Polk, Rowan, Transylvania, Vance
21 to 30	9.6%	Alexander, Burke, Caldwell, Caswell, Cleveland, Cumberland, Edgecombe, Harnett,
		Jones, Lee, Pender
11 to 20	15.4%	Beaufort, Franklin, Granville, Hertford, Johnston, Lenoir, McDowell, Moore, Nash,
		Onslow, Person, Pitt, Randolph, Rutherford, Stanly, Wayne, Wilson
1 to 10	13.3%	All the rest, except Hyde (41 counties)
0	0.06%	Hyde*

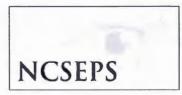
Approximately 71.2% of NC residents have access to at least 21 ophthalmologists (Medical Doctors/Surgeons) within 25 miles of the county seat.

References: http://www.census.gov/quickfacts/table/PST045216/37,

https://www.healthgrades.com/ophthalmology-directory/nc-north-carolina

^{*}Hyde County, the only county in NC with no ophthalmologist within 25 miles of its county seat, has 16 ophthalmologists within 50 miles of its county seat.





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Examples of Surgical Treatments Authorized by HB 36

HB 36 purports to "exclude" specific surgical procedures from the practice of optometry. However, with any such attempt to specify what is NOT included comes the fact that <u>everything not specifically listed IS included</u>, as well as any FUTURE surgery modalities (or variation of an existing surgery) that are not specifically listed.

Specific exclusions from "the practice of optometry" would be:

- Retina laser procedures, LASIK, and PRK (specifically)
- Numerous activities that are "non-laser" (meaning if the same activity CAN be done with a laser it is "OK"),
- Administration of general anesthesia (meaning that procedures done under general anesthesia).

The following are some examples of surgical procedures PERMITTED outside the "Exclusions":

Procedure Possible Complications Laser Eyelid Resurfacing Infection Usuallycosmetic Scarring Removes fine wrinkles and Pigmentary changes in skin irregularities Ectropion/entropion (turning in or out of eyelids preventing proper lid closure and potential for corneal infection/ongoing dryness Photos: (Upper) Day 1 Post-operative appearance. (Middle) Note permanent excess pigmentation in skin under eyelids that developed with healing in Latin American woman (preexisting ethnic pigment). (Lower) Schematic of ectropion (turning out of eyelid), which can cause corneal exposure or chronic tearing. Lid Laceration Repair Lacerations can be sutured with local Infection (including atypical bacteria, etc.) anesthesia, but possible injury to adjacent structures including the eye, Ectropion/entropion (turning in or out of eyelid muscles, and the tear drainage system margin preventing proper lid closure and must be considered, diagnosed, and potential for corneal infection/ongoing carefully treated to avoid complications. Epiphora (tearing because of The laceration pictured is from a dog bite, undetected damage to lacrimal which can result in atypical bacterial structures). infections that may not respond to common antibiotics.



Eyelid lesions

- Eyelid lesions can be cancerous. While the picture shows a somewhat "suspicious" lesion, others are not obvious and can look "benign."
- Improper technique in removing what ends up being a malignant tumor can have devastating consequences.
- Infection
- Scarring
- Damage to nearby structures (e.g., lacrimal system, causing chronic tearing or dryness).
- Possible systemic spread of cancer. and hastened death.







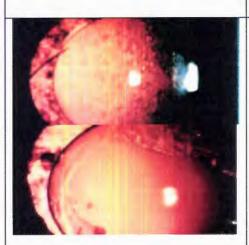
Glaucoma Laser Procedures

Argon Laser Trabeculoplasty (ALT) Selective Laser Trabeculoplasty (SLT) Argon/YAG Peripheral Iridotomy (PI) Laser Iridoplasty

- Involve careful placement of laser energy to structures, some smaller than a human hair to achieve effect
- Requires special high power lenses and mirrors
- Improper treatment can permanently damage drainage structures (possibly making intraocular pressure problems worse) and cause cataract.

Photos: (Upper) Laser equipment is delivered in conjunction with a high powered microscope. (Middle) In ALT/SLT, laser energy is focused on very fine structures in between cornea and iris ("angle"). (Lower) Peripheral Lens is just behind PI shown at arrow. Placement more toward the pupil could cause cataract.

- Severe Post-operative intraocular pressure rises, possibly "snuffing out" an already damaged/weakened optic nerve in severe glaucoma, causing blindness
- Cataract due to laser injuries to lens capsule (cellophane like "bag" holding gellike material).
- 0 Iritis
- 0 Corneal abrasion/infection/ulcer(from contactlens)
- Conjunctivitis 0
- Bleeding inside the eye (hyphema) 0
- Glare, blurred vision, or haloes



Laser Capsulotomy

- Done after cataract surgery to create opening in membrane behind the artificial lens that has become cloudy/opaque(upper photo)
- Careful placement/restriction of laser energy needed to limit size of hole (note in lower photo how close opening is to lens edge) as lens can lose support and fall into back of eye.
- Requires high power lenses and special mirrors

- Retinal Detachment (energy used creates a "shock wave")
- Dislocation of artificial lens into back
- Severe Post-operative intraocular pressure rises, possibly "snuffing out" an already damaged/weakened optic nerve in severe glaucoma (if present).
- Damage to artificial lens impairing vision
- Corneal abrasion/infection/ulcer(from contact lens)
- Conjunctivitis and Iritis
- Spread of rare infections of the capsule inside the eye



CAPSULOTOMY.



CLEAR CORNEAL INCISION

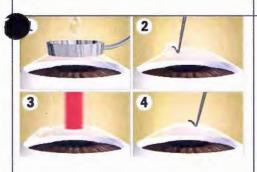


LENS FRAGMENTATION

Laser "Only" Cataract Surgery

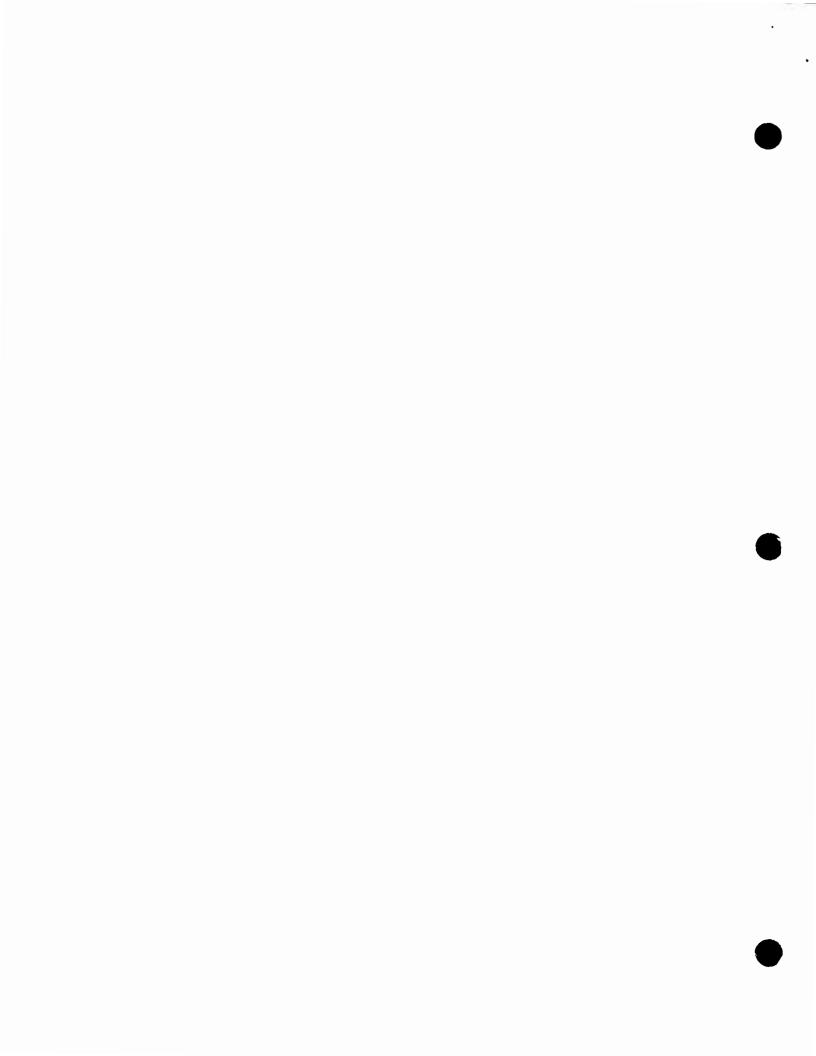
- Although still in the developmental, many
 of the steps of cataract surgery can be
 performed with a laser device, including
 making an incision into the eye.
 Therefore, under the wording of HB 36,
 cataract surgery might very well be
 included as part of the "practice of
 optometry" even though it might "appear
 excluded."
- Despite such changes, the complications
 of cataract surgery would not be
 expected to change because the eye
 would still be entered (and indeed the new
 technology might create new laser related
 ones, e.g., off- center placement of the
 opening in the front of the lens
 [capsulotomy], disruption of the posterior
 capsule by the laser energy, etc.)

- Retinal Detachment
- Choroidal hemorrhage (sudden "explosive" bleeding under theretina)
- Severe Infection inside the eye (endophthalmitis) that may lead to loss of sight or the eye itself.
- Retained lens fragments in the eye, causing severe inflammation
- "Dropped Intraocular Lens" (caused by weakness or rupture of the posterior capsule intended to hold the artificial lens in place.
- Post-operative severe pressure elevations.
- Post-operative retinal edema ["Cystoid Macular Edema" (CME)]



"Other" Laser Refractive Procedures

- LASEK: Not LASIK, and similar to PRK, but not exactly PRK (or called PRK), this procedure is for all intents and purposes, PRK. The only difference is that the thin layer of epithelium (removed at step 2 in the diagram) is replaced at step 4 rather than it being just scraped off). Yet strict interpretation of the "exclusions" would appear to allow it because it is not specifically listed.
- "Laser 'Only' Clear Lens Extraction:
 This is functionally the same as "Laser 'Only" Cataract Surgery" but involves a clear (non-cataractous) lens.
- LASEK: Corneal scarring/infection/ulcer, irregular astigmatism, off-center laser application, glare, haloes, and exacerbation of dry eye syndrome
- "Laser 'Only" Clear Lens Extraction: See complications of "Laser 'Only' Cataract Surgery" above



Which lesion is life-threatening?

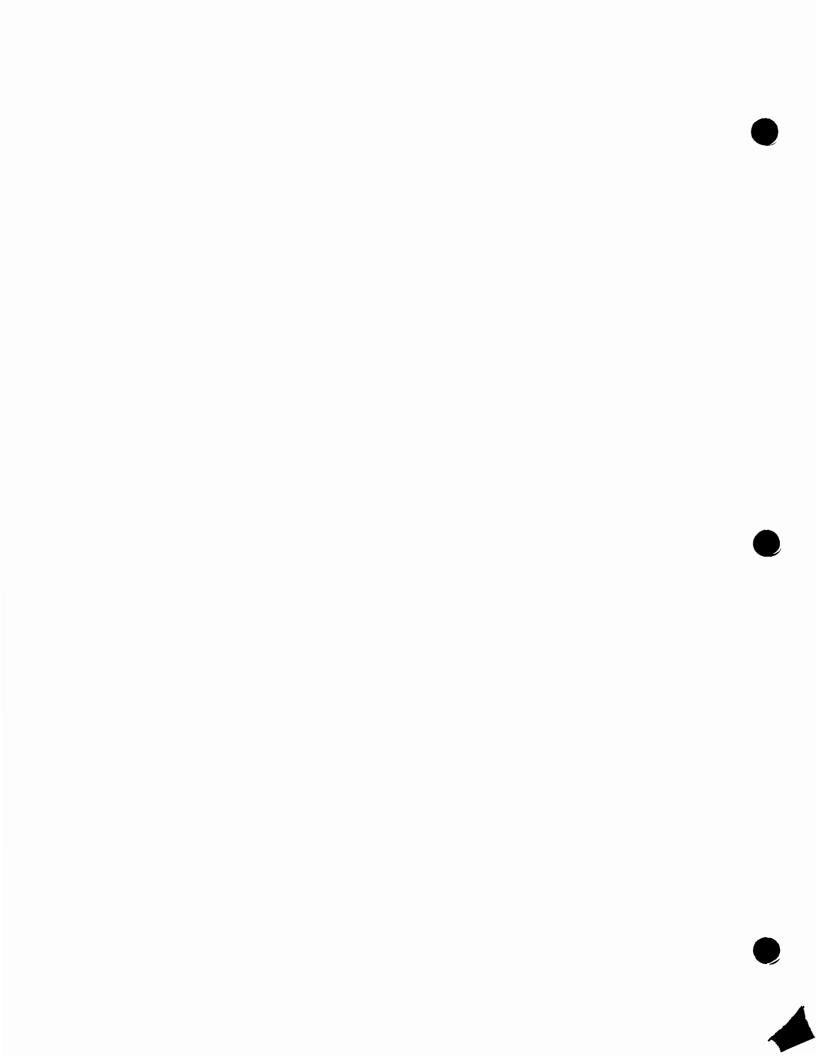








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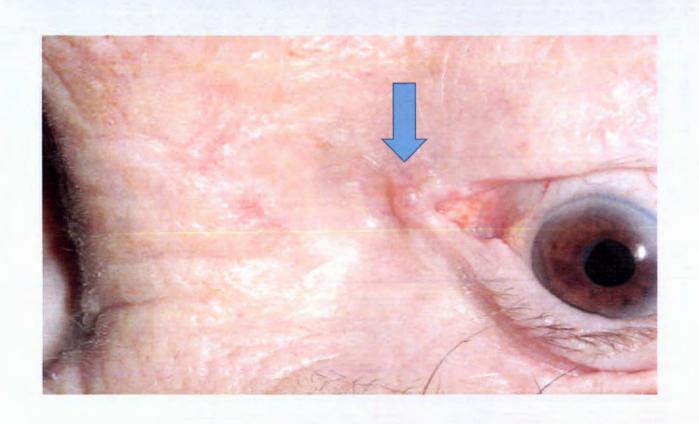
House Bill 36: Puts Patient Safety at Risk

Susan Burden, MD

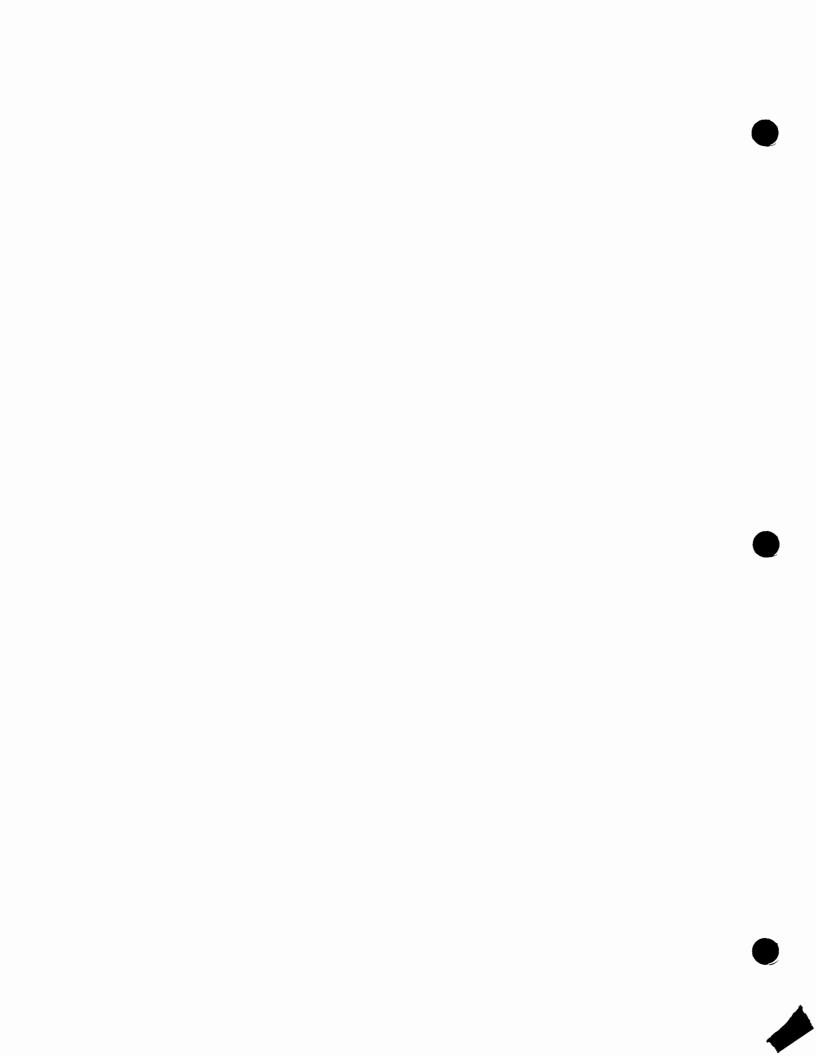
Past President, North Carolina Society of Eye Physicians and Surgeons
Associate Professor, Wake Forest University
Best Doctors, 2011 to present

The views expressed in this talk are my own and do not necessarily reflect the views of my employers



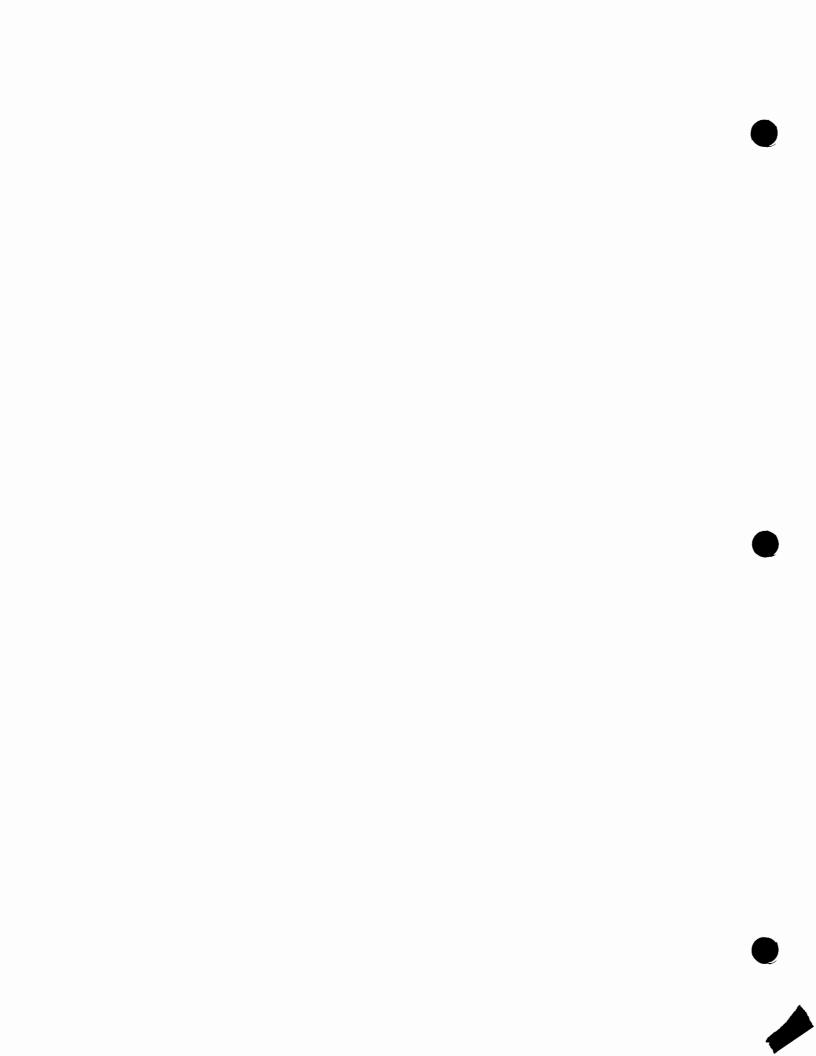


"Bump" on eyelid?



Or Basal Cell Carcinoma (post excision)?

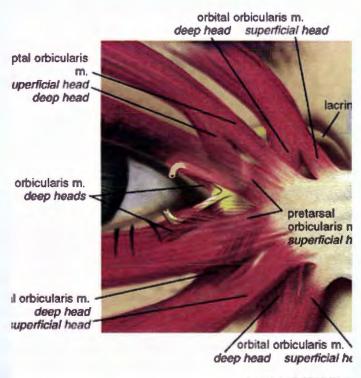




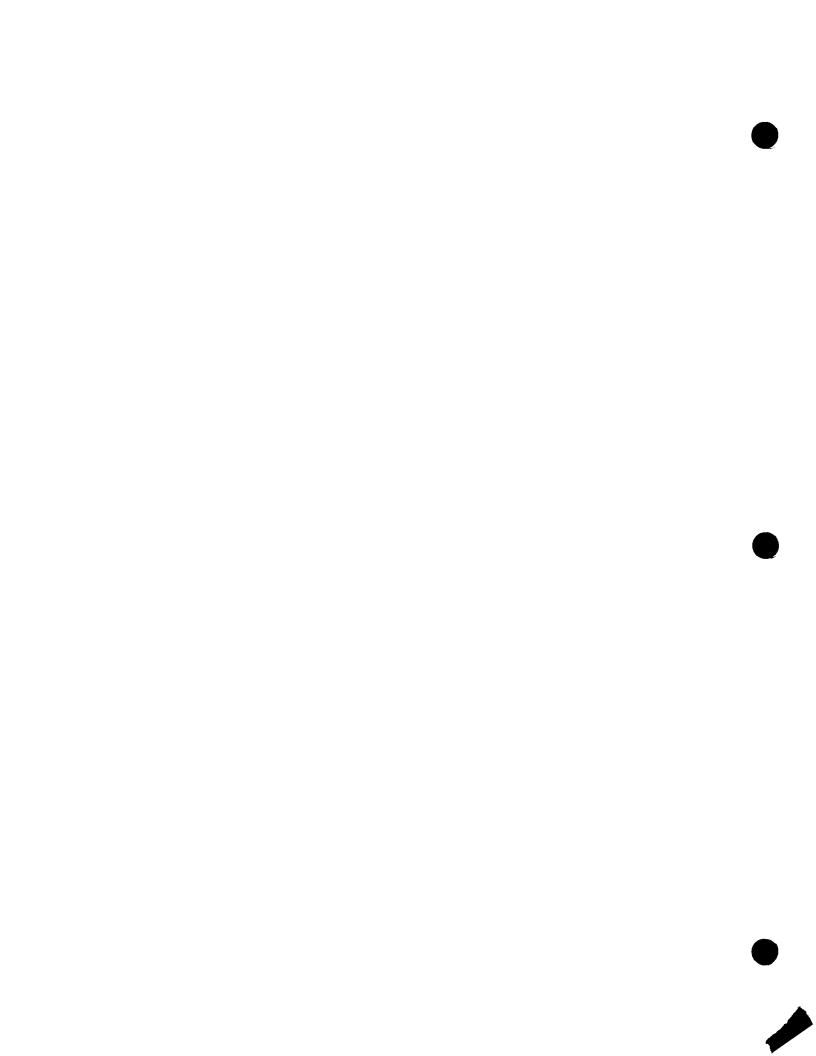
HB 36: The Eyelid is Complex

NCSEPS





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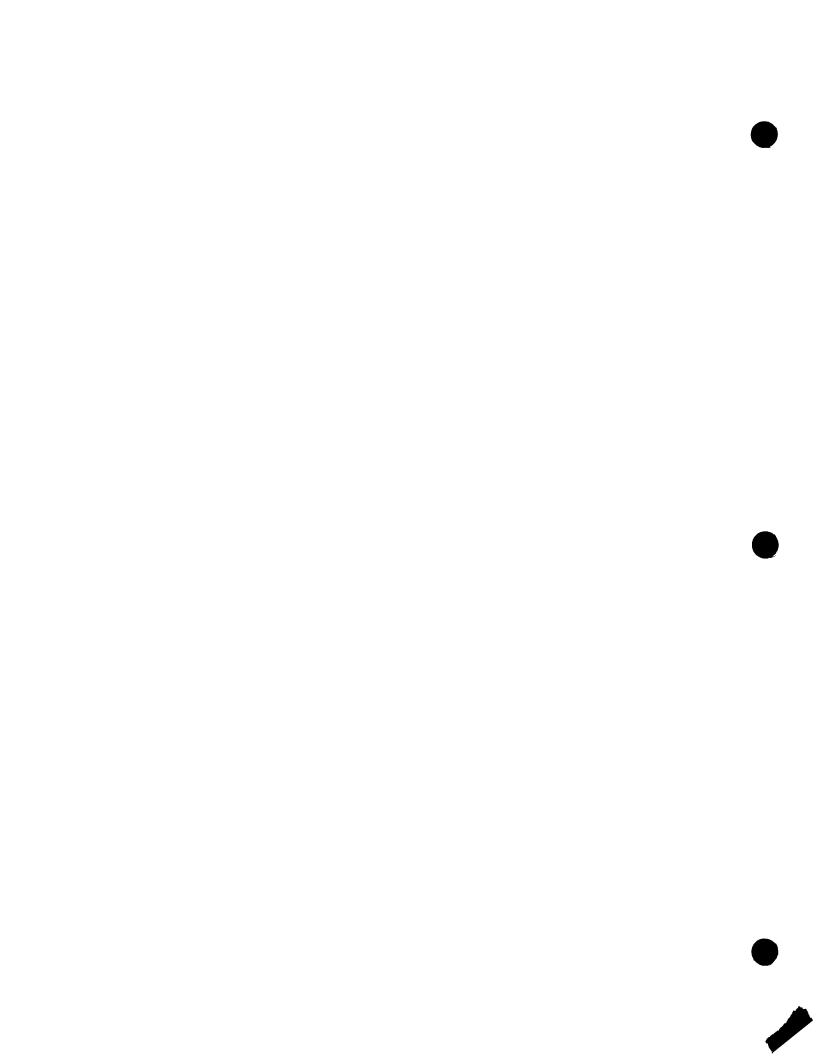
Remove? Then Repair?

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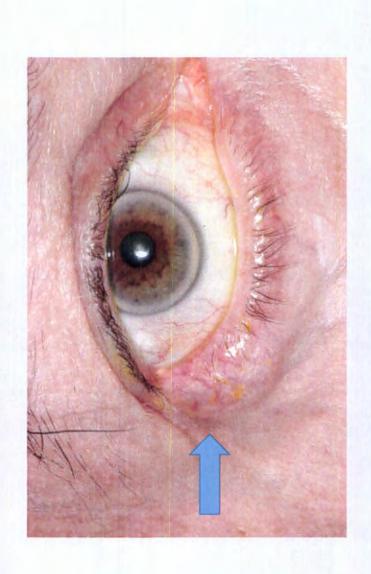








Chalazion?

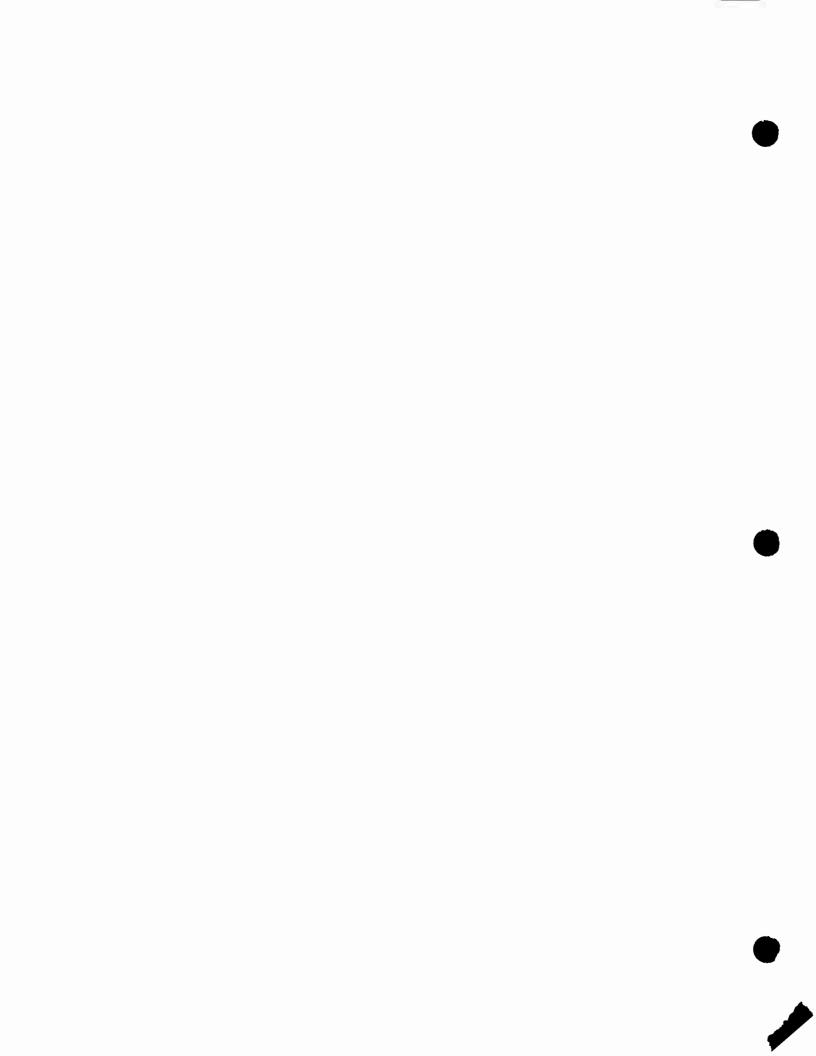




Cancer!

Sadly this patient passed away from that cancer which had already metastasized when finally referred





Lymphoma

- Chemotherapy not surgery
- Biopsy sent with specific instructions and in a special way or the diagnosis will be missed

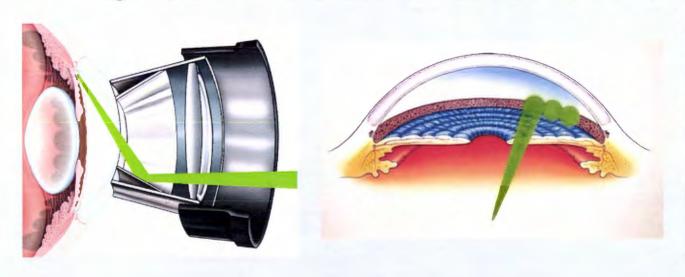


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"Simple Lasers"? No such thing

NCSEPS

Argon/selective Laser Trabeculoplasty





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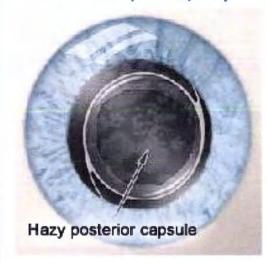
"Simple Lasers" nD:YAG Capsulotomy

The laser makes an opening in the cloudy capsule. This allows light to pass through again.

Posterior capsule

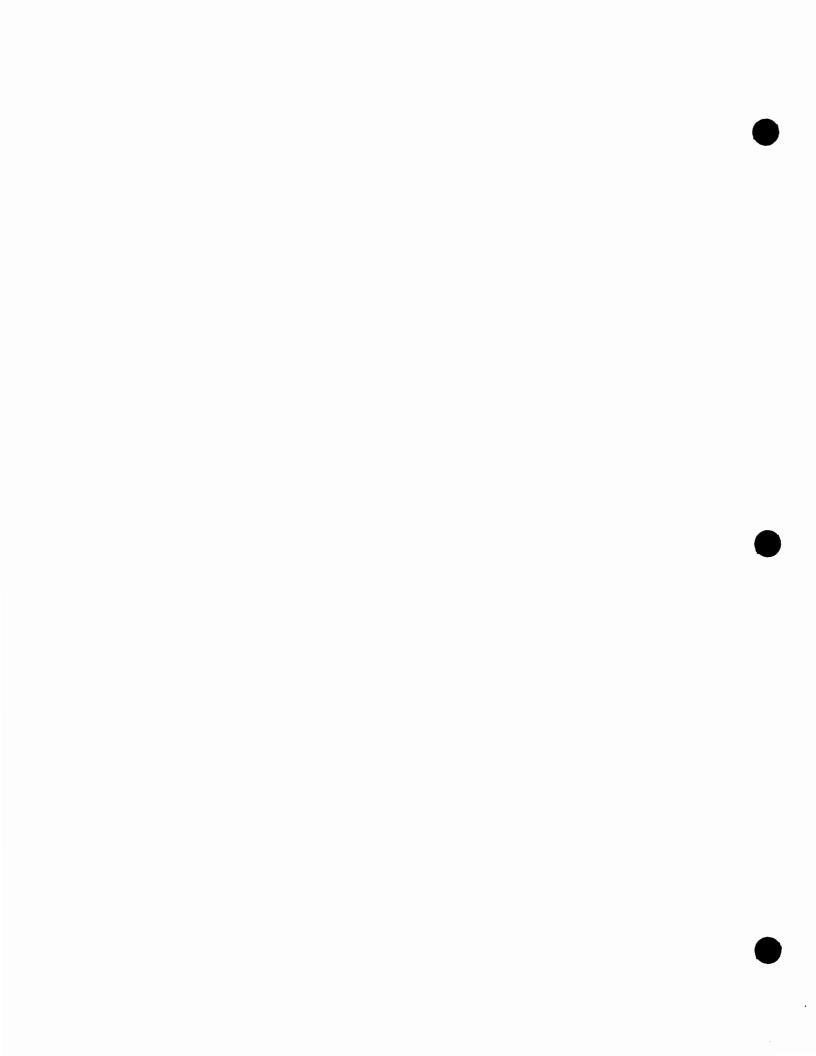
Opening in cloudy capsule

Posterior Capsule Opacity

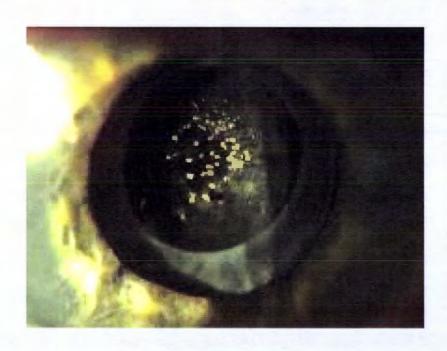


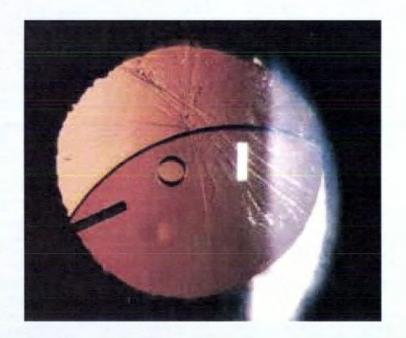
Post-Op YAG Laser Capsulotomy



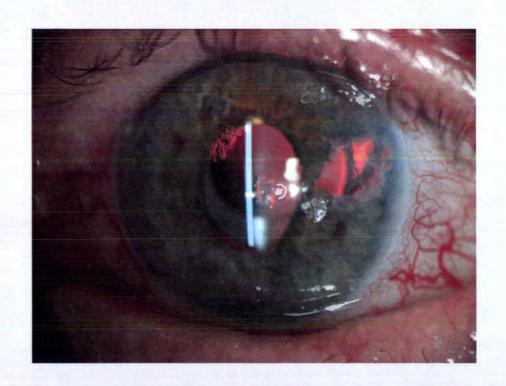


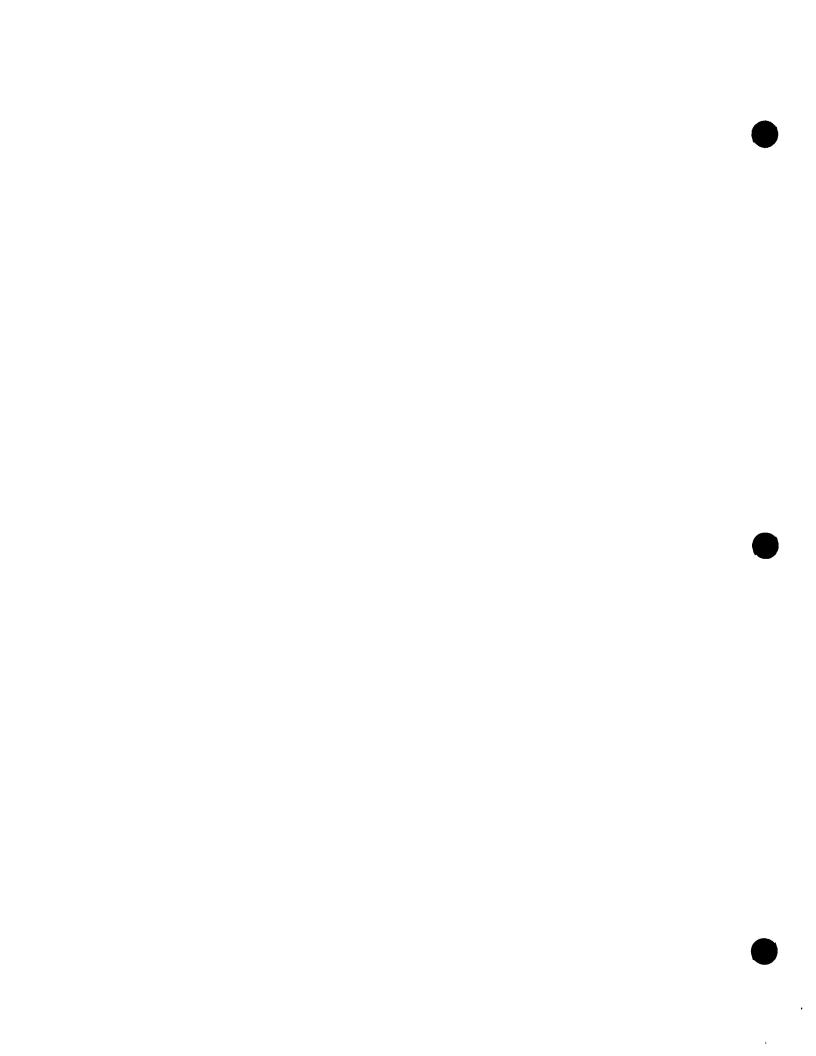
"Simple Lasers" nD:YAG Capsulotomy



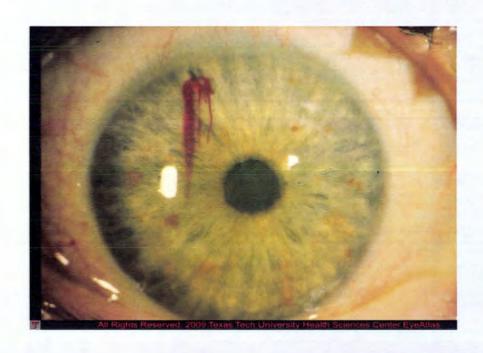


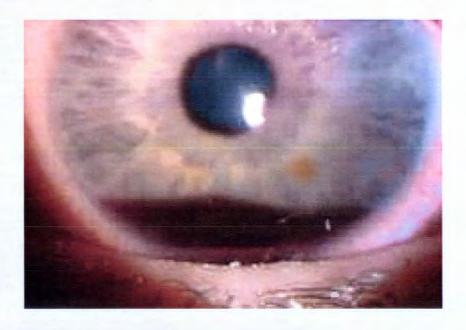
"Simple" LasersLaser Peripheral Iridotomy

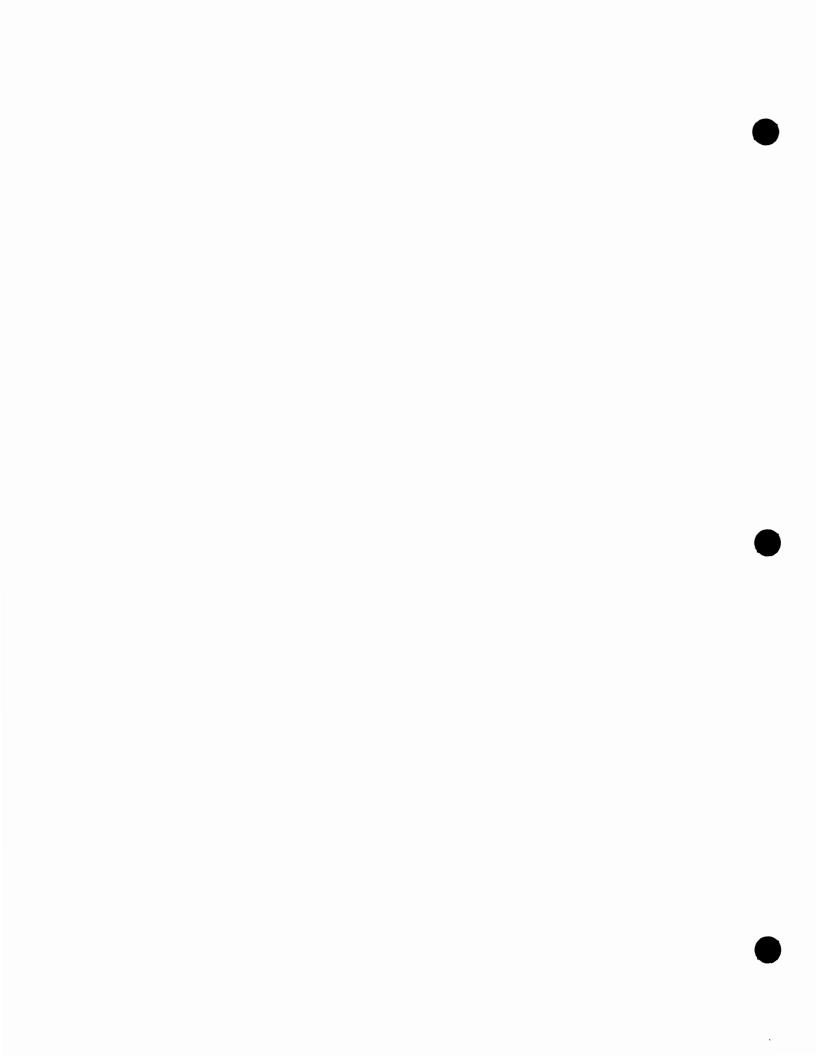




"Simple" Laser Laser Peripheral Iridotomy







HB 36: North Carolina Deserves Better!



OPTOMETRY NEWS

VA rules that only MDs may perform therapeutic laser procedures

Young Care Opnestry News January 2005

The Veterans Health Administration proclaimed in late December that "only ophthalmologists will be privileged to perform therapeutic laser eye procedures in Department of Veterans Affairs medical facilities," nullifying a previous ruling in favor of optometry

See Also

VA rules that only MDs may perform therapeutic laser

Presenter Ask about allergies before performing injections Kentucky governor signs bill to expand optometric privileges

Featured

American Academy of Optometry
Vision Expo West
ARVO

In August 2004, the VA had stated optometrists with appropriate training and licensure could perform therapeutic liser eye procedures under the supervision of an ophthalmologist. This directive VHA-2004-045 has been rescinded. The new decision, VHA Directive 2004-070, specifies that "therapeutic liser eye procedures only be performed by ophthalmologists with the requisite training and exercision."

Oklahoma is the only state that licenses optometrists to perform laser surgery

The optometric community is unhappy with the VA's decision

"We are deeply disappointed in the VA's decision to restrict optometrists' laser privileges in the VA system, said Wesley E. Pittman, OD, president of the American Optometric Association, in a prepared statement, "This broubling action is unprecedented, and not based on any evidence of quality of care concerns. In fact, the VA's medical inspector reviewed the cases of laser therapy performed by VA optometrists and found the outcomes met VA standards of care."

Dr Pittman further suggested that quality of care is not necessarily the real issue. "Instead, it is about ophthalmology and organized medicine's desire to control optometry and prevent expansion in our professional responsibilities," he said "it is regretable the department caved in to those self-serving motives."

The American Academy of Ophthalmology (AAO) has credited a group called the Veterans Eye Treatment Safety (VETS) coalition with the eventual rescriding of the WA's August directive. Members of the VETS Coalition sought to

VHA Directive 1132 (May 5, 2015)

Only Ophthalmologists may perform therapeutic laser eye procedures at VA facilities in all 50 states

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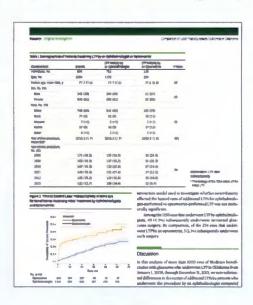
Laser in Oklahoma: Less Effective According to JAMA

NCSEPS

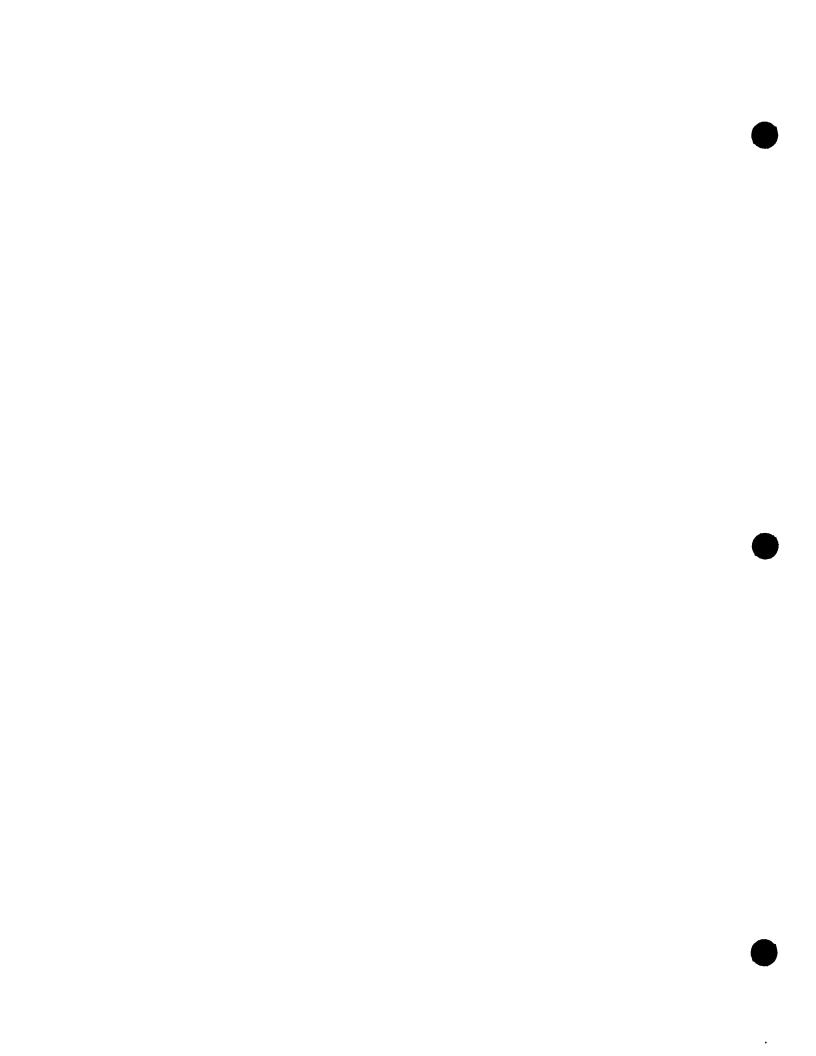
Studies begin to show disturbing ineffectiveness of optometric surgery*



"Health policy makers should be cautious about approving laser privileges for optometrists practicing in other states until the reasons for these differences are better understood."



^{*}Stein et al., "Comparison of outcomes of laser trabeculoplasty performed by optometrists vs ophthalmologists in Oklahoma" in JAMA Ophthalmology October 2016. JAMA Ophthalmol. 2016;134(10):1095-1101

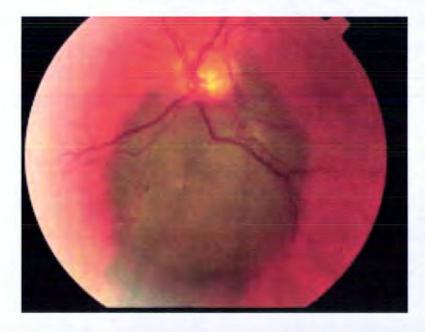


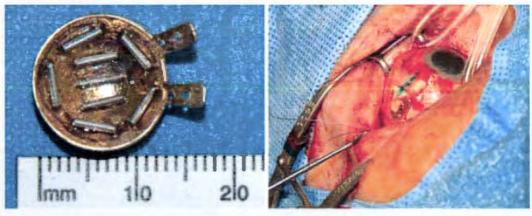
HB 36: Not Excluded...

NCSEPS

Choroidal Melanoma



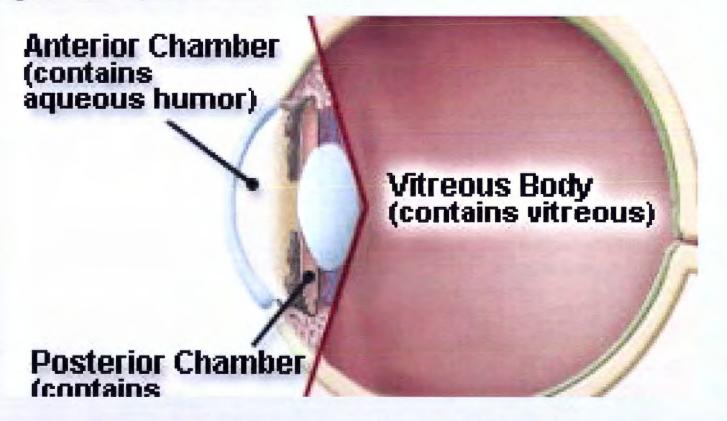


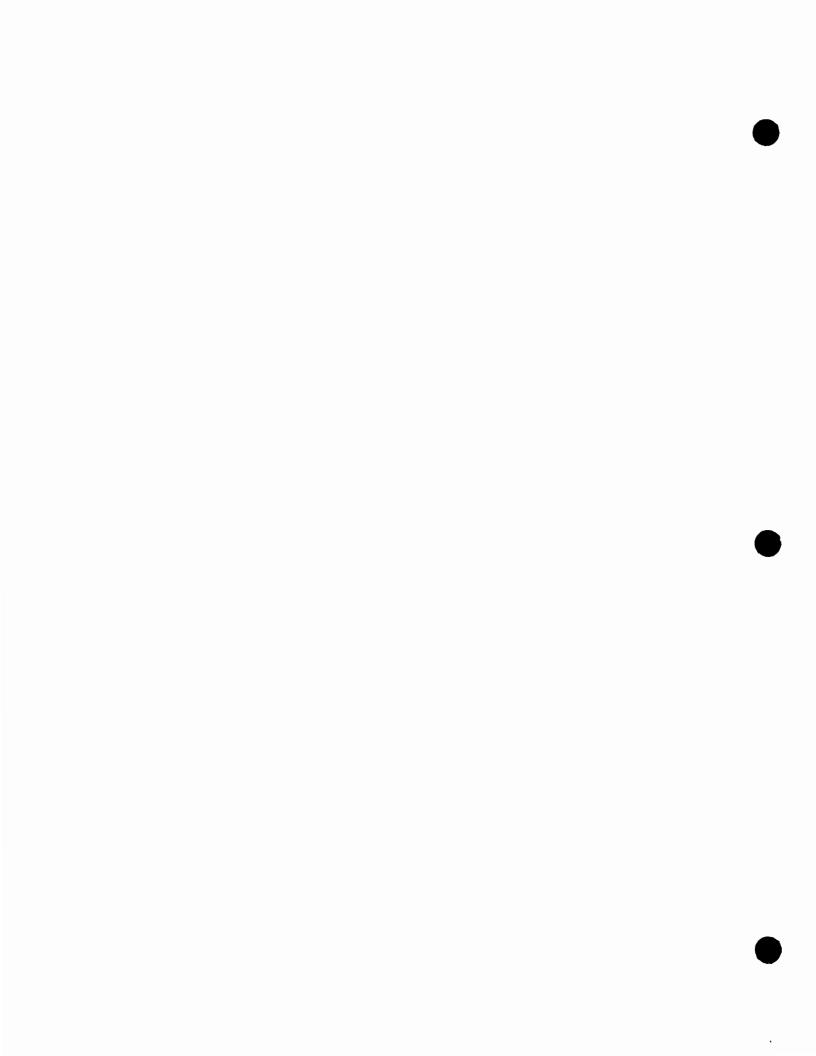


HB 36: Would allow Injections for Macular Degeneration and Diabetes

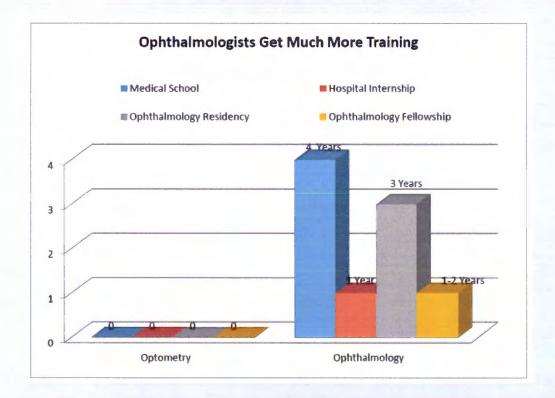
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#16:
Laser or
nonlaser
injection into
the posterior
chamber of the
eye to treat any
macular or
retinal disease





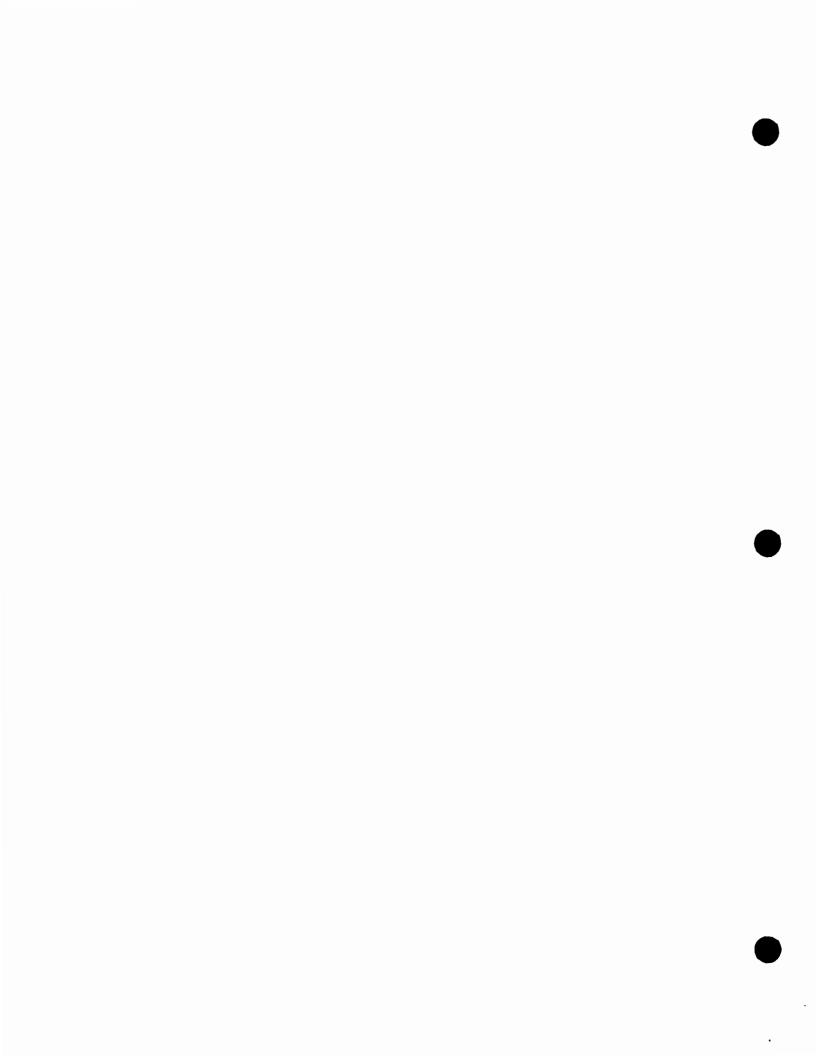
Optometrists ***** Surgeons



NCSEPS

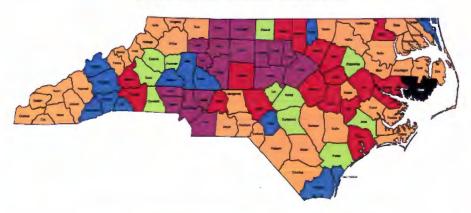
Optometry: On average, 1,900 hours of clinical training over 4 years in optometry school

Ophthalmology: approx. 20,000 hours of medical and surgical training over 8-10 years



HB 36: Access Issues?

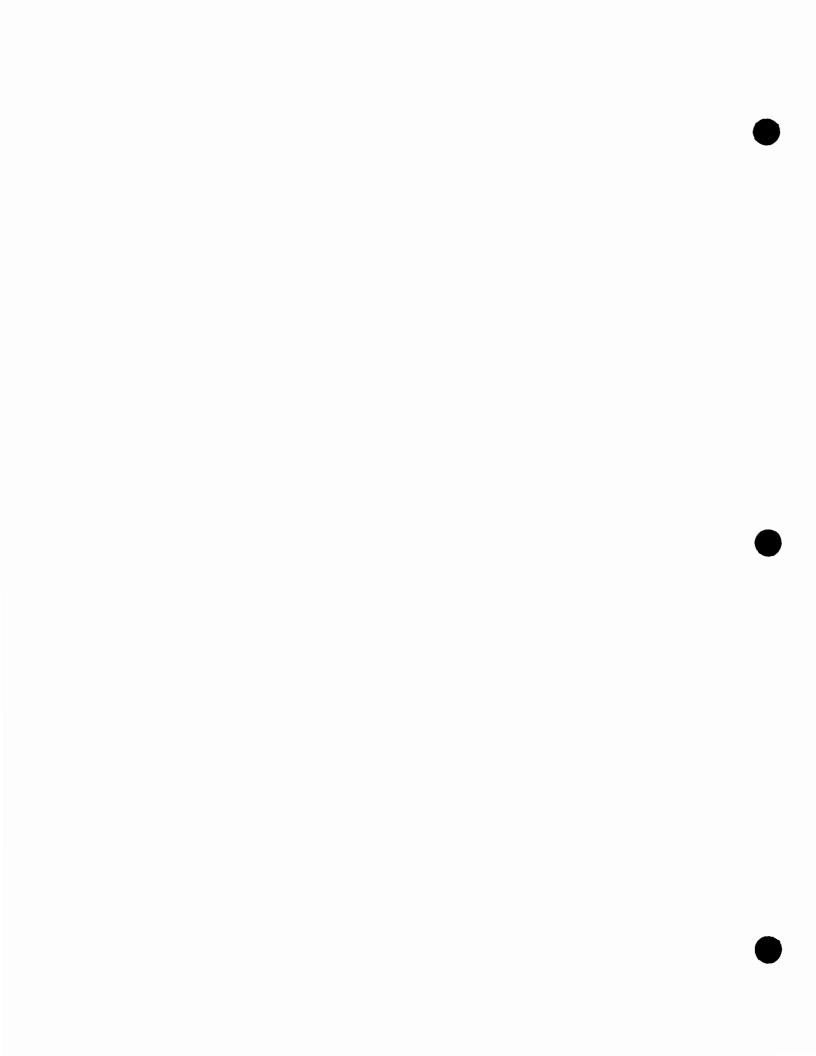
Ophthalmologists (Eye Physicians and Surgeons) Coverage COUNTIES OF NORTH CAROLINA



Number of ophthalmologists within 25 miles of the county seat and the percent of the NC population this represents:

>50	48.0%	Alamance, Cabarrus, Chatham, Davidson, Davie, Durham, Forsyth, Gaston, Guilford,
		Lincoln, Mecklenburg, Orange, Rockingham, Stokes, Union, Wake, Yadkin
31 to 50	13.6%	Brunswick, Buncombe, Catawba, Currituck, Henderson, Hoke, Iredell, Madison, New
		Hanover Polk, Rowan, Transylvania, Vance
21 to 30	9,65	Alexander, Burke, Caldwell, Caswell, Cleveland, Cumberland, Edgecombe, Harnett,
		Jones, Lee, Pender
11 to 20	15.4%	Beaufort, Franklin, Granville, Hertford, Johnston, Lenoir, McDowell, Moore, Nash,
		Onslow, Person, Pitt, Randolph, Rutherford, Stanly, Wayne, Wilson
1 to 10	13.3%	All the rest, except Hyde (41 counties)
0	0.06%	Hyde*

- Except for Hyde County, there are 1 to 10 ophthalmologists within 25 miles of every county seat (and for Hyde County, 16 ophthalmologists within 50 miles)
- 71.2% of NC residents have 21 or more ophthalmologists within 25 miles of the county seat



HB 36: North Carolina Already Has the Best!

NCSEPS

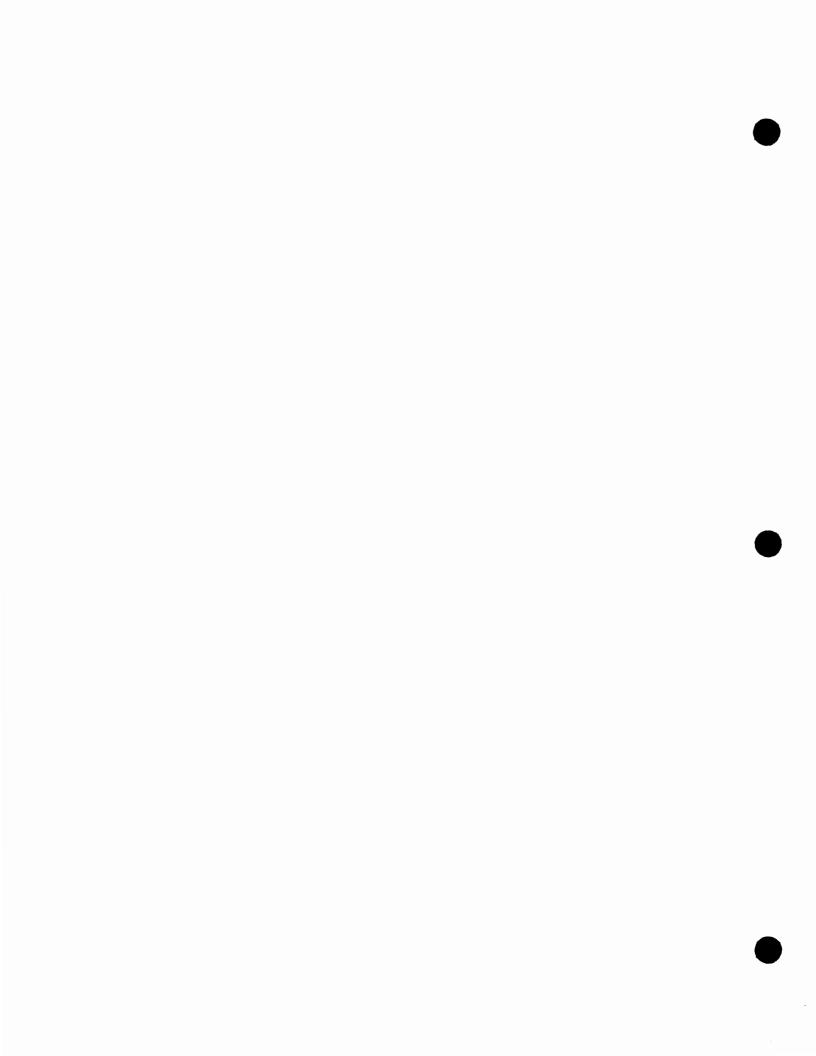
Three of the finest ophthalmology residency programs in the entire world:







Go Duke, UNC, and Wake Forest!



































North Carolina Society of Pathologists





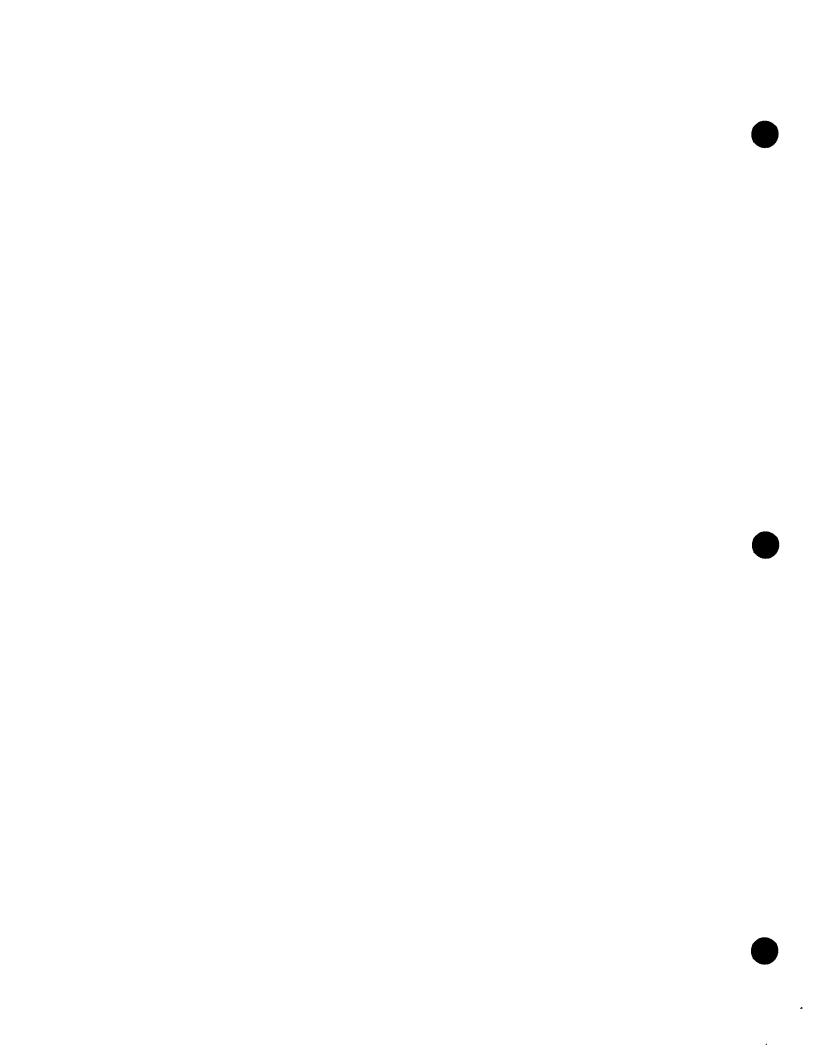


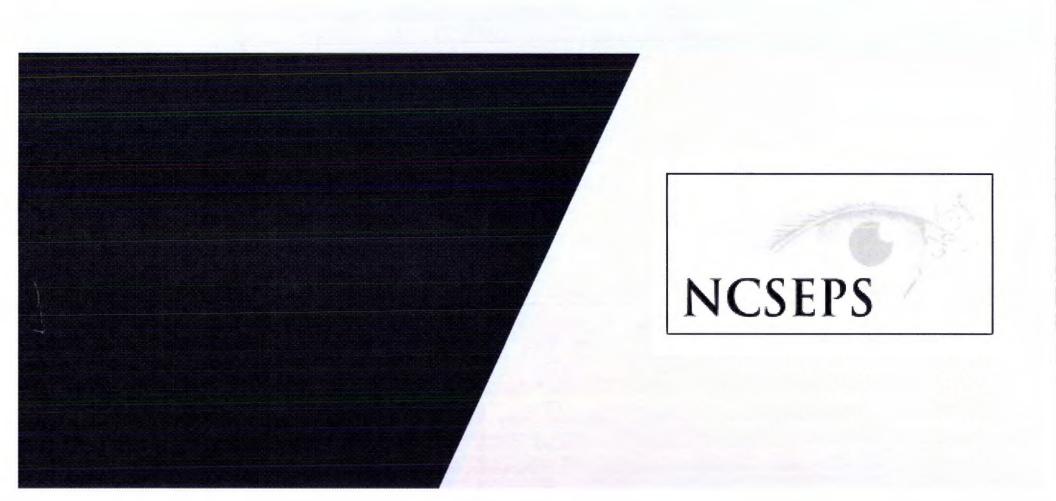


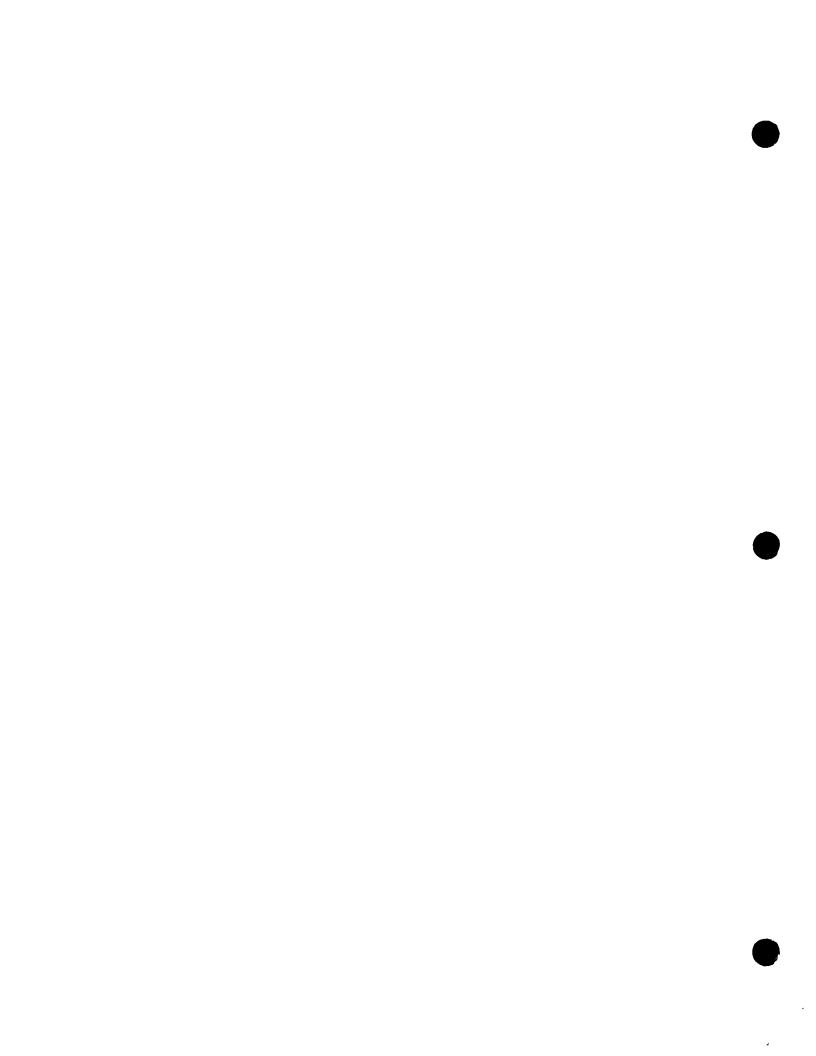












Committee Sergeants at Arms

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2. Name: <u>Jim Moran</u>		18 g Afrikan distantum angle katasa managananga Managananga Managananga Managananga Managananga Managananga Ma	
3. Name: Joe Crook	A Commission of the Commission		
4. Name: Jonas Cherr	У	\$ V4 - 10 - 2 - 10 - 10 - 10 - 10 - 10 - 10	
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House Pages Assignments Wednesday, March 01, 2017

Session: 2:00 PM

Committee	Room	Time	Mayace) Staff	Comments	Member
Health	643	11:00 AM	Elizabeth Sebestyen		Rep. Phillip Shepard
			Mariah-Sydney		Rep. Speaker Tim Moore
			Steele		



House Committee Health

02/29/17 3/1/17

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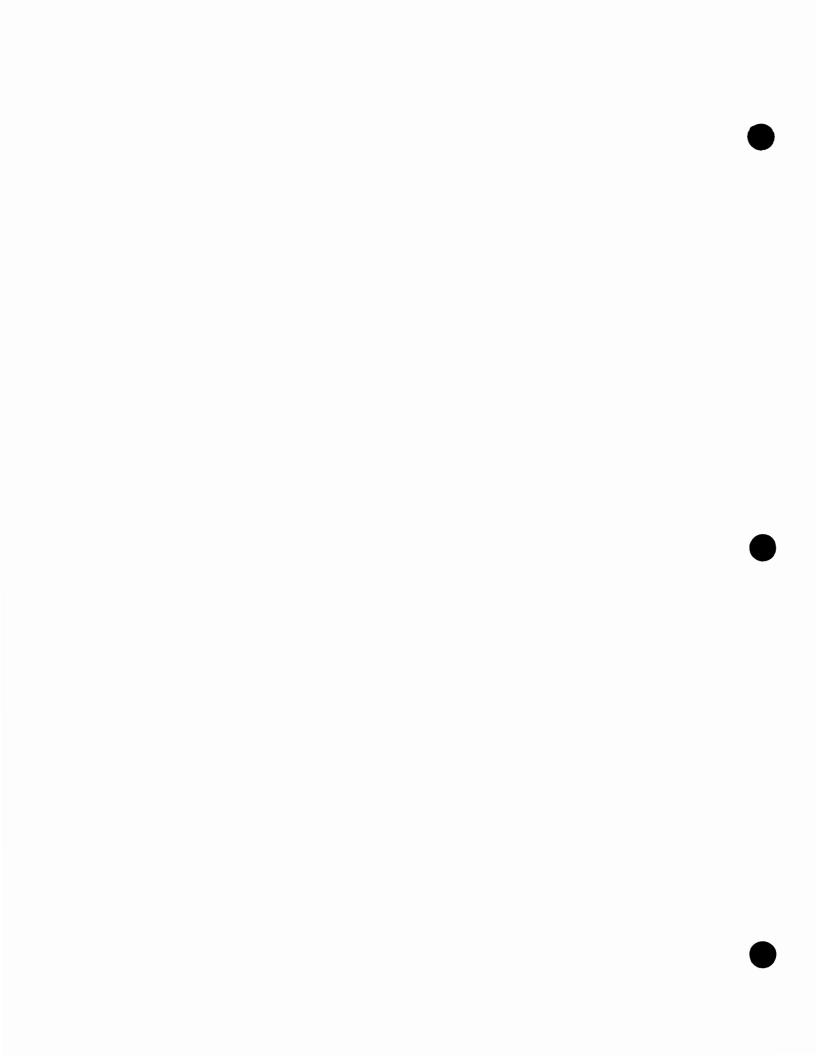
Date

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Paul Kranze	NCOS - Rateigh
Chris Well	· PG
Ron Farajoth	Clinton NC NCSOS
SCOTT ATHACS OD	PENRHURST, - NCOS
Elizabeth Leon	Mereditti College Swk stud.
Lee McPherson	OPTOME 17715T
Jennifer Murphy	Optometrist NCOS
Samantha McPherson	Optometrist



House Committee Health

02/29/17 3/1/17

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Date

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Charles Sikes, CD	Optometry
JAMIE CASPER OD PHOFAGO	optometry
Jill Bryant, OD, FAAO, FSLS	Optometry
Adrianne Drollette	NCOS
Angel Sams	Devivo & Sams
TED WARSON, OD	Optonetry
Adrienne Pak, OD	Optometry
Aaron Rosenstrin OD	Optonetry
POBERT ROSENSTEIN, OD	OPTOMETRY
Shep Hamridgos	

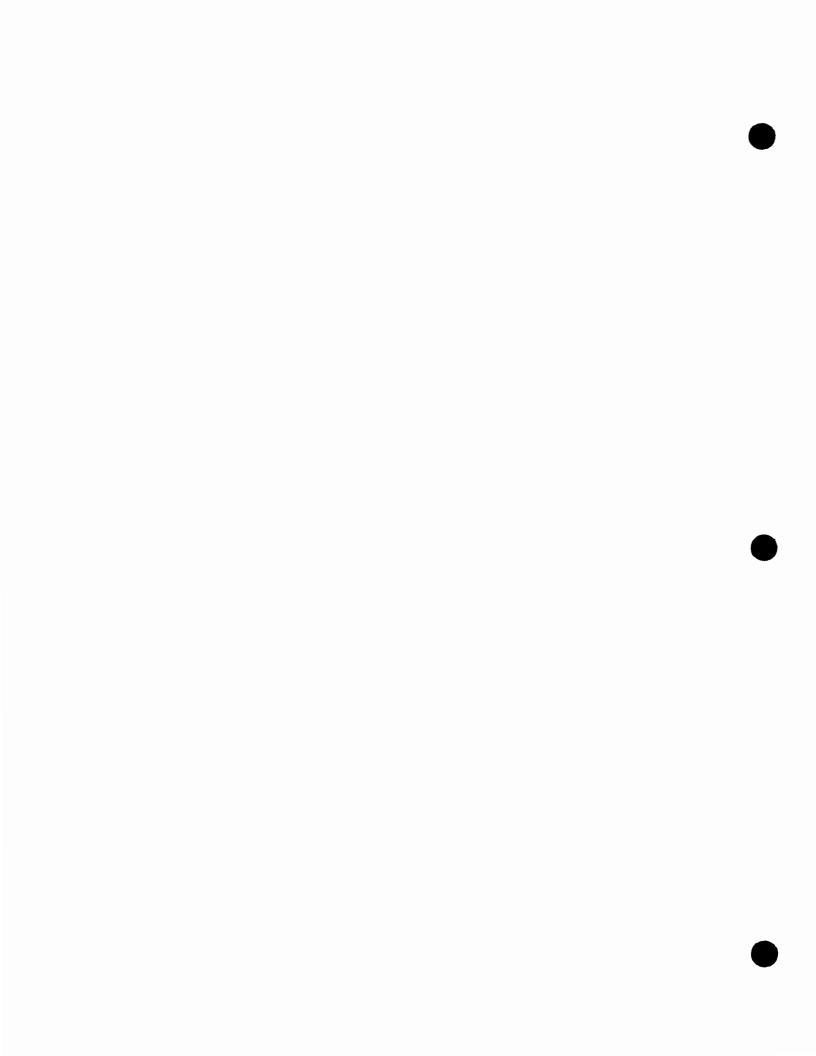
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02/29/17 3/1/17

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Laura De Vivo	DZS
Monica Galony	Barton College SW
Alisha Moore	Barton College
Hannah Cashell	Barton College
Tom Akers I	optometrist
Michael Samuels	optometrist
Mark Nowwen	6 Jourty
MICHAEL HAINES 00	OPTOMETRIST
ara Lieberman	Optometry
W.Chric Holland	Optomot rit
Haley Perry	b ptametry



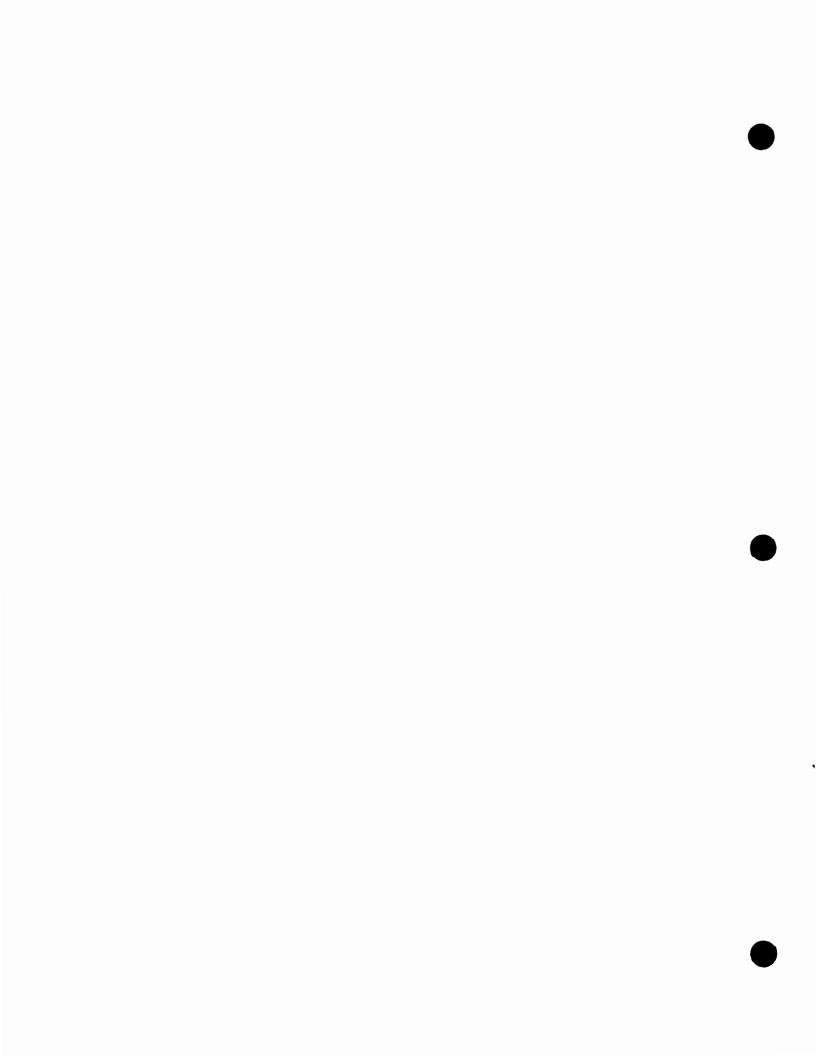
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John Hardin	MFS
Marilya Avila	Rep Stevens
Andrew May, 00	Johnson Optometre Associates Garner, No
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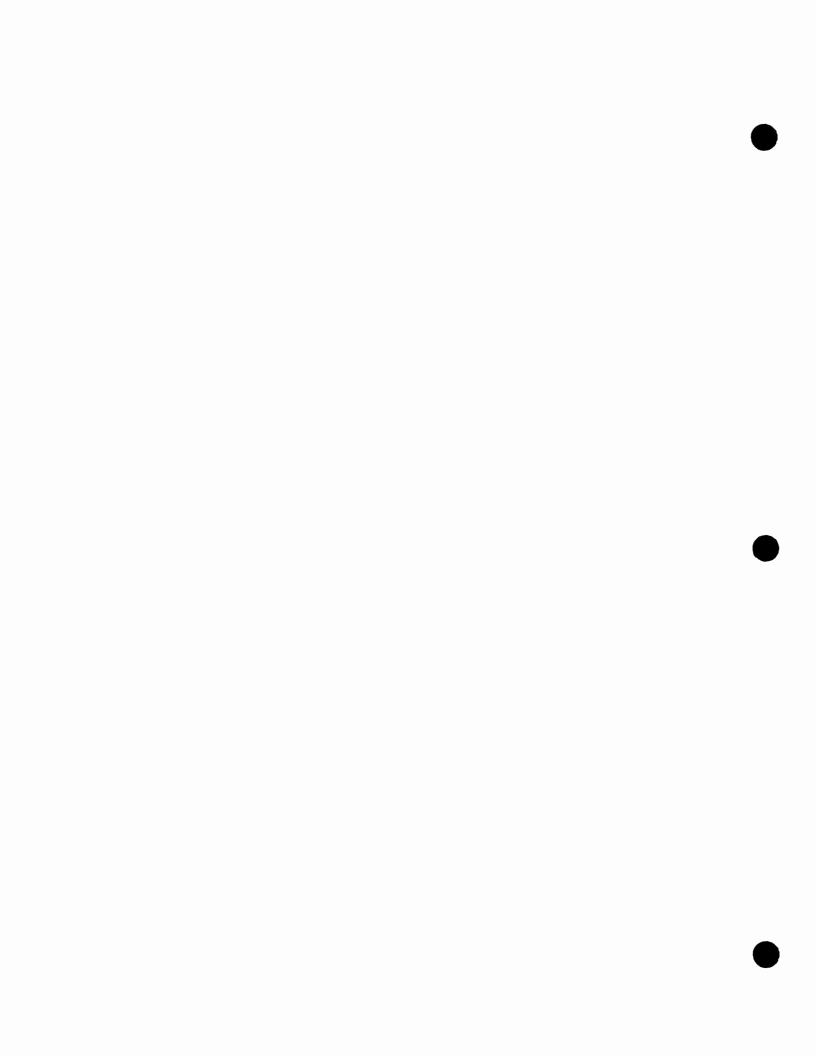


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Ken Statsick	Optometrist
VEFT STRAND	OPTOMETRIST
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DR BOD JOHNSON	· Optometrist
Du Kenny Bumagarner	Optometrist
Dr Peter K Dunn	Optometrist
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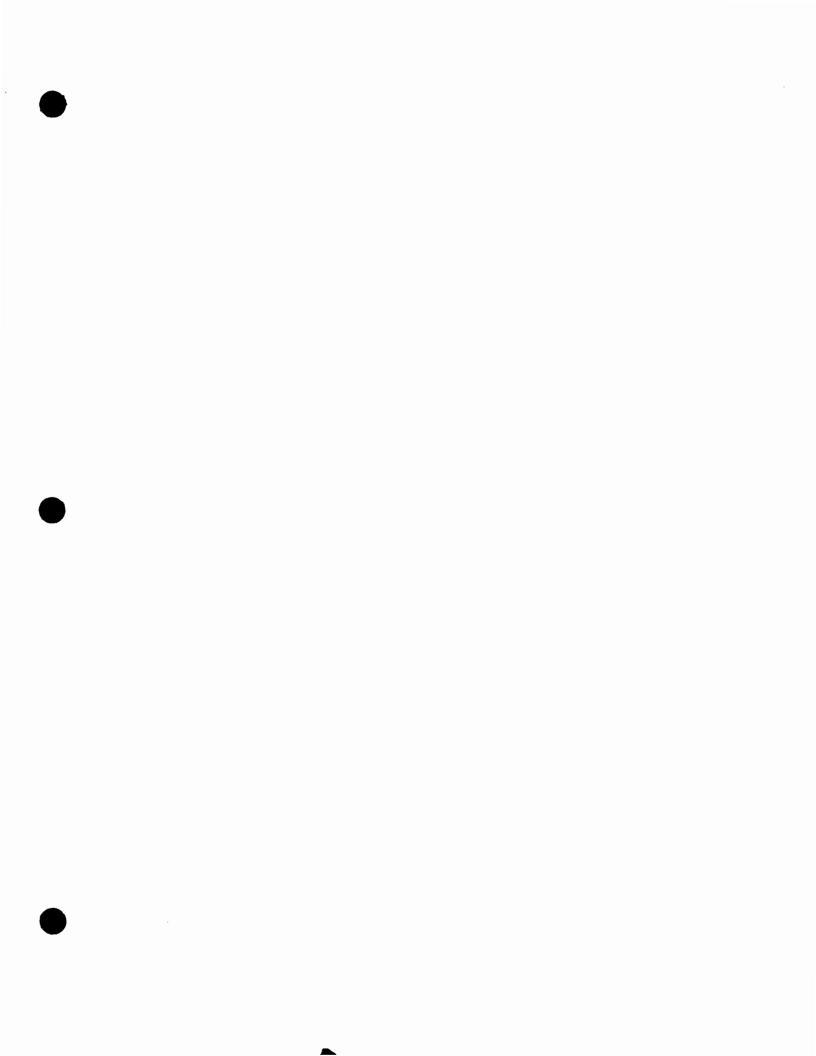
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C. Savid Miller	Optometrist
caroline Miller	AMGA
Marisa Ingraham	Social Work Student
Allie Johnson	Merdin soin student
Lori Kroll	Nova & Health
Keshav Bhat	optomotrist
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Dave Home	Smith And
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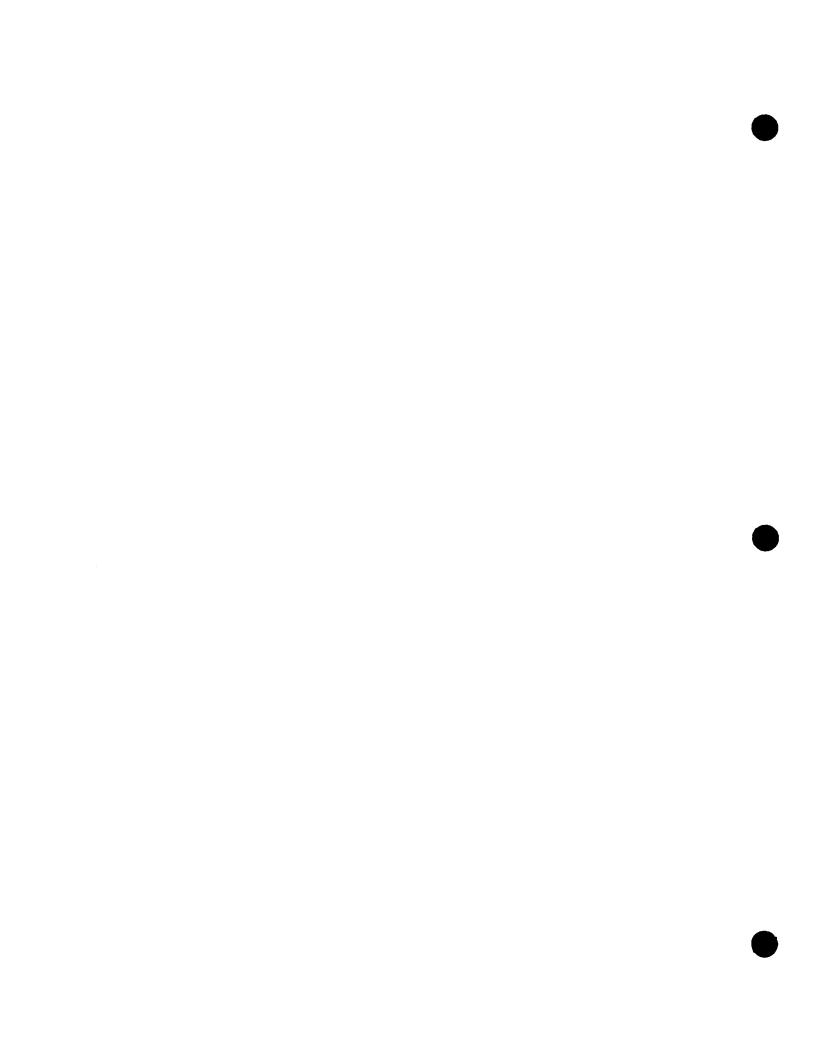
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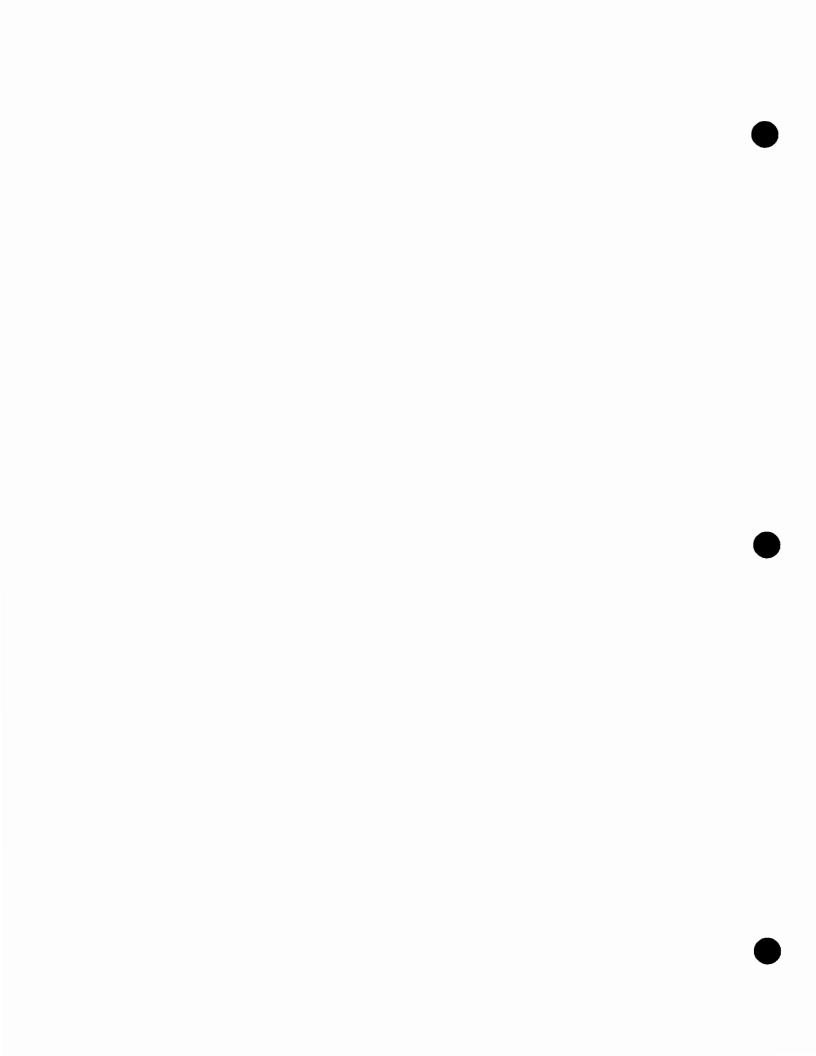
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Adam Rothman MD	Duke Eye Center, resident physician
CHRISTAHER WELLEMA	DUKE EYE CENTER , CHLOFAGA PLASTEL SUR
Michael Taggart MD	UNC Eye Center, resident physician
Lauren Rushing MO	UNC Eye Center, Resident physician
CHEIS HUMM, MD	UN EYE CHARR, PERDENT THYSICIAL
Gargi K. Vora, MD	Duke Eye Center, Attending Physician
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Christine Craig	wakeMed
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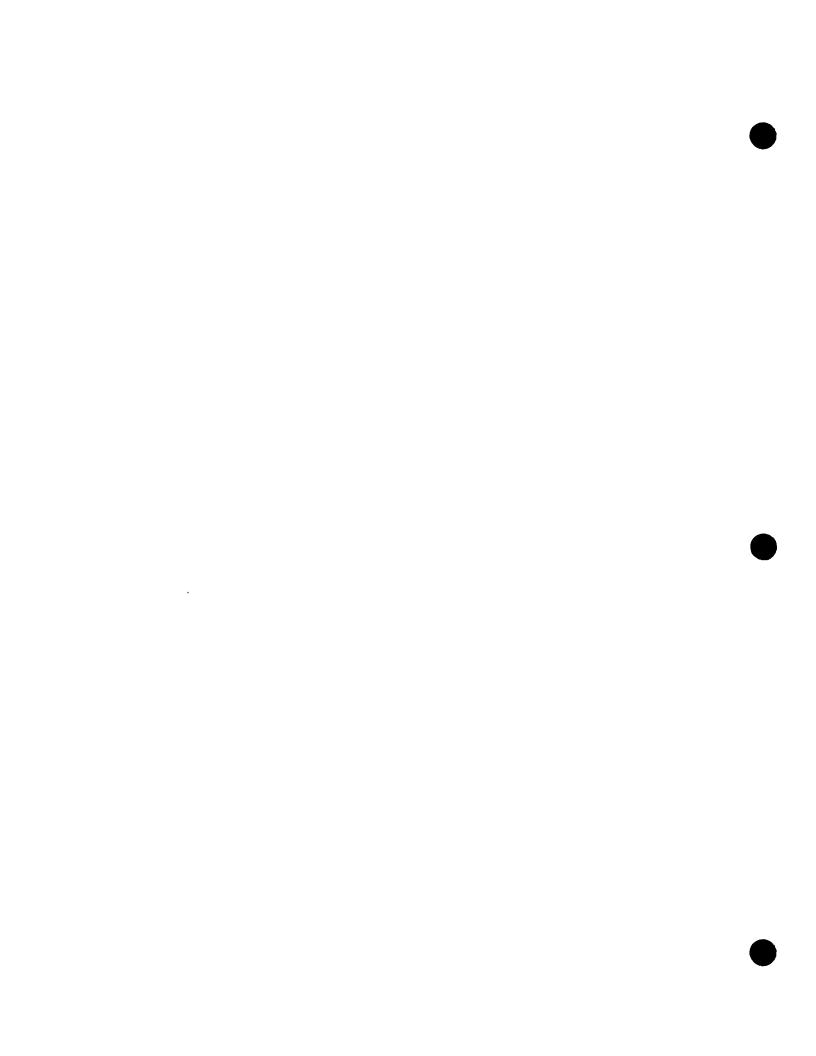
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Milliel Johnson	waxhan NC
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HAL HEARING OD	· FAIRMONT NC
Amix Khashrenis, 00	Charlotte, NC
Rachael Wruble, OD	charlotte, NC
Andy HANNED	Mathews XC
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Margnente Gross OD	Cary NC
MARCIA DETTLOFF, OD	CARY, Ne
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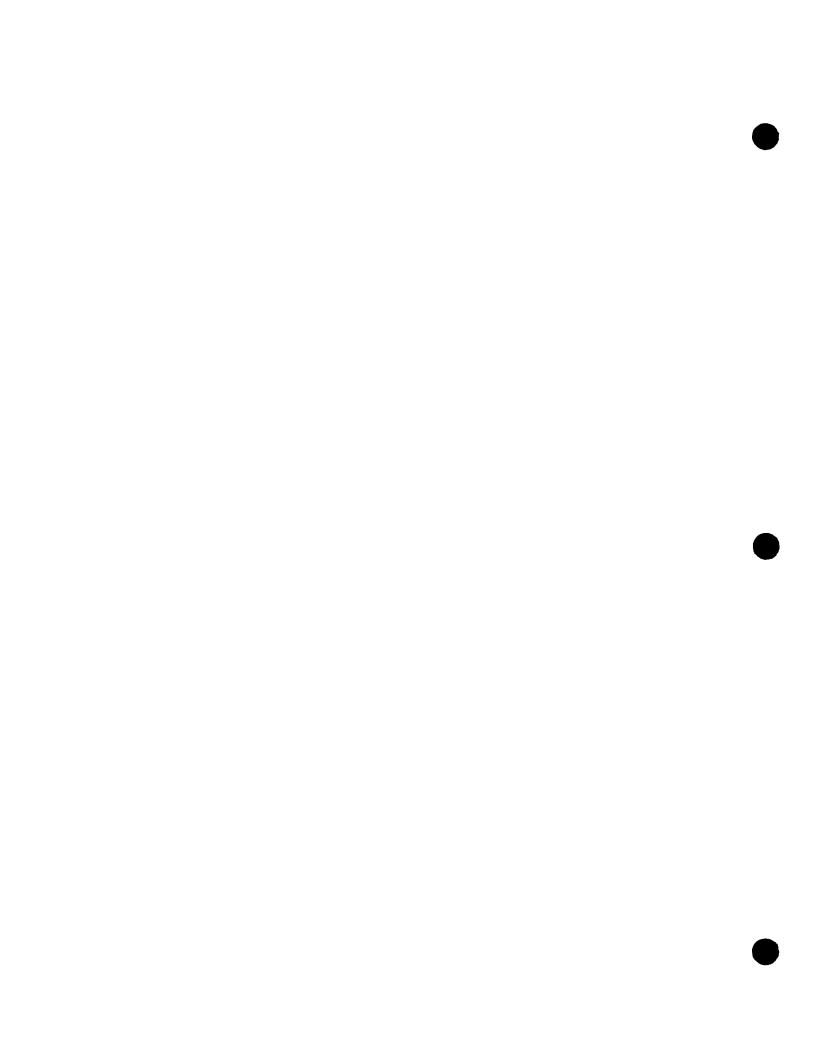
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Shana Rubino Mo	
Kevin O'Neal, MD, PhD	Cary Eye Center 950 Ophthalmais, Associator,
Sara Stoneburner, MD	gso Ophthalmaly, Associates, Access bors, NC
Rachel Tesser, MD	
James Bryon, MO	CHARLE HELL NE
Will Brackord	Whiston Salem, NC



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5-06
NC optometry Board.

House Committee Health 3/1/17 Firm or agency and Adress Name SUSAN VISNIMESKI MID MAU Bob Pamer 30 FSt. NW #460 Levi Kouffman mo Chad Brasugar, MD Wru Paul J. Dichiss- Mp Lm Off. of RUC PLCC Dick Coller C55 JUB mon DMalha Haleh, my NCDHHS Ben Popkin Walk West Lannie Crease ROBERT S. HAMMONDOD

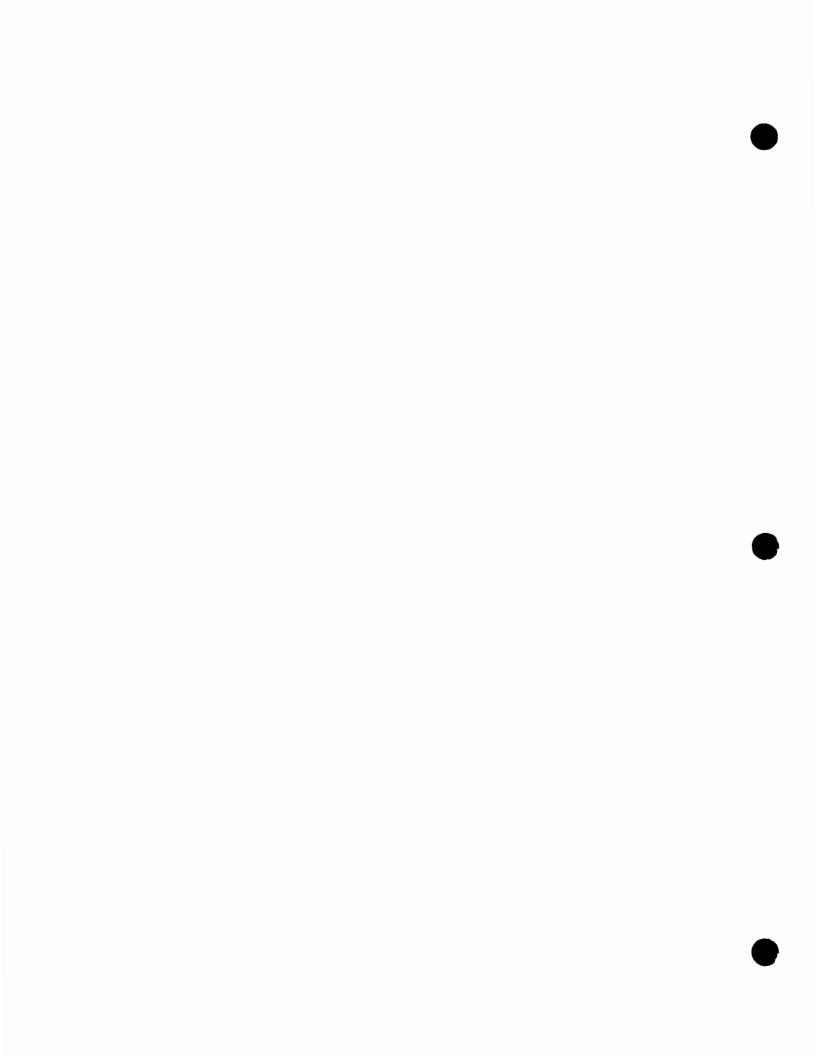
House Committee Health

02/29/17 3/1/17

Name of Committee

Date

NAME	FIRM OR AGENCY AND ADDRESS	
John Del Glords DR J. David Apock	Brubaker + Acroc.	
DR J. David Aycock	NC optometrist	
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House Committee on Health Wednesday, March 8, 2017 at 11:00 AM Room 643 of the Legislative Office Building

MINUTES

The House Committee on Health met at 11:00 AM on March 8, 2017 in Room 643 of the Legislative Office Building. Representatives Adcock, Ball, Blackwell, Boswell, Burr, Carney, Cunningham, Dobson, Dollar, Dulin, Earle, Ford, Howard, Hunter, Insko, Jackson, Bert Jones, Lucas, Malone, Murphy, Potts, Rogers, Setzer, Shepard, Szoka, Wray, Yarborough, and Zachary attended.

Representative Gregory F. Murphy, MD, Chair, presided.

The following bills were considered:

HB 156 Eyeglasses Exemption From Medicaid Capitation. (Representatives McNeill, Lambeth, Dobson, Brisson)

Rep. McNeill explained the bill. After questions from the Committee members, Rep. Shepard motioned for a Favorable Report for the bill. All being in favor, the bill passed.

HB 199 Establish Standards for Surgical Technology. (Representatives Murphy, Lambeth)

Rep. Murphy explained the bill after Rep. Jones took over as Chair of the Committee. HB 199 has a PCS. After discussion and questions from several members, Rep. Adcock motioned for Unfavorable to the Original Bill, favorable to the PCS. All in favor, HB 199 passed.

HB 243 Strengthen Opioid Misuse Prevention (STOP) Act. (Representatives Murphy, Davis, Malone, Horn)

Rep. Jones continued to chair, as Rep. Murphy explained the bill. He pointed out the increasing number of deaths resulting from use of Opioid drugs. Attorney General Josh Stein was recognized to speak in support of HB 243. Dr. Bobby Lowery, NC Board of Nursing, also spoke in support of this bill.

No vote was taken.

The meeting adjourned at 11:55.

Represe tative Gregory F. Murphy, MD, Chair

Brenda Olls, Committee Clerk



NORTH CAROLINA HOUSE OF REPRESENTATIVES COMMITTEE MEETING NOTICE AND BILL SPONSOR NOTIFICATION 2017-2018 SESSION

You are hereby notified that the House Committee on Health will meet as follows:

DAY & DATE: Wednesday, March 8, 2017

TIME: 11:00 AM LOCATION: 643 LOB

The following bills will be considered:

BILL NO. HB 156	SHORT TITLE Eyeglasses Exemption From Medicaid Capitation.	SPONSOR Representative McNeill Representative Lambeth Representative Dobson Representative Brisson
HB 199	Establish Standards for Surgical	Representative Murphy
	Technology.	Representative Lambeth
HB 243	Strengthen Opioid Misuse Prevention	Representative Murphy
	(STOP)Act.	Representative Davis
		Representative Malone
		Representative Horn

Respectfully,

Representative Justin P. Burr, Co-Chair Representative Josh Dobson, Co-Chair Representative Bert Jones, Co-Chair Representative Donny Lambeth, Co-Chair Representative Gregory F. Murphy, MD, Co-Chair

I hereby certify this notice was filed by the committee assistant at the following Tuesday, March 07, 2017.	offices at 12:12 PM on
Principal Clerk Reading Clerk – House Chamber	

Brenda Olls (Committee Assistant)



Corrected #2: HB 243 will be FOR DISCUSSION ONLY.

NORTH CAROLINA HOUSE OF REPRESENTATIVES COMMITTEE MEETING NOTICE AND BILL SPONSOR NOTIFICATION 2017-2018 SESSION

You are hereby notified that the House Committee on Health will meet as follows:

DAY & DATE: Wednesday, March 8, 2017

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HB 199	Establish Standards for Surgical Technology.	Representative Murphy Representative Lambeth
HB 243	Strengthen Opioid Misuse Prevention (STOP)Act.	Representative Murphy Representative Davis Representative Malone Representative Horn

Respectfully,

Representative Justin P. Burr, Co-Chair Representative Josh Dobson, Co-Chair Representative Bert Jones, Co-Chair Representative Donny Lambeth, Co-Chair Representative Gregory F. Murphy, MD, Co-Chair

I hereby certify this notice was filed by the committee assistant at the following offices at 3:06 PM on Tuesday, March 07, 2017.

Principal Clerk	
Reading Clerk - House	Chambe

Brenda Olls (Committee Assistant)



House Committee on Health Wednesday, March 8, 2017, 11:00 AM 643 Legislative Office Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

BILL NO.	SHORT TITLE	SPONSOR
HB 156	Eyeglasses Exemption From Medicaid	Representative McNeill
	Capitation.	Representative Lambeth
		Representative Dobson
		Representative Brisson
HB 199	Establish Standards for Surgical	Representative Murphy
	Technology.	Representative Lambeth
HB 243	Strengthen Opioid Misuse Prevention	Representative Murphy
	(STOP)Act.	Representative Davis
		Representative Malone
		Representative Horn

Presentations

Other Business

Adjournment





HOUSE BILL 156: Eyeglasses Exemption From Medicaid Capitation.

2017-2018 General Assembly

Committee: House Health Date: March 8, 2017
Introduced by: Reps. McNeill, Lambeth, Dobson, Brisson
Analysis of: First Edition Prepared by: Staff Attorney

OVERVIEW: House Bill 156 would exempt the coverage of eyeglasses from the services that will be covered by Prepaid Health Plans under Medicaid transformation and would allow payment for eyeglasses to continue under existing arrangements.

BILL ANALYSIS: Medicaid transformation legislation, S.L. 2015-245, as amended by S.L. 2016-121, requires transition of the current Medicaid and NC Health Choice service delivery system to capitated contracts with Prepaid Health Plans (PHPs). Beginning 18 months after federal approval for the transformation is obtained, PHPs will receive a capitated per enrollee/per month payment to cover all services currently covered by the Medicaid and NC Health Choice programs, except for specified services.

Section 1 of the bill adds the fabrication of eyeglasses, including complete eyeglasses, eyeglass lenses, and ophthalmic frames, to the list of services that will not be included in the service package covered by PHPs. This would allow reimbursement for eyeglasses to continue under existing arrangements.

EFFECTIVE DATE: This act is effective when it becomes law.

CURRENT LAW / BACKGROUND: Eyeglasses are covered for Medicaid beneficiaries under the age of 21 and NC Health Choice beneficiaries aged 6 through 18, pursuant to G.S. 108A-70.21(b)(2) and Medicaid and Health Choice Clinical Coverage Policy 6A. The Department of Public Safety Nash Optical Plant Optical Laboratory is the optical laboratory contracted by the Department of Health and Human Services (DHHS), Division of Medical Assistance, to fabricate eyeglasses for Medicaid and NC Health Choice beneficiaries. When Medicaid transformation is implemented, the State will no longer contract directly with providers for services that are covered by PHPs. Services that are not covered by PHPs but are covered by Medicaid and NC Health Choice will continue to be covered through other payment arrangements established by DHHS.

Karen Cochrane-Brown Director



Legislative Analysis Division 919-733-2578



GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2017

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HOUSE BILL 156

(Public) Short Title: Eyeglasses Exemption From Medicaid Capitation. Representatives McNeill, Lambeth, Dobson, and Brisson (Primary Sponsors). Sponsors: For a complete list of sponsors, refer to the North Carolina General Assembly web site. Referred to: Health February 22, 2017 A BILL TO BE ENTITLED AN ACT TO EXEMPT THE FABRICATION OF EYEGLASSES FROM CAPITATED PREPAID HEALTH PLAN CONTRACTS UNDER MEDICAID TRANSFORMATION. The General Assembly of North Carolina enacts: **SECTION 1.** Subsection (4) of Section 4 of S.L. 2015-245, as amended by Section 2(b) of S.L. 2016-121, reads as rewritten: Services covered by PHPs. - Capitated PHP contracts shall cover all Medicaid and NC Health Choice services, including physical health services, prescription drugs, long-term services and supports, and behavioral health services for NC Health Choice recipients, except as otherwise provided in this subdivision. The capitated contracts required by this subdivision shall not cover: Behavioral health services for Medicaid recipients currently covered by a. entities/managed care management (LME/MCOs) for four years after the date capitated contracts begin. Dental services. b. Services provided through the Program of All-Inclusive Care for the c. Elderly (PACE). Audiology, speech therapy, occupational therapy, physical therapy, d. nursing, and psychological services prescribed in an Individualized Education Program (IEP) and performed by schools or individuals contracted with Local Education Agencies. Services provided directly by a Children's Developmental Services e. Agency (CDSA) or by a provider under contract with a CDSA if the service is authorized through the CDSA and is included on the child's Individualized Family Service Plan. Services for Medicaid program applicants during the period of time f. prior to eligibility determination. The fabrication of eyeglasses, including complete eyeglasses, eyeglass g.



lenses, and ophthalmic frames."

SECTION 2. This act is effective when it becomes law.



HOUSE BILL 199: Establish Standards for Surgical Technology.

2017-2018 General Assembly

Committee: House Health

Introduced by: Reps. Murphy, Lambeth Analysis of: PCS to First Edition

H199-CSTA-2

Date: March 7, 2017

Prepared by: Jennifer Mundt

Committee Staff

OVERVIEW: House Bill 199 would create standards for surgical technology care in both hospitals and ambulatory surgical facilities.

The PCS for House Bill 199 makes technical, conforming, and other related changes to the 1st Edition of the bill.

BILL ANALYSIS: House Bill 199 would create new sections in Part 2 of Article 5 and Part 4 of Article 6 of Chapter 131E of the General Statutes pertaining to hospital and ambulatory surgical facility (ASF) licensure respectively, that establish standards for the employment and contract of surgical technologists in both hospitals and ASFs as follows:

Qualifications for employment: Hospitals and AFSs must not employ or contract with a surgical technologist unless the individual provides evidence of one of the following four criteria:

- Successful completion of a program accredited by the Commission on Accreditation of Allied Health Education Programs or another nationally accredited educational program for surgical technologists and holds and maintains the Certified Surgical Technologist credential issued by the National Board of Surgical Technology and Surgical Assisting (NBSTSA or Board).
- 2. Successful completion of an appropriate training program for surgical technology in the United States Armed Forces or United States Public Health Service.
- 3. Documentation of either: (i) employment practicing surgical technology in a licensed hospital or ASF on December 31, 2017, or (ii) employment practicing surgical technology during the two years immediately preceding December 31, 2017.
- 4. Practice of surgical technology as an employee of an agency or institution of the federal government.

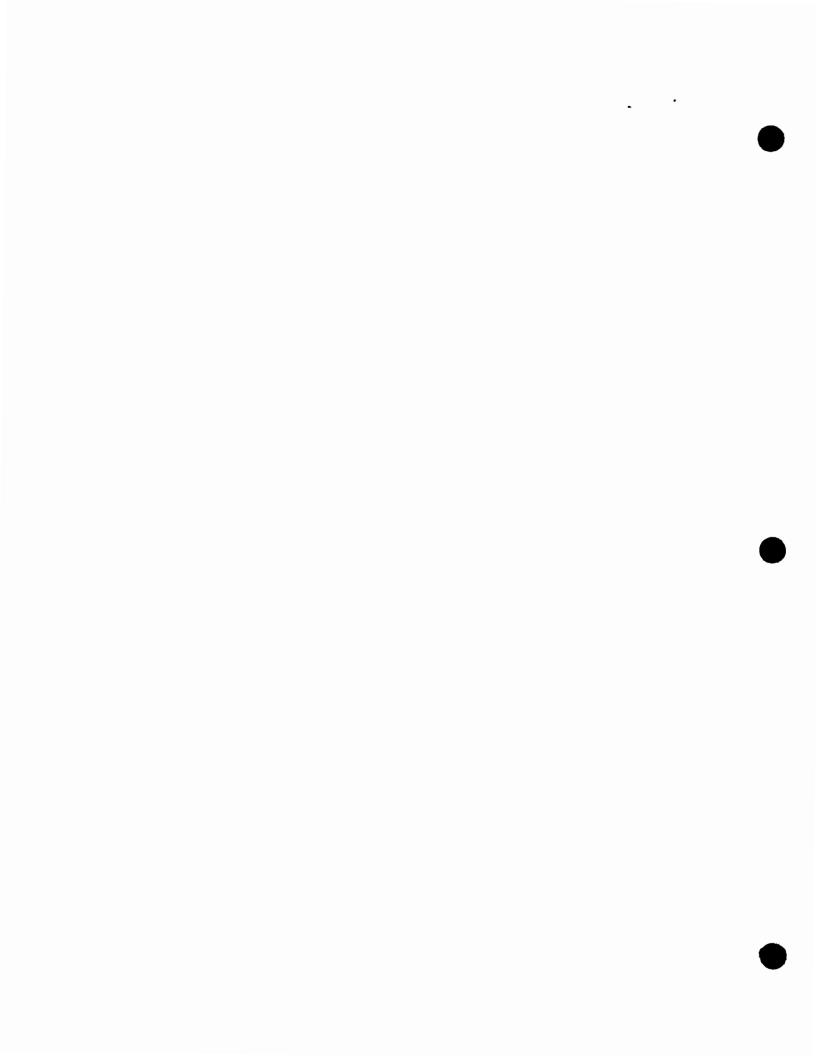
<u>Probationary practice:</u> Hospitals and ASFs may employ or contract with an individual during the 12 months that follow their completion of an accredited surgical technology program. However, hospitals and ASFs may not continue to employ or contract with such an individual beyond the initial 12 months without documentation that the employee or contractor holds and maintains a Certified Surgical Technologist credential issued by the Board.

Continuing education: Hospitals and ASFs may employ or contract with an individual to practice surgical technology who qualifies based on their completion of training in the U.S. Armed Forces or

Karen Cochrane-Brown Director



Legislative Analysis Division 919-733-2578



House PCS 199

Page 2 .

documentation of previous employment (items 2, 3 or 4 above), provided the individual annually completes 15 hours of Board-approved continuing education.

<u>Verification of continuing education or credential</u>: Hospitals and ASFs that employ or contract with an individual to practice surgical technology must either verify that the individual satisfies the continuing education requirements or verify that the individual holds and maintains the Certified Surgical Technologist credential.

<u>Exceptions:</u> Hospitals and AFSs may employ or contract with a surgical technologist who does not meet any of the four qualifying criteria if the following requirements are met:

- 1. The hospital or ASF makes a diligent and thorough effort and, after completion of such an effort, is unable to employ or contract with a sufficient number of qualified surgical technologists who satisfy the four qualifying criteria.
- 2. The hospital or ASF documents and retains, on the hospital premises, a written record of its efforts made to employ or contract with a sufficient number of qualified surgical technologists.

<u>Scope of practice:</u> a clarifying provision to state that the new statutes not to be construed to prohibit a licensed practitioner from performing surgical technology tasks or functions if the practitioner is acting within the scope of their license.

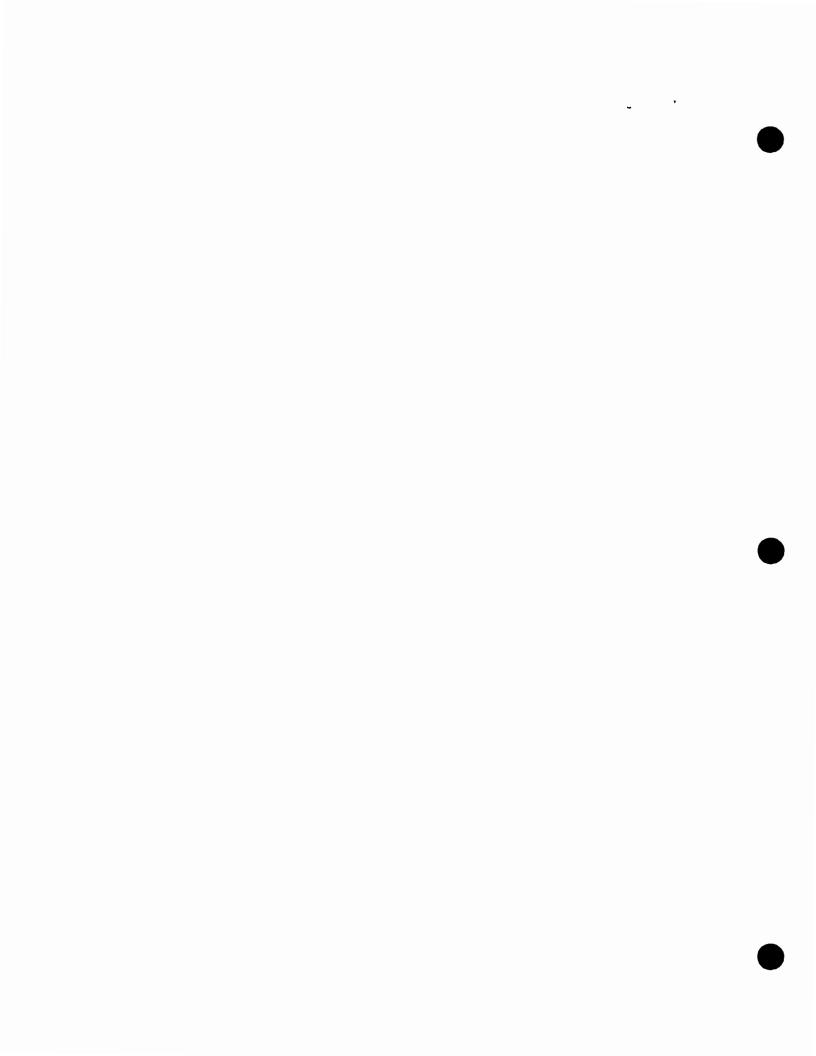
Adverse action: The Department of Health and Human Services may take adverse action against a hospital or ASF for a violation of these provisions.

EFFECTIVE DATE: This act would become effective January 1, 2018.

BACKGROUND: According to the Commission on Accreditation of Allied Health Education Programs (Commission or CAAHEP), *surgical technologists* are an integral part of the team of medical practitioners providing surgical care to patients in a variety of settings. Surgical patient care includes preparing the operating room and the sterile field for surgical procedures by ensuring that surgical equipment is functioning properly and safely and preparing sterile supplies, instruments, and equipment using sterile technique, and as directed by the surgical team, performing tasks in the sterile field.

The Commission is a programmatic postsecondary accrediting agency recognized by the Council for Higher Education Accreditation and carries out its accrediting activities in cooperation with 23 review committees. CAAHEP currently accredits over 2,100 entry level education programs in 28 health science professions.

The National Board of Surgical Technology and Surgical Assisting (NBSTSA) is the certifying agency for surgical technologists. The NBSTSA's duty is to determine, through examination, if an individual has acquired both theoretical and practical knowledge of surgical technology. Certification, while voluntary, demonstrates that the individual meets the national standard for knowledge that underlies surgical technologist practice. Certified individuals possess a mastery of a broad range of skills related to surgical procedures, aseptic technique, and patient care.



GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2017

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HOUSE BILL 199

Short Title: (Public) Establish Standards for Surgical Technology. Representatives Murphy and Lambeth (Primary Sponsors). Sponsors: For a complete list of sponsors, refer to the North Carolina General Assembly web site. Referred to: Health February 28, 2017 A BILL TO BE ENTITLED AN ACT ESTABLISHING STANDARDS FOR SURGICAL TECHNOLOGY CARE IN HOSPITALS AND AMBULATORY SURGICAL FACILITIES. The General Assembly of North Carolina enacts: SECTION 1. Part 2 of Article 5 of Chapter 131E of the General Statutes is amended by adding a new section to read: "§ 131E-79.3. Hospital standards for surgical technology care. Definitions. - The following definitions apply in this section: (a) Surgical technologist. - An individual who is employed or contracted by a (1) hospital to perform surgical technology tasks and functions. Surgical technology. - Surgical patient care that includes the following tasks or (2) functions: Preparing the operating room and the sterile field for surgical <u>a.</u> procedures by ensuring that surgical equipment is functioning properly and safely and preparing sterile supplies, instruments, and equipment using sterile technique. As directed, performing tasks at the sterile field, including the b. following: (1)Maintaining asepsis and correcting breaks in the sterile field. Passing supplies, equipment, or instruments according to the (2)needs of the surgical team. Sponging or suctioning an operative site. (3)Preparing and cutting suture material. (4) Transferring and irrigating with fluids. (5)Transferring but not administering drugs within the sterile field. (6)Handling specimens. (7)(8)Holding retractors and other instruments. Applying electrocautery to clamps on bleeders. (9) (10)Connecting drains to suction apparatus. Applying dressings to closed wounds. (11)Performing sponge, needle, supply, and instrument counts with (12)the registered nurse circulator. Except as provided in subsection (f) of this section, a hospital shall not employ or otherwise contract for the services of a surgical technologist in that hospital unless the individual



meets at least one of the following qualifications:

- (1) Has successfully completed a program accredited by the Commission on Accreditation of Allied Health Education Programs or other nationally accredited educational program for surgical technologists and holds and maintains the Certified Surgical Technologist credential administered by the National Board of Surgical Technology and Surgical Assisting or its successor. Has successfully completed an appropriate training program for surgical <u>(2)</u> technology in the United States Army, Navy, Air Force, Marine Corps, or Coast Guard or in the United States Public Health Service.
 - Provides evidence that the individual meets either of the following requirements:
 - a. Was employed to practice surgical technology in a hospital licensed under this Part or an ambulatory surgical facility licensed under Part 4 of Article 6 of this Chapter on December 31, 2017.
 - b. Was employed to practice surgical technology during the two years immediately preceding December 31, 2017.
 - (4) <u>Is in the service of the federal government, to the extent the individual is performing duties related to that service.</u>
 - (c) A hospital may employ or contract with an individual to practice surgical technology during the 12-month period immediately following successful completion of a surgical technology program described in subdivision (1) of subsection (b) of this section but may not continue to employ or contract with that individual beyond this initial 12-month period without documentation that the employee or contractor holds and maintains the certified surgical technologist credential described in subdivision (1) of subsection (b) of this section.
 - (d) A hospital may employ or contract with an individual who qualifies to practice surgical technology pursuant to subdivision (2) or (3) of subsection (b) of this section as long as that individual annually completes 15 hours of continuing education approved by the National Board of Surgical Technology and Surgical Assisting or its successor.
 - (e) A hospital that employs or contracts with an individual to practice surgical technology shall verify that the individual meets the continuing education requirements of subsection (d) of this section or, if applicable, that the individual holds and maintains the Certified Surgical Technologist credential described in subdivision (1) of subsection (b) of this section.
 - (f) A hospital may employ or otherwise contract with an individual who does not meet any of the qualifications specified in subsection (b) of this section if both of the following requirements are met:
 - (1) The hospital makes a diligent and thorough effort, but was unable to employ or contract with a sufficient number of qualified surgical technologists who meet the requirements of this section.
 - (2) The hospital makes and retains, at the hospital, a written record of its effort under subdivision (1) of this subsection.
 - (g) Nothing in this section shall be construed to prohibit a licensed practitioner from performing surgical technology tasks or functions if the practitioner is acting within the scope of his or her license.
 - (h) The Department of Health and Human Services may take adverse action against a hospital under G.S. 131E-78 for a violation of this section."
 - **SECTION 2.** Part 4 of Article 6 of Chapter 131E of the General Statutes is amended by adding a new section to read:
 - "§ 131E-147.10. Ambulatory surgical facility standards for surgical technology care.
 - Definitions. The following definitions apply in this section:
 Surgical technologist. An individual who is employed or contracted by an ambulatory surgical facility to perform surgical technology tasks and functions.

(a)

section as long as that individual annually completes 15 hours of continuing education approved 1 2 by the National Board of Surgical Technology and Surgical Assisting or its successor. 3 An ambulatory surgical facility that employs or contracts with an individual to practice surgical technology shall verify that the individual meets the continuing education requirements of 4 subsection (d) of this section or, if applicable, that the individual holds and maintains the Certified 5 Surgical Technologist credential described in subdivision (1) of subsection (b) of this section. 6 An ambulatory surgical facility may employ or otherwise contract with an individual 7 8 who does not meet any of the qualifications specified in subsection (b) of this section if both of the 9 following requirements are met: 10 (1)The facility makes a diligent and thorough effort but was unable to employ or contract with a sufficient number of qualified surgical technologists who meet 11 12 the requirements of this section. 13 (2)The facility makes and retains, at the facility, a written record of its effort under subdivision (1) of this subsection. 14 Nothing in this section shall be construed to prohibit a licensed practitioner from 15 16 performing surgical technology tasks or functions if the practitioner is acting within the scope of 17 his or her license. The Department of Health and Human Services may take adverse action against an 18 (h) ambulatory surgical facility under G.S. 131E-148 for a violation of this section." 19

SECTION 3. This act becomes effective January 1, 2018.

GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2017

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HOUSE BILL 199 PROPOSED COMMITTEE SUBSTITUTE H199-CSTA-2 [v.3]

03/07/2017 05:45:53 PM Short Title: Establish Standards for Surgical Technology.

(Public)

Sponsors:
Referred to:

February 28, 2017

					, , , , , , , , , , , , , , , , , , , ,
1					A BILL TO BE ENTITLED
2	AN AC	T EST.	ABLISH	HING S	STANDARDS FOR SURGICAL TECHNOLOGY CARE IN
3	HOS	PITALS	AND	AMBUL	LATORY SURGICAL FACILITIES.
4	The Gen	eral Ass	embly o	f North	Carolina enacts:
5					of Article 5 of Chapter 131E of the General Statutes is amended
6	by addin				
7	"§ 131E-	79.3. H	lospital	standa	rds for surgical technology care.
8	<u>(a)</u>	Defin	itions	The fo	llowing definitions apply in this section:
9		(1)	Surgio	cal tech	nologist An individual who is employed or contracted by a
10			hospit	al to pe	rform surgical technology tasks and functions.
11		<u>(2)</u>	Surgio	cal techi	nology Surgical patient care that includes the following tasks or
12			functi	ons:	
13			<u>a.</u>	Prepar	ring the operating room and the sterile field for surgical
14					dures by ensuring that surgical equipment is functioning properly
15					afely and preparing sterile supplies, instruments, and equipment
16					sterile technique.
17			<u>b.</u>		rected by the surgical team, performing tasks in the sterile field,
18					ing the following:
19				(1)	Maintaining asepsis and correcting breaks in the sterile field.
20				<u>(2)</u>	Passing supplies, equipment, or instruments according to the
21				(0)	needs of the surgical team.
22				<u>(3)</u>	Sponging or suctioning an operative site.
23				<u>(4)</u>	Preparing and cutting suture material.
24				<u>(5)</u>	Transferring and irrigating with fluids.
25				<u>(6)</u>	Transferring, but not administering, drugs within the sterile field.
26				<u>(7)</u>	Handling specimens.
27				(8)	Holding retractors and other instruments.
28				<u>(9)</u>	Applying electrocautery to clamps on bleeders.
29				(10)	Connecting drains to suction apparatus.
30				(11)	Applying dressings to closed wounds.
31				<u>(12)</u>	Performing sponge, needle, supply, and instrument counts with
32	(1-)	01	Č* 4*	· C	the registered nurse circulator.
33	(<u>b</u>)				inployment or contract. – Except as provided by subsection (f) of
34					ot employ or otherwise contract for the services of a surgical
35	technolog	gist in t	nat hos	pital un	tless the individual meets, at a minimum, one of the following



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qualifications:



- of qualified surgical technologists who satisfy the requirements of this section.
- (2)The hospital documents and retains, on the hospital premises, a written record of its efforts made pursuant to subdivision (1) of this subsection.
- Scope of practice. Nothing in this section shall be construed to prohibit a licensed practitioner from performing surgical technology tasks or functions if the practitioner is acting within the scope of his or her license.
- Adverse action. The Department of Health and Human Services may take adverse action against a hospital under G.S. 131E-78 for a violation of this section."

SECTION 2. Part 4 of Article 6 of Chapter 131E of the General Statutes is amended by adding a new section to read:

"§ 131E-147.2. Ambulatory surgical facility standards for surgical technology care.

Definitions. – The following definitions apply in this section: (a)

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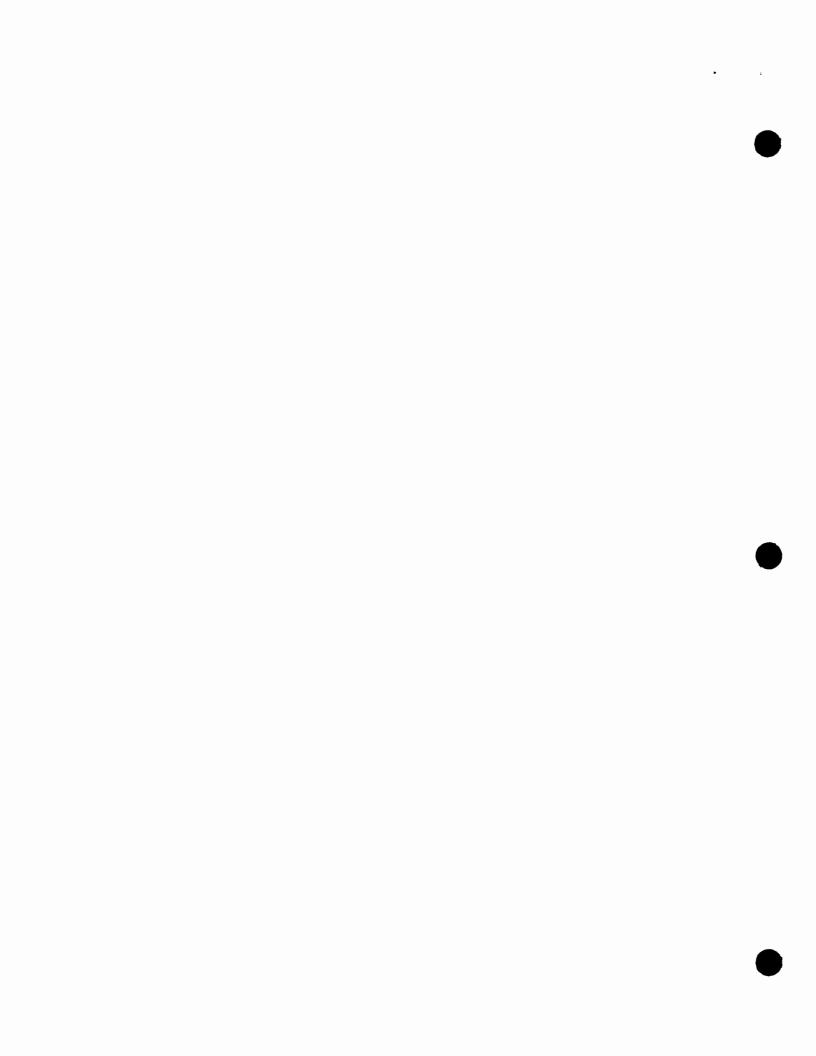
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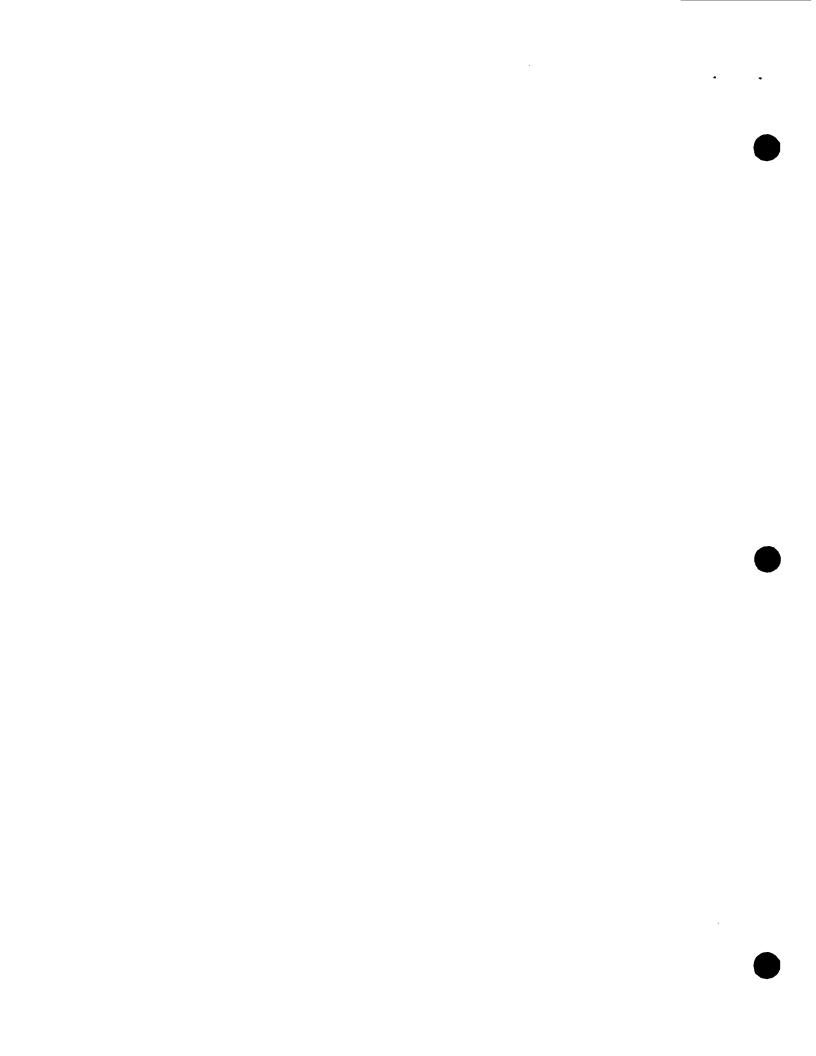
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maintains the certified surgical technologist credential as described in subdivision (1) of subsection (b) of this section.

- Continuing education. An ambulatory surgical facility may employ or contract with an individual who qualifies to practice surgical technology pursuant to subdivisions (2), (3), or (4) of subsection (b) of this section, provided the individual annually completes 15 hours of continuing education approved by the National Board of Surgical Technology and Surgical Assisting or its successor.
- Verification of continuing education or credential. An ambulatory surgical facility (e) that employs or contracts with an individual to practice surgical technology shall verify that the individual satisfies the continuing education requirements of subsection (d) of this section or, if applicable, that the individual holds and maintains the Certified Surgical Technologist credential as described in subdivision (1) of subsection (b) of this section.
- Exception. An ambulatory surgical facility may employ or otherwise contract with an individual who does not meet any of the qualifications specified in subsection (b) of this section if both of the following requirements are met:
 - The ambulatory surgical facility makes a diligent and thorough effort, and after (1) such an effort is completed, the facility is unable to employ or contract with a sufficient number of qualified surgical technologists who satisfy the requirements of this section.
 - The ambulatory surgical facility documents and retains, on the facility (2) premises, a written record of its efforts made pursuant to subdivision (1) of this subsection.
- Scope of practice. Nothing in this section shall be construed to prohibit a licensed practitioner from performing surgical technology tasks or functions if the practitioner is acting within the scope of his or her license.
- Adverse action. The Department of Health and Human Services may take adverse action against an ambulatory surgical facility under G.S. 131E-148 for a violation of this section." **SECTION 3.** This act becomes effective January 1, 2018.

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HOUSE BILL 243: Strengthen Opioid Misuse Prevention (STOP) Act.

2017-2018 General Assembly

Committee: House Health. If favorable, re-refer to Date: March 8, 2017

Appropriations

Introduced by: Reps. Murphy, Davis, Malone, Horn Prepared by: Augustus D. Willis

Analysis of: First Edition Jason Moran-Bates

Committee Co-Counsel

OVERVIEW: House Bill 243 would (i) extend the statewide standing order for opioid antagonists to allow practitioners to prescribe an opioid antagonist to any governmental or nongovernmental agency (ii) make changes to the laws for prescribing Schedule II through IV controlled substances, (iii) clarify the allowable funds for syringe exchange programs, (iv) make changes to the statutes governing the Controlled Substance Reporting System (CSRS) database, and (v) appropriate \$10 million in each of the next two fiscal years to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities and Substance Abuse for increasing the availability of community-based treatment and recovery services for substance abuse disorders.

[As introduced, this bill was identical to S175, as introduced by Sens. J. Davis, McInnis, Rabon, which is currently in an unknown committee.]

BILL ANALYSIS:

Part I. TITLE OF ACT

Section 1 sets forth the title of the act as the Strengthen Opioid Misuse Prevention (STOP) Act of 2017.

Part II. EXTEND STANDING ORDERS FOR OPIOID ANTAGONIST TO COMMUNITY HEALTH GROUPS

G.S. 90-12.7 sets forth statutes governing the prescribing of opioid antagonists for treatment of a drug overdose. These statutes allow a practitioner to, either directly or by standing order, prescribe an opioid antagonist to a person at risk of experiencing an opiate-related overdose, or their family member, friend, or other person in a position to assist such a person. In 2016, the General Assembly expanded this to allow the State Health Director to issue prescriptions to such persons by way of a statewide standing order.

Section 2 would amend the statutes on the treatment of overdoses with opioid antagonist to (1) allow the State Health Director to name a designee to prescribe an opioid antagonist by statewide standing order, and (2) allow practitioners to either directly, or by standing order, prescribe an opioid antagonist to any governmental or nongovernmental organization for the purpose of distribution to persons at risk of experiencing an opiate-related overdose or to a family member, friend, or other person in a position to assist such a person. Any organization distributing the opioid antagonist would be required to include with it basic instruction and information on how to administer it.

PART III. IMPROVE OPIOID PRESCRIBING PRACTICES

Karen Cochrane-Brown Director



Legislative Analysis Division 919-733-2578

House Bill 243

Page 2

Current law authorizes licensed physician assistants and nurse practitioners to write prescriptions so long as a supervising physician has provided written instructions for prescribing drugs and a written policy for periodic review by the physician of drugs prescribed.

Absent an emergency situation, the dispensing of Schedule II controlled substances generally requires a written prescription, made out no more than 6 months prior to the date the substance is dispensed, with an exception that no prescription is needed if the substance is dispensed directly by a practitioner to an ultimate user. Prescriptions for Schedule II controlled substances may not be refilled. Schedule III and IV controlled substances require a prescription no older than 6 months old and may not be refilled more than five times after the date of the prescription.

Section 3 would amend the statutes authorizing physician assistants to write prescriptions by requiring a physician assistant to consult with the supervising physician prior to prescribing controlled substances included in Schedules II through V if the therapeutic use of the controlled substance will or is expected to exceed a period of 30 days. For as long as a Schedule II through V controlled substance is continuously prescribed to the same patient, the physician assistant must consult with the supervising physician at least once every 90 days to verify that the prescription remains medically appropriate for the patient.

Section 4 would amend the statutes authorizing nurse practitioners to write prescriptions by including the same requirements in Section 3.

Section 5 would require electronic prescriptions for all controlled substances in Schedules II through V except for prescriptions issued by:

- A practitioner who is dispensing directly to an ultimate user.
- A practitioner who orders a controlled substance to be administered in a hospital, nursing home, hospice facility, or residential care facility.
- A practitioner who experiences temporary technological or electrical failure that prevents the prescription from being transmitted electronically and the reason for this exception is documented in the patient's medical record.
- A practitioner who writes a prescription to be dispensed by a pharmacy located on federal property and the reason for this exception is documented in the patient's medical record.

Prescriptions for controlled substances included in Schedules II through V would be limited to no more than a 5 day supply upon the initial consultation and treatment of a patient for acute pain, unless the prescription is for immediate post-operative pain relief, in which case the practitioner may not prescribe more than a 7-day supply. Upon any subsequent consultation for the same pain, the practitioner may issue any appropriate renewal, refill, or new prescription for a Schedule II through V controlled substance. Acute pain is defined as pain that the practitioner reasonably expects to last for three months or less and does not include chronic pain or pain being treated as part of cancer care, hospice care, palliative care, or medication-assisted treatment for substance use disorder. Chronic pain is defined as pain that typically lasts for longer than three months or that lasts beyond the time of normal tissue healing.

Section 6 would require any hospice or palliative care provider who prescribes a Schedule II through V controlled substance to be administered to a patient in the patient's home to make diligent efforts to ensure that any residual portion of the controlled substance is safely disposed of following the death of the patient.

Section 7 would add a new section to Article 51 of Chapter 58 of the General Statutes to require any insurance plan that charges a co-payment for prescription drugs to charge a co-payment for any limited, initial prescription of a Schedule II through Schedule V controlled substance. This co-payment would

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have to be either proportional to the amount charged for a thirty-day supply and the amount of the substance actually prescribed, or the full rate for a thirty-day supply, so long as no additional co-payment is charged for additional prescriptions of the same substance for the remainder of the thirty-day supply.

PART IV: CLARIFY ALLOWABLE FUNDS FOR SYRINGE EXCHANGE PROGRAMS

Section 8 would clarify language in the statute authorizing needle and syringe exchange programs to prohibit the use of State funds to purchase needles, hypodermic syringes, or other injection supplies. Non-State public funds could still be used for this purpose.

PART V: STRENGTHEN CONTROLLED SUBSTANCES REPORTING SYSTEM

The Controlled Substances Reporting System (CSRS) is a database maintained by the Department of Health and Human Services that tracks prescriptions for Schedule II through V controlled substances. Dispensers are required to report certain information on prescriptions they fill within 3 days after the prescription is delivered, but are encouraged to report such information within 24 hours. Such information is confidential and may only be accessed by certain persons for specific purposes set forth by statute.

Section 9 would make technical changes to the definitions used in the CSRS laws and define the term "pharmacy" as a person or entity who holds a valid pharmacy permit.

Section 10 would require dispensers to report required information within 24 hours of filling a prescription and would require the Department of Health and Human Services to assess civil penalties of up to \$250 for a first violation and up to \$500 for each subsequent violation, not to exceed \$10,000 per pharmacy in a calendar year to pharmacies found to have failed to report required information within a reasonable period of time after being informed that such information is missing or incomplete.

Section 11 would amend the laws governing the confidentiality of CSRS data to allow the Department to notify practitioners of prescribing behavior that increases risk of diversion of controlled substances, increases risk of harm to the patient, or is an outlier among other practitioner behavior.

Section 12 would amend the laws governing the confidentiality of CSRS data to add to the list of persons to whom the Department man release CSRS data (i) any third-party payer or pharmacy benefits manager acting as agent of a third-party payer for the purposes of claimant case management, (ii) detection of inappropriate prescribing of a controlled substance to a claimant, or (iii) detection of misuse or diversion of a controlled substance by a claimant.

Section 13 would add the following new sections to Article 5E of Chapter 90 of the General Statutes governing the CSRS:

- 90-113.74A: would require recipients of new or renewed pharmacist licenses to demonstrate to the NC Board of Pharmacy registration for access to the CSRS within 30 days of licensure.
- 90-113.74B: would require practitioners to review a patient's 12-month history in the CSRS prior to prescribing a Schedule II through Schedule V drug and review the patient's 12-month history in the CSRS every three months while the controlled substance remains part of the patient's medical care plan. These reviews would have to be documented in the patient's medical records, along with the occasion of any CSRS outage that prevents such a review; the practitioner would be required to review the 12-month history upon restoration of the CSRS after an outage. In addition, a practitioner would be able to, but not required to, review a patient's CSRS history if: 1) the controlled substance is to be administered to the patient in a hospital or other health care facility; 2) the controlled substance is for the treatment of cancer or a cancer-associated condition; 3) the controlled substance is prescribed to a patient in hospice care; or 4) the prescription is for five days or less and cannot be refilled, or is for seven days or less for relief of post-operative pain.

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- 90-113.74C: would require a dispenser to review an individual's 12-month history in the CSRS whenever: 1) the dispenser believes the individual is seeking controlled substances for reasons other than treatment of a medical condition; 2) the prescriber is located outside of the usual area the dispenser serves; 3) the individual lives outside the usual area the dispenser serves; 4) the individual pays with cash when there is an insurance plan on file with the dispenser; or 5) the individual demonstrates potential misuse of a controlled substance. A dispenser would be required to withhold delivery of a prescription until verified if the dispenser believes it to be duplicative or fraudulent.
- 90-113.75A: would create a special revenue fund in DHHS for use in administering the CSRS.
- 90-113.75B: would require all boards which license individuals who can prescribe controlled substances to charge a \$20 CSRS annual fee. The boards would be required to retain 10% of the fees collected and remit 90% to DHHS for the special revenue fund created in G.S. 90-113.75A.
- 90-113.75C: would require DHHS to make annual reports, starting November 1, 2018, to the Joint Legislative Oversight Committee on Health and Human Services, the North Carolina Medical Board, the North Carolina Dental Board, the North Carolina Veterinary Medicine Board, and the North Carolina Board of Pharmacy. The reports would be required to include the following information on Schedule II through Schedule V substances reported to the CSRS: 1) total prescriptions dispensed, broken down by Schedule; 2) demographics of ultimate users; 3) number of pills dispensed per prescription; 4) number of ultimate users who were prescribed a controlled substance by two or more practitioners; 5) number of ultimate users to whom a prescription was dispensed in more than one county; 6) the categories of practitioners prescribing controlled substances and the number of prescriptions authorized by each category of practitioner; 7) prescribing behavior of practitioners that (i) increases risk of diversion of controlled substances, (ii) increases risk of harm to the patient, or (iii) is an outlier among other practitioner behavior; and 8) any other data deemed appropriate and requested by the Joint Legislative Oversight Committee on Health and Human Services, the North Carolina Medical Board, the North Carolina Dental Board, the North Carolina Veterinary Medicine Board, and the North Carolina Board of Pharmacy.

PART VI: APPROPRIATION FOR COMMUNITY-BASED SUBSTANCE USE DISORDER TREATMENT AND RECOVERY SERVICES

Section 14 would appropriate 10 million dollars each for the 2017-2018 and the 2018-2019 fiscal year to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services. The funds would only be used for increasing the availability of community-based treatment and recovery services for substance use disorders, including medication-assisted treatment.

EFFECTIVE DATE: Sections 1, 2, 3, 4, 6, 8, and 14 would become effective July 1, 2017. Sections 5 and 7 would become effective July 1, 2018. The portion of Section 13 creating the new statutes G.S. 90-113.75A through G.S. 90-113.75C would become effective September 1, 2017. The remainder of the act would become effective when it becomes law and would apply to acts committed on or after the date the State Chief Information Officer notifies the Revisor of Statutes that (i) the upgrades to the CSRS database described in subdivisions (1) and (2) of subsection (a) of Section 12F.7 of S.L. 2016-94 have been completed and (ii) the upgraded CSRS database is fully operational within the Department of Information Technology and connected to the statewide health information exchange.



GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2017

HOUSE BILL 243*

Short Title: Strengthen Opioid Misuse Prevention (STOP)Act.

(Public)

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Sponsors:

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Representatives Murphy, Davis, Malone, and Horn (Primary Sponsors).

For a complete list of sponsors, refer to the North Carolina General Assembly web site.

Referred to: Health, if favorable, Appropriations

March 6, 2017

A BILL TO BE ENTITLED AN ACT STRENGTHENING OPIOID MISUSE PREVENTION BY EXTENDING STANDING ORDERS FOR OPIOID ANTAGONIST TO COMMUNITY HEALTH GROUPS; REQUIRING SUPERVISING PHYSICIANS TO PERSONALLY CONSULT WITH PHYSICIAN ASSISTANTS AND NURSE PRACTITIONERS WHO PRESCRIBE SCHEDULE II THROUGH V CONTROLLED SUBSTANCES FOR LONG-TERM USE; REQUIRING ELECTRONIC PRESCRIBING OF SCHEDULE II THROUGH V CONTROLLED SUBSTANCES; ESTABLISHING MAXIMUM LIMITS FOR INITIAL PRESCRIPTIONS OF SCHEDULE II THROUGH V CONTROLLED SUBSTANCES; CLARIFYING ALLOWABLE FUNDS FOR SYRINGE EXCHANGE PROGRAMS; REOUIRING VETERINARIAN PARTICIPATION IN THE CONTROLLED SUBSTANCES REPORTING SYSTEM; ESTABLISHING CIVIL PENALTIES FOR PHARMACIES THAT EMPLOY DISPENSERS WHO IMPROPERLY REPORT INFORMATION TO THE CONTROLLED SUBSTANCES REPORTING SYSTEM (CSRS); EXPANDING THE ROLE OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (DHHS) IN USING CSRS DATA TO DETECT AND PREVENT FRAUD AND MISUSE; MANDATING DISPENSER REGISTRATION FOR ACCESS TO THE CSRS: MANDATING DISPENSER AND PRACTITIONER USE OF THE CSRS; REQUIRING DHHS TO REPORT PRACTITIONERS WHO FAIL TO PROPERLY USE THE CSRS; CREATING A SPECIAL REVENUE FUND TO SUPPORT THE CSRS; IMPOSING AN ANNUAL FEE ON PRACTITIONERS TO BE DEPOSITED INTO THE CSRS SPECIAL REVENUE FUND: REQUIRING AN ANNUAL REPORT FROM DHHS ON THE CSRS; AND APPROPRIATING FUNDS FOR COMMUNITY-BASED SUBSTANCE USE DISORDER TREATMENT AND RECOVERY SERVICES.

The General Assembly of North Carolina enacts:

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PART I. TITLE OF ACT

SECTION 1. This act shall be known and may be cited as the "Strengthen Opioid Misuse Prevention Act of 2017" or the "STOP Act."

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PART II. EXTEND STANDING ORDERS FOR OPIOID ANTAGONIST TO

COMMUNITY HEALTH GROUPS

SECTION 2. G.S. 90-12.7 reads as rewritten:

"§ 90-12.7. Treatment of overdose with opioid antagonist; immunity.



- (a) As used in this section, "opioid antagonist" means naloxone hydrochloride that is approved by the federal Food and Drug Administration for the treatment of a drug overdose.
- (b) The following individuals may prescribe an opioid antagonist in the manner prescribed by this subsection:
 - (1) A practitioner acting in good faith and exercising reasonable care may directly or by standing order prescribe an opioid antagonist to (i) a person at risk of experiencing an opiate-related overdose or (ii) a family member, friend, or other person in a position to assist a person at risk of experiencing an opiate-related overdose. As an indicator of good faith, the practitioner, prior to prescribing an opioid under this subsection, may require receipt of a written communication that provides a factual basis for a reasonable conclusion as to either of the following:
 - a. The person seeking the opioid antagonist is at risk of experiencing an opiate-related overdose.
 - b. The person other than the person who is at risk of experiencing an opiate-related overdose, and who is seeking the opioid antagonist, is in relation to the person at risk of experiencing an opiate-related overdose:
 - 1. A family member, friend, or other person.
 - 2. In the position to assist a person at risk of experiencing an opiate-related overdose.
 - (2) The State Health Director <u>or a designee</u> may prescribe an opioid antagonist pursuant to subdivision (1) of this subsection by means of a statewide standing order.
 - A practitioner acting in good faith and exercising reasonable care may directly or by standing order prescribe an opioid antagonist to any governmental or nongovernmental organization, including a local health department, a law enforcement agency, or an organization that promotes scientifically proven ways of mitigating health risks associated with substance use disorders and other high-risk behaviors, for the purpose of distributing, through its agents, the opioid antagonist to (i) a person at risk of experiencing an opiate-related overdose or (ii) a family member, friend, or other person in a position to assist a person at risk of experiencing an opiate-related overdose.
- (c) A pharmacist may dispense an opioid antagonist to a person described in subdivision (b)(1) of this section or organization pursuant to a prescription issued pursuant to in accordance with subsection (b) of this section. For purposes of this section, the term "pharmacist" is as defined in G.S. 90-85.3.
- (c1) A governmental or nongovernmental organization, including a local health department, a law enforcement agency, or an organization that promotes scientifically proven ways of mitigating health risks associated with substance use disorders and other high-risk behaviors may, through its agents, distribute an opioid antagonist obtained pursuant to a prescription issued in accordance with subdivision (3) of subsection (b) of this section to (i) a person at risk of experiencing an opiate-related overdose or (ii) a family member, friend, or other person in a position to assist a person at risk of experiencing an opiate-related overdose. An organization, through its agents, shall include with any distribution of an opioid antagonist pursuant to this subsection basic instruction and information on how to administer the opioid antagonist.
- (d) A person who receives an opioid antagonist that was prescribed pursuant to subsection (b) of this section or distributed pursuant to subsection (c1) of this section may administer an opioid antagonist to another person if (i) the person has a good faith belief that the other person is experiencing a drug-related overdose and (ii) the person exercises reasonable care in administering the drug to the other person. Evidence of the use of reasonable care in administering the drug shall include the receipt of basic instruction and information on how to administer the opioid antagonist.

SECTION 3. G.S. 90-18.1(b) is amended by adding a new subdivision to read:

If the prescription is for a controlled substance included in Schedule II through V of Article 5 of Chapter 90 of the General Statutes and therapeutic use of the controlled substance will or is expected to exceed a period of 30 days, the physician assistant shall personally consult with the supervising physician prior to prescribing the controlled substance to verify that the prescription is medically appropriate for the patient. For as long as a Schedule II through V controlled substance is continuously prescribed to the same patient, the physician assistant shall consult with the supervising physician at least once every 90 days to verify that the prescription remains medically appropriate for the patient."

SECTION 4. G.S. 90-18.2(b) is amended by adding a new subdivision to read:

If the prescription is for a controlled substance included in Schedule II through V of Article 5 of Chapter 90 of the General Statutes and therapeutic use of the controlled substance will or is expected to exceed a period of 30 days, the nurse practitioner shall personally consult with the supervising physician prior to prescribing the controlled substance to verify that the prescription is medically appropriate for the patient. For as long as a Schedule II through V controlled substance is continuously prescribed to the same patient, the nurse practitioner shall consult with the supervising physician at least once every 90 days to verify that the prescription remains medically appropriate for the patient."

SECTION 5. G.S. 90-106 reads as rewritten:

"§ 90-106. Prescriptions and labeling.

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- Except when dispensed directly by a practitioner, other than a pharmacist, to an ultimate user, no controlled substance included in Schedule II of this Article may be dispensed without the written prescription of a practitioner. No Schedule II substance shall be dispensed pursuant to a written or electronic prescription more than six months after the date it was prescribed.
- Unless otherwise exempted by this subsection, a practitioner shall electronically (a1) prescribe all controlled substances included in Schedule II through V of this Article. This subsection does not apply to prescriptions for Schedule II through V controlled substances issued by any of the following:
 - A practitioner, other than a pharmacist, who dispenses directly to an ultimate (1)user.
 - A practitioner who orders a controlled substance to be administered in a (2) hospital, nursing home, hospice facility, or residential care facility as defined in G.S. 14-32.2.

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- (3) A practitioner who experiences temporary technological or electrical failure that prevents the prescription from being transmitted electronically; provided, however, that the practitioner documents the reason for this exception in the patient's medical record.
- <u>(4)</u> A practitioner who writes a prescription to be dispensed by a pharmacy located on federal property; provided, however, that the practitioner documents the reason for this exception in the patient's medical record.
- A dispenser is not required to verify that a practitioner properly falls under one of the exceptions specified in subsection (a1) of this section prior to dispensing a controlled substance included in Schedule II through V of this Article. A dispenser may continue to dispense controlled substances included in Schedules II through V of this Article from valid written, oral, or facsimile prescriptions that are otherwise consistent with applicable laws.
- A practitioner may not prescribe more than a five-day supply of any controlled substance included in Schedule II through V of this Article upon the initial consultation and treatment of a patient for acute pain, unless the prescription is for immediate post-operative pain relief. A practitioner may not prescribe more than a seven-day supply of any controlled substance included in Schedule II through V of this Article for immediate post-operative pain relief. Upon any subsequent consultation for the same pain, the practitioner may issue any appropriate renewal, refill, or new prescription for a Schedule II through V controlled substance.
 - As used in this subsection, the following terms have the following meanings: (a4)
 - Acute pain. Pain, whether resulting from disease, accident, intentional trauma, (1)or other cause, that the practitioner reasonably expects to last for three months or less. The term does not include chronic pain or pain being treated as part of cancer care, hospice care, palliative care, or medication-assisted treatment for substance use disorder.
 - Chronic pain. Pain that typically lasts for longer than three months or that (2) lasts beyond the time of normal tissue healing.
- In emergency situations, as defined by rule of the Commission, Schedule II drugs may be dispensed upon oral prescription of a practitioner, reduced promptly to writing and filed by the dispensing agent. Prescriptions shall be retained in conformity with the requirements of G.S. 90-104. No prescription for a Schedule II substance may be refilled.
- Except when dispensed directly by a practitioner, other than a pharmacist, to an ultimate user, no controlled substance included in Schedules III or IV, except paregoric, U.S.P., as provided in G.S. 90-91(e)1, may be dispensed without a prescription, and oral prescriptions shall be promptly reduced to writing and filed with the dispensing agent. Such prescription may not be filled or refilled more than six months after the date thereof or be refilled more than five times after the date of the prescription.
- No controlled substance included in Schedule V of this Article or paregoric, U.S.P., may be distributed or dispensed other than for a medical purpose.
- No controlled substance included in Schedule VI of this Article may be distributed or dispensed other than for scientific or research purposes by persons registered under, or permitted by, this Article to engage in scientific or research projects.
- No controlled substance shall be dispensed or distributed in this State unless such substance shall be in a container clearly labeled in accord with regulations lawfully adopted and published by the federal government or the Commission.
- When a copy of a prescription for a controlled substance under this Article is given as required by G.S. 90-70, such copy shall be plainly marked: "Copy – for information only." Copies of prescriptions for controlled substances shall not be filled or refilled.
- A pharmacist dispensing a controlled substance under this Article shall enter the date of dispensing on the prescription order pursuant to which such controlled substance was dispensed.

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A manufacturer's sales representative may distribute a controlled substance as a complimentary sample only upon the written request of a practitioner. Such request must be made on each distribution and must contain the names and addresses of the supplier and the requester and the name and quantity of the specific controlled substance requested. The manufacturer shall maintain a record of each such request for a period of two years."

SECTION 6. Article 5 of Chapter 90 of the General Statutes is amended by adding a new section to read:

"§ 90-106.3. Disposal of residual pain prescriptions following death of hospice or palliative care patient.

Any hospice or palliative care provider who prescribes a controlled substance included in Schedule II through V of this Article to be administered to a patient in his or her home for the treatment of pain as part of in-home hospice or palliative care shall make diligent efforts to ensure that any residual portion of the controlled substance is safely disposed of following the death of the patient. The hospice or palliative care provider shall comply with all applicable State and federal laws in carrying out the requirements of this section."

SECTION 7. Article 51 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"§ 58-51-56. Limitation on co-payments for limited, initial opioid prescriptions.

Every health benefit plan delivered or issued for delivery in this State that provides coverage for prescription drugs subject to co-payment shall charge a co-payment for a limited, initial prescription of a Schedule II through V controlled substance prescribed in accordance with G.S. 90-106(a3) in an amount that is (i) proportional between the co-payment charged for a 30-day supply of the controlled substance and the amount of the controlled substance prescribed to the beneficiary or (ii) equivalent to the co-payment for a 30-day supply of the controlled substance; provided, however, that the health benefit plan shall not subject the beneficiary to any additional co-payments for any additional prescriptions of the same controlled substance for the remainder of the 30-day supply."

PART IV. CLARIFY ALLOWABLE FUNDS FOR SYRINGE EXCHANGE PROGRAMS **SECTION 8.** G.S. 90-113.27(b)(2) reads as rewritten:

Needles, hypodermic syringes, and other injection supplies at no cost and in "(2)quantities sufficient to ensure that needles, hypodermic syringes, and other injection supplies are not shared or reused. No public-State funds may be used to purchase needles, hypodermic syringes, or other injection supplies."

PART V. STRENGTHEN CONTROLLED SUBSTANCES REPORTING SYSTEM **SECTION 9.** G.S. 90-113.72 reads as rewritten:

"§ 90-113.72. Definitions.

The following definitions apply in this Article:

- "Commission" means the Commission. The Commission for Mental Health, (1) Developmental Disabilities, and Substance Abuse Services established under Part 4 of Article 3 of Chapter 143B of the General Statutes.
- (2) "Controlled substance" means a Controlled Substance. – A controlled substance as defined in G.S. 90-87(5).
- "Department" means the Department. The Department of Health and Human (3)
- "Dispenser" means a Dispenser. A person who delivers a Schedule II through (4) V controlled substance to an ultimate user in North Carolina, but does not include any of the following:
 - A licensed hospital or long-term care pharmacy that dispenses such substances for the purpose of inpatient administration.

A dispenser shall not be required to report instances in which a Schedule V

provided directly to the ultimate user and the quantity provided does not exceed a 48-hour supply.

A dispenser shall not be required to report instances in which a controlled substance is

National Drug Code of dispensed drug.

Method of payment for the prescription.

Prescriber's DEA number.

non-narcotic, non-anorectic Schedule V controlled substance is provided directly to the ultimate user for the purpose of assessing a therapeutic response when prescribed according to indications approved by the United States Food and Drug Administration.

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(e) The Department shall assess, against any pharmacy that employs dispensers found to have failed to report information in the manner required by this section within a reasonable period of time after being informed by the Department that the required information is missing or incomplete, a civil penalty of not more than two hundred fifty dollars (\$250.00) for a first violation and five hundred dollars (\$500.00) for each subsequent violation if the pharmacy fails to report as required under this section, up to a maximum of ten thousand dollars (\$10,000) per pharmacy per calendar year. Each day of a continuing violation shall constitute a separate violation. The clear proceeds of penalties assessed under this section shall be deposited to the Civil Penalty and Forfeiture Fund in accordance with Article 31A of Chapter 115C of the General Statutes. The Commission shall adopt rules to implement this subsection that include factors to be considered in determining the amount of the penalty to be assessed."

SECTION 11. G.S. 90-113.74(b1) reads as rewritten:

- "(b1) The Department may review the prescription information data in the controlled substances reporting system and upon review may:
 - (1a) Notify practitioners of prescribing behavior that (i) increases risk of diversion of controlled substances, (ii) increases risk of harm to the patient, or (iii) is an outlier among other practitioner behavior.

SECTION 12. G.S. 90-113.74(c) reads as rewritten:

- "(c) The Department shall release data in the controlled substances reporting system to the following persons only:
 - (11) Any third-party payer or pharmacy benefits manager acting as agent of a third-party payer, for the purposes of (i) claimant case management, (ii) detection of inappropriate prescribing of a controlled substance to a claimant, or (iii) detection of misuse or diversion of a controlled substance by a claimant."

SECTION 13. Article 5E of Chapter 90 of the General Statutes is amended by adding new sections to read:

"§ 90-113.74A. Mandatory dispenser registration for access to controlled substances reporting system.

Within 30 days after obtaining an initial or renewal license to practice pharmacy, the licensee shall demonstrate to the satisfaction of the North Carolina Board of Pharmacy that he or she is registered for access to the controlled substances reporting system. A violation of this section may constitute cause for the Board of Pharmacy to suspend or revoke the license.

"§ 90-113.74B. Practitioner use of controlled substances reporting system; mandatory reporting of violations.

(a) Prior to initially prescribing a Schedule II through V controlled substance to a patient, a practitioner shall review the information in the controlled substances reporting system pertaining to the patient for the 12-month period preceding the initial prescription. For every subsequent three-month period that the controlled substance remains a part of the patient's medical care, the practitioner shall review the information in the controlled substances reporting system pertaining to the patient for the 12-month period preceding the determination that the controlled substance should remain a part of the patient's medical care. Each instance in which the practitioner reviews the information in the controlled substances reporting system pertaining to the patient shall be documented in the patient's medical record. In the event the practitioner is unable to review the information in the controlled substances reporting system pertaining to the patient because the system is not operational or there is some other electrical or technological failure, this inability shall be documented in the patient's medical record. Once the electrical or technological failure has been resolved, the practitioner shall review the information in the controlled substances

General Assembly Of North Carolina reporting system pertaining to the patient and the review shall be documented in the patient's 1 2 medical record. 3 (b) A practitioner may, but is not required to, review the information in the controlled 4 substances reporting system pertaining to a patient prior to prescribing a Schedule II through V 5 controlled substance to the patient in any of the following circumstances: 6 The controlled substance is to be administered to a patient in a health care (1)setting, hospital, nursing home, or residential care facility as defined in 7 8 G.S. 14-32.2. 9 The controlled substance is prescribed for the treatment of cancer or another (2) condition associated with cancer. 10 The controlled substance is prescribed to a patient in hospice care or palliative 11 (3) 12 care. 13 <u>(4)</u> The controlled substance is prescribed in an amount indicated for a period not to exceed five days and does not allow a refill, or for a period not to exceed 14 15 seven days if the prescription indicates the controlled substance is for 16 immediate post-operative pain relief. The Department shall conduct periodic audits of the review of the controlled 17 (c) substances reporting system by prescribers. The Department shall determine a system for selecting 18 19 a subset of prescriptions to examine during each auditing period. The Department shall report to the appropriate licensing board any prescriber found to be in violation of this section. A violation 20 21 of this section may constitute cause for the licensing board to suspend or revoke a prescriber's 22 license. "§ 90-113.74C. Dispenser use of controlled substances reporting system. 23 Prior to dispensing a Schedule II through V controlled substance, a dispenser shall 24 25 review the information in the controlled substances reporting system pertaining to the patient for 26 the preceding 12-month period and document this review whenever: 27 The dispenser has a reasonable belief that the ultimate user may be seeking a (1)28 Schedule II through V controlled substance for any reason other than the treatment of the ultimate user's existing medical condition. 29 The prescriber is located outside of the usual geographic area served by the 30 (2) 31 dispenser. The ultimate user resides outside of the usual geographic area served by the 32 <u>(3)</u> 33 dispenser. 34 (4) The ultimate user pays for the prescription with cash when the patient has prescription insurance on file with the dispenser. 35 36 **(5)** The ultimate user demonstrates potential misuse of a controlled substance by any one or more of the following: 37 38

Over-utilization of the controlled substance. <u>a.</u>

<u>b.</u> Requests for early refills.

Utilization of multiple prescribers. C.

An appearance of being overly sedated or intoxicated upon presenting a d. prescription.

A request by an unfamiliar ultimate user for an opioid drug by a specific <u>e.</u> name, street name, color, or identifying marks.

If a dispenser has reason to believe a prescription for a Schedule II through V controlled substance is fraudulent or duplicative, the dispenser shall withhold delivery of the prescription until the dispenser is able to contact the prescriber and verify that the prescription is medically appropriate. A dispenser shall be immune from any civil or criminal liability for actions authorized by this subsection.

"§ 90-113.75A. Creation of Controlled Substances Reporting System Fund.

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- (a) The Controlled Substances Reporting System Fund is created within the Department as a special revenue fund. The Department shall administer the Fund. The Department shall use the Fund only for operation of the controlled substances reporting system and to carry out the provisions of this Article.
 - (b) The Fund shall consist of the following:
 - (1) Moneys transmitted to the Fund pursuant to G.S. 90-113.75B.
 - (2) Any moneys appropriated to the Fund by the General Assembly.
 - (3) Any moneys received from State, federal, private, or other sources for deposit into the Fund.
- (c) All interest that accrues to the Fund shall be credited to the Fund. Any balance remaining in the Fund at the end of any fiscal year shall remain in the Fund and shall not revert to the General Fund.

"§ 90-113.75B. Controlled substances reporting system fee.

- (a) Beginning January 1, 2018, each licensing board authorized to issue an initial or renewal license that confers upon the licensee the authority to prescribe a controlled substance for the purpose of providing medical care for a patient shall impose an annual controlled substances reporting system fee in the amount of twenty dollars (\$20.00) on the licensee. This fee shall be in addition to any other initial or renewal license fee the licensing board is authorized to collect from the licensee under Chapter 90 of the General Statutes. The licensing board shall collect the fee required by this subsection at the same time it collects the initial or renewal license fee imposed on the licensee. Each licensing board shall retain ten percent (10%) of the total amount of moneys collected for the controlled substances reporting system fee pursuant to this subsection to cover the costs incurred by the licensing board for collecting and providing an accounting of all moneys received as payment of this fee. On the first day of each calendar quarter, each licensing board shall transmit ninety percent (90%) of the total amount of moneys collected pursuant to this subsection during the preceding calendar quarter to the Controlled Substances Reporting System Fund created in G.S. 90-113.75A.
- (b) This section shall not be construed to apply to an individual licensed to practice veterinary medicine pursuant to Article 11 of Chapter 90 of the General Statutes.

"§ 90-113.75C. Annual report to General Assembly and licensing boards.

Annually on November 1, beginning November 1, 2018, the Department shall report to the Joint Legislative Oversight Committee on Health and Human Services, the North Carolina Medical Board, the North Carolina Board of Nursing, the North Carolina Dental Board, the North Carolina Veterinary Medical Board, and the North Carolina Board of Pharmacy on data reported to the controlled substances reporting system. The report shall include at least all of the following information about Schedule II through V controlled substances reported to the system during the preceding calendar year:

- (1) The total number of prescriptions dispensed, broken down by Schedule.
- (2) Demographics about the ultimate users to whom prescriptions were dispensed.
- (3) Statistics regarding the number of pills dispensed per prescription.
- (4) The number of ultimate users who were prescribed a controlled substance by two or more practitioners.
- (5) The number of ultimate users to whom a prescription was dispensed in more than one county.
- (6) The categories of practitioners prescribing controlled substances and the number of prescriptions authorized by each category of practitioner. For the purpose of this subdivision, medical doctors and surgeons shall be treated as distinct categories of practitioners.
- (7) Prescribing behavior of practitioners that (i) increases risk of diversion of controlled substances, (ii) increases risk of harm to the patient, or (iii) is an outlier among other practitioner behavior.

(8) Any other data deemed appropriate and requested by the Joint Legislative Oversight Committee on Health and Human Services, the North Carolina Medical Board, the North Carolina Board of Nursing, the North Carolina Dental Board, the North Carolina Veterinary Medical Board, or the North Carolina Board of Pharmacy."

PART VI. APPROPRIATION FOR COMMUNITY-BASED SUBSTANCE USE DISORDER TREATMENT AND RECOVERY SERVICES

SECTION 14. There is appropriated from the General Fund to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, the sum of ten million dollars (\$10,000,000) for the 2017-2018 fiscal year and the sum of ten million dollars (\$10,000,000) for the 2018-2019 fiscal year. These funds shall not be used for any purpose other than to increase the availability of community-based treatment and recovery services for substance use disorders, including medication-assisted treatment. These funds shall not supplant existing funds for community-based treatment and recovery services for substance use disorders.

PART VII. EFFECTIVE DATE

SECTION 15.(a) Sections 1, 2, 3, 4, 6, 8, and 14 of this act become effective July 1, 2017.

SECTION 15.(b) Sections 5 and 7 of this act become effective July 1, 2018.

SECTION 15.(c) G.S. 90-113.75A through G.S. 90-113.75C, as enacted by Section 13 of this act, become effective September 1, 2017.

SECTION 15.(d) The remainder of this act is effective when it becomes law and applies to acts committed on or after the date the State Chief Information Officer notifies the Revisor of Statutes that (i) the upgrades to the Controlled Substances Reporting System (CSRS) database described in subdivisions (1) and (2) of subsection (a) of Section 12F.7 of S.L. 2016-94 have been completed and (ii) the upgraded CSRS database is fully operational within the Department of Information Technology and connected to the statewide health information exchange.

NORTH CAROLINA GENERAL ASSEMBLY HOUSE OF REPRESENTATIVES

HEALTH COMMITTEE REPORT

Representative Justin P. Burr, Co-Chair Representative Josh Dobson, Co-Chair Representative Bert Jones, Co-Chair Representative Donny Lambeth, Co-Chair Representative Gregory F. Murphy, MD, Co-Chair

FAVORABLE

HB **156**

Eyeglasses Exemption From Medicaid Capitation.

Draft Number:

None

Serial Referral:

None

Recommended Referral: None

Long Title Amended:

No

Floor Manager:

McNeill

FAVORABLE COM SUB, UNFAVORABLE ORIGINAL BILL

HB 199

Establish Standards for Surgical Technology.

Draft Number:

H199-PCS10112-TA-2

Serial Referral:

None

Recommended Referral: None Long Title Amended:

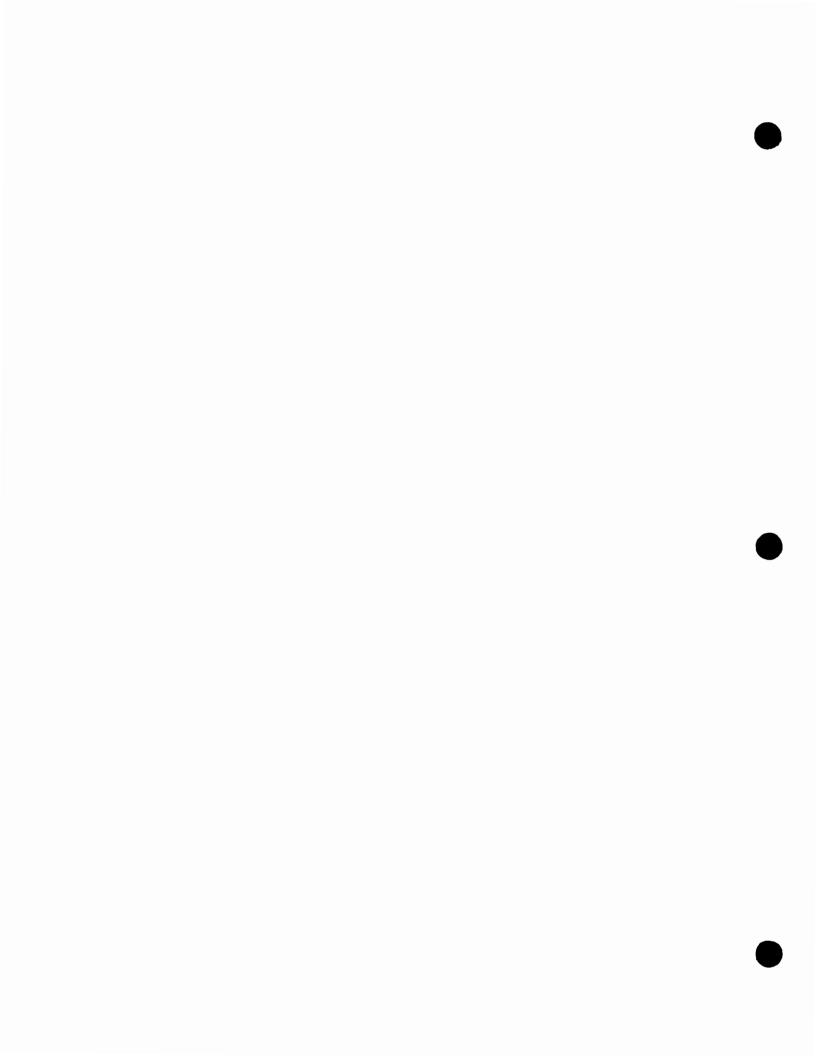
No

Floor Manager:

Murphy

TOTAL REPORTED: 2





Committee Sergeants at Arms

NAME OF COMMITTEE _	<u> House Comrn. c</u>	n Health
DATE: <u>03/08/17</u>	Room:	643
	House Sgt-At Arms:	
1. Name: Young Bae		
2. Name: Jim Moran		
3. Name: Bill Riley		Company of the Compan
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House Pages Assignments Wednesday, March 08, 2017 Session: 2:00 PM

Committee	Room	Time	Staff	Comments	Member
Aging	Other	11:00 AM	Nikyah Bowers		Rep. Speaker Tim Moore
Appropriations, Information Technology	544	11:00 AM	Dylan Gabard		Rep. Speaker Tim Moore
			Jacob Harris		Rep. Ted Davis
Health	643	11:00 AM	Kaleah Poole)	Rep. Speaker Tim Moore
			Shaun Robinson	<u>></u>	Rep. Speaker Tim Moore

House Comm. on Health

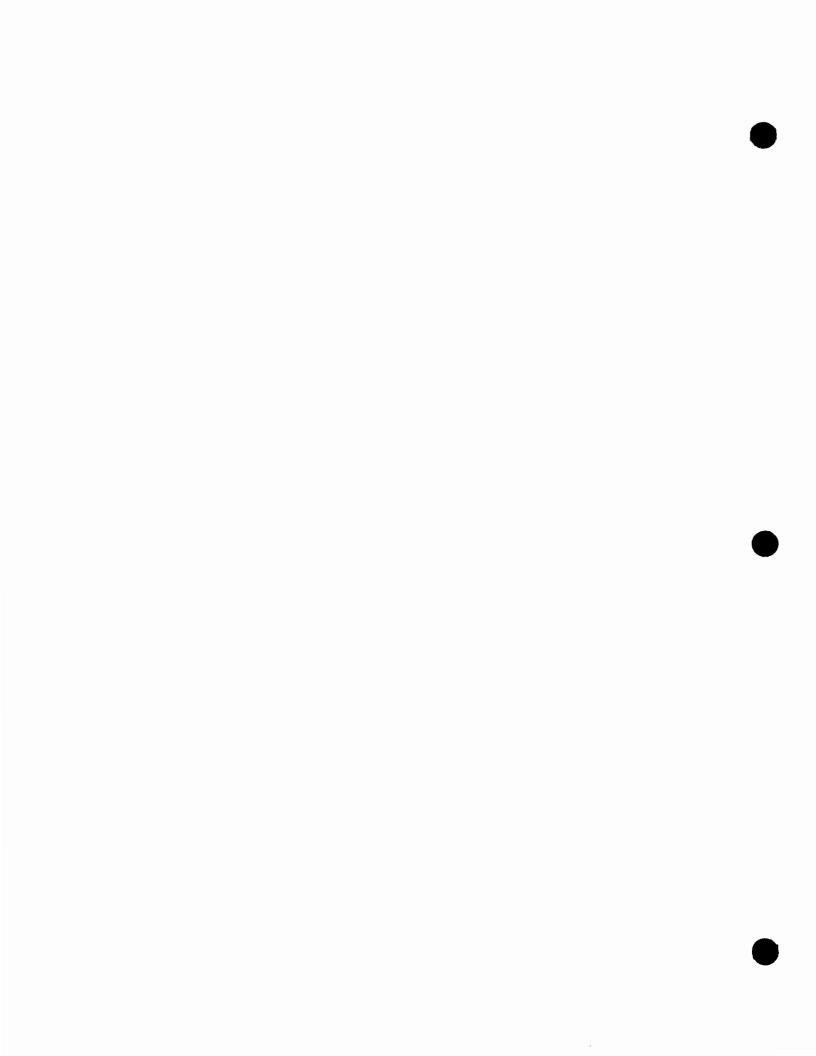
03/08/17

NAME	FIRM OR AGENCY AND ADDRESS
Rin on Mewald	WM
Sarah McGullan	KOANC
Egora Kilian	V15-A
Steve Wange	NC DOJ
Annie Cleaver	· NC DOJ
Trace Larabee	NCDOJ
M. du le Trorier	SML
Pulla A	BC1
Chur M. Duch	KTS.
Mark Ezzell	ADNC
Person 18 pg/	E53_

House Comm. on Health

03/08/17

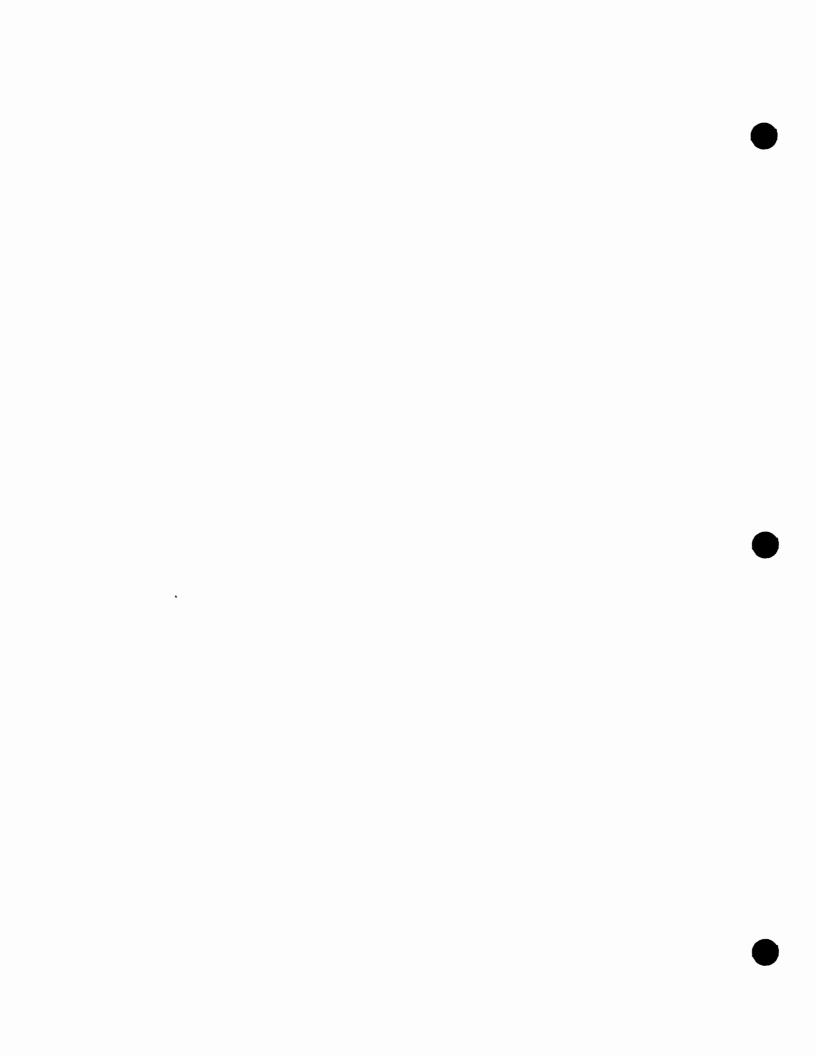
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The Hand	M75
John Mchille	Mos
Karen Brown	DPS - Correction Enterprises
Harr Gersonski	SATE L'ENT PLAN
JOE PEATER	NCDPS
TRACY GLVATA	AHAC
Amy Fulle	30 PR
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House Comm. on Health

03/08/17

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Julia Adams Schwirch	Oak City GR
auch Brandon	NC DP5
Sarah Bales	Pulaker o Of ssocialis
Matt Balls	NCCFH
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Shann beEsch	Private Practice Addiction / Interventions
Elizabeth Langdon	NC Board of Nursing
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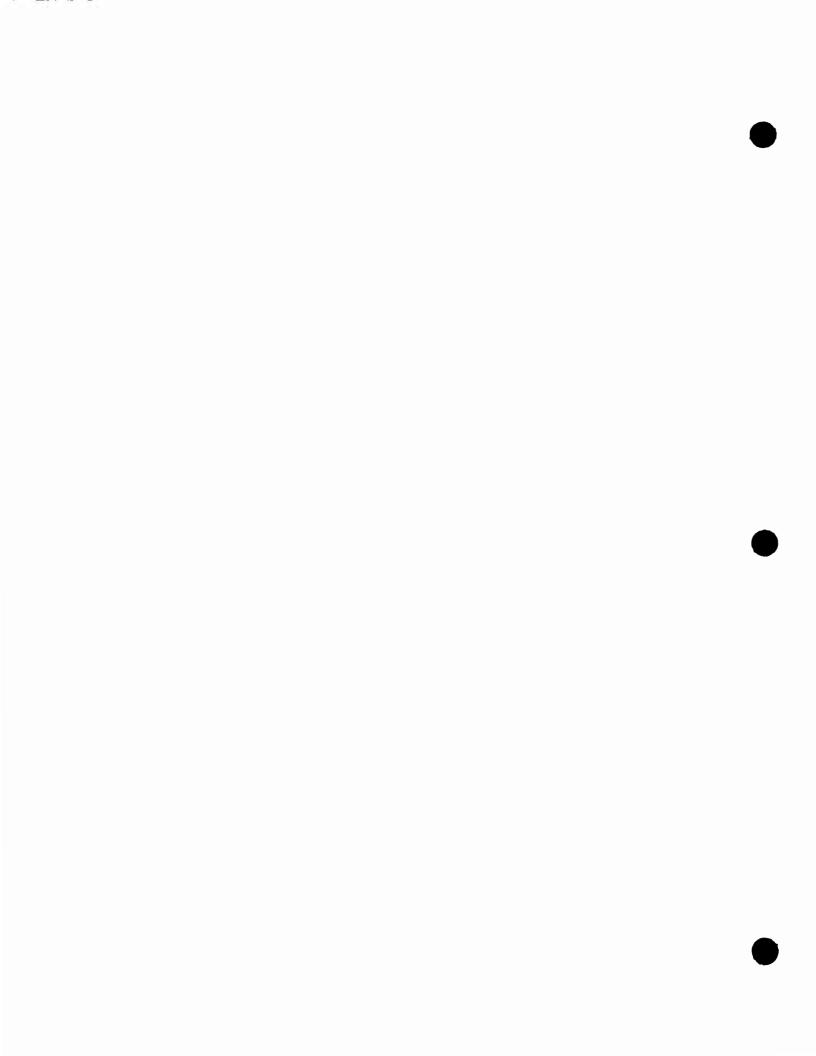
House Comm. on Health

03/08/17

Name of Committee

Date

NAME	FIRM OR AGENCY AND ADDRESS
Courney adams	TROSA 1820 James St. Durham 2770
EliSha McLawhorn	TROSA 1820 James St. Durham, K. 20170
Kevin McDonald	TROSA 1820 James St. Durhan, NC 2000
Charles CThomas	Vishor in Recovery
Bin Hoursques	· 9 SOUTH MAIN STRUCT INAYMENTILLY DE 28786
Gere Rugell	NCFPC
Jake Spe	NC FPC
David Neal	Momentum Recovery Wilmington NC 25403
Rick Barney Pam Bowman RN	Legislative Nurse of the Day Duke University Hospital



House Comm. on Health

03/08/17

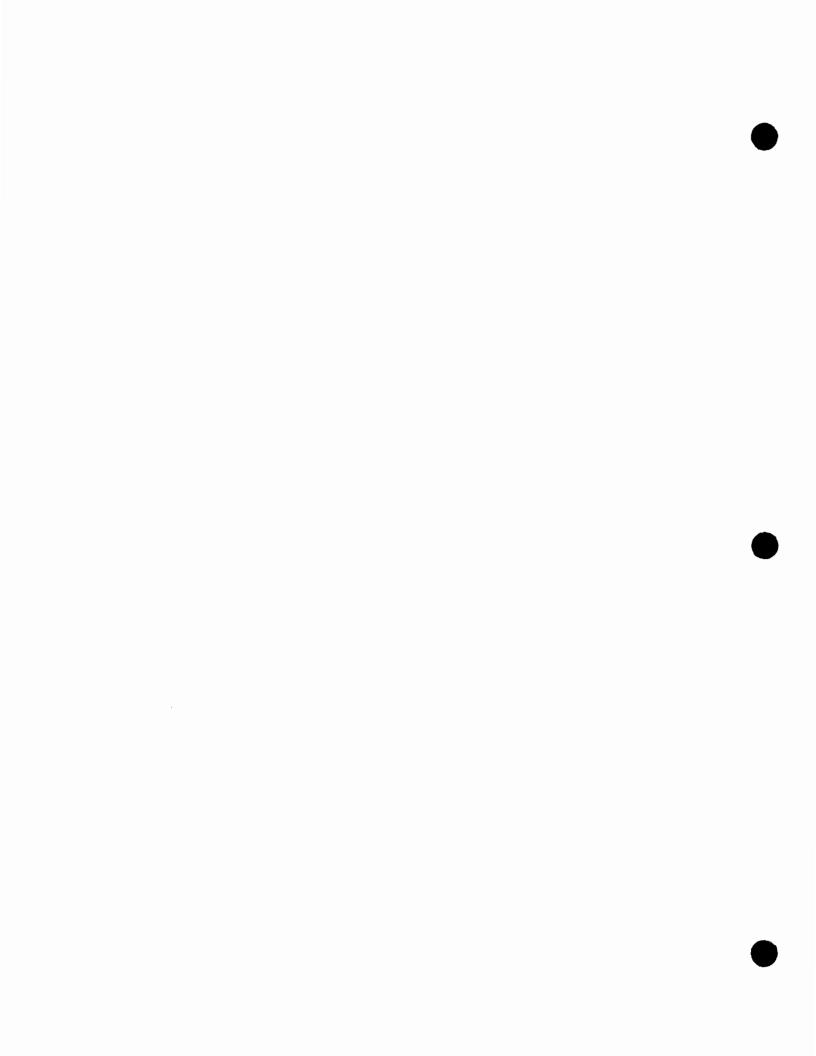
NAME	FIRM OR AGENCY AND ADDRESS
Dr. Bophy Lowery	NC Board of Nursing
DAVID Kolknokon	Ne Board of Nursing
Steren LEWIS	DHER
JESSE GUSQU	DH#3 DH30
Cepthin Sarrett	Christian Science Committee in Publications NC
Jam Van Maile	ADDICTION RECEIVENT & MASTINE
Jane E. alfrece	Ne Foundation for Ale, + Drug Studies
Billingalon	NC Physicians Hould Program -
NIcole Ellington	NC Lawyer Assistance Program
Sally Dudley	St. Paul's Episcopal Church W-S
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House Comm. on Health

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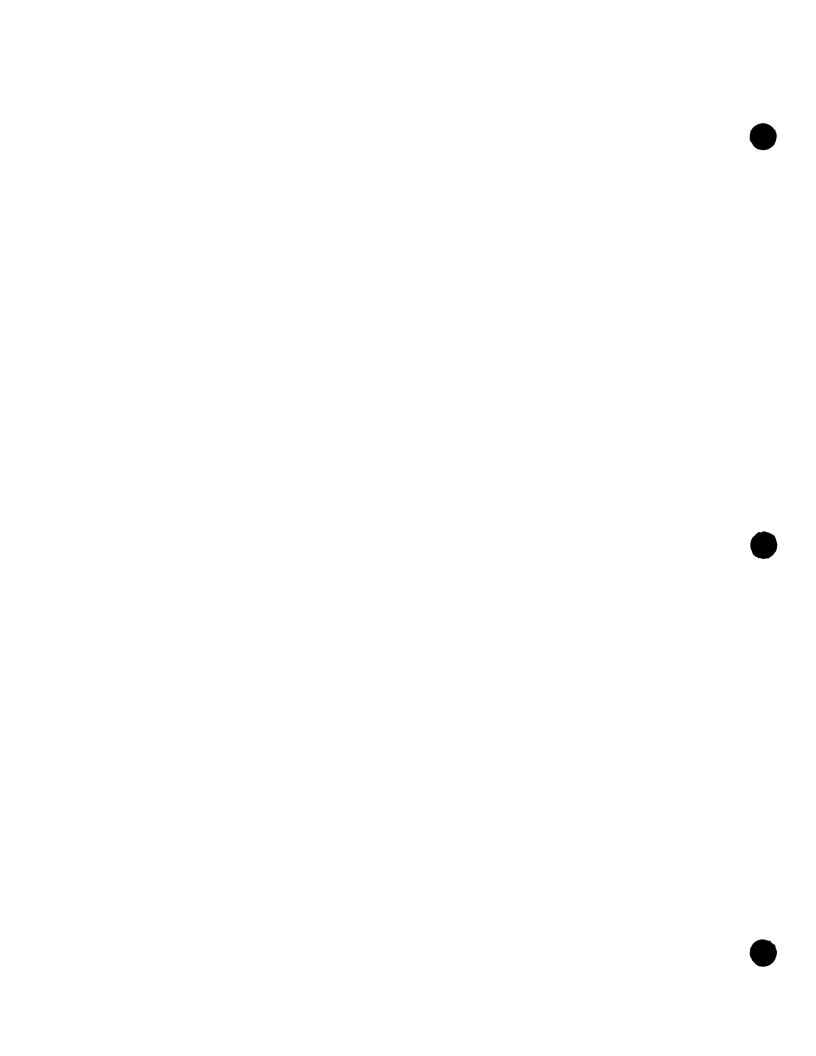
NAME	FIRM OR AGENCY AND ADDRESS
Tony Adams	adams and associates
Hasen Harrer	Fecarery Communities of North Carolina
Ralph Rodland	Recovery Communities of NC
Jany ParrEll	Ne Physicians Health Program
Kelly Scaggs	
Amanda Bue	Fellowship Hall, Gransborn, NC Healing Transitions 1251 Goode St. Raleigh NC 27603 BURKIE RECOVERY
LOE MARKS	203 WHITEST MORGANION NCZ865
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Brian Buland	TROSA



House Comm. on Health

03/08/17

NAME	FIRM OR AGENCY AND ADDRESS
Laura Gunter	NCBIO
Maen Garde	GSD
Dode Renfer	CCR
Carson Stanley	CCR
Thom Mansfield	NCMB
Evelyn Contre	NCMB
Flo Stein	DMHDDSAS
Worth Bolton	recovery advocate
DeDe Severino	DMHDOSAS
Tessie Castillo	NC Harm Reduction Coalition
Moreha Dirtie	NCHRC



House Comm. on Health

03/08/17

Name of Committee

Date

FIRM OR AGENCY AND ADDRESS
NC HRC
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BCBSNC
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House Comm. on Health

03/08/17

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Rudel Bearli	PBLan
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James Cioe	Garenois Bustitute
BRENDA Monford'	Rene
JASON YHTES	CARING SERVICES, INC HIGH POINT, NC
Chase Holleman	Guilford NAIO Youne Task Force 828 N Elm St Elb Greensbiro NC
Jon BASHORE	Town of Nikhvile - Chief of Police Nash UNC Health Care-CPH
Amanda Florey	Dash UNC Health Care-CPH 2301 Med pack Deive, Rodan Wount, NC
Ginny Mills	2301 Med pack Deive Rocky Wout, NC Full Life Courseling + Recovery Winston-Salem, NC

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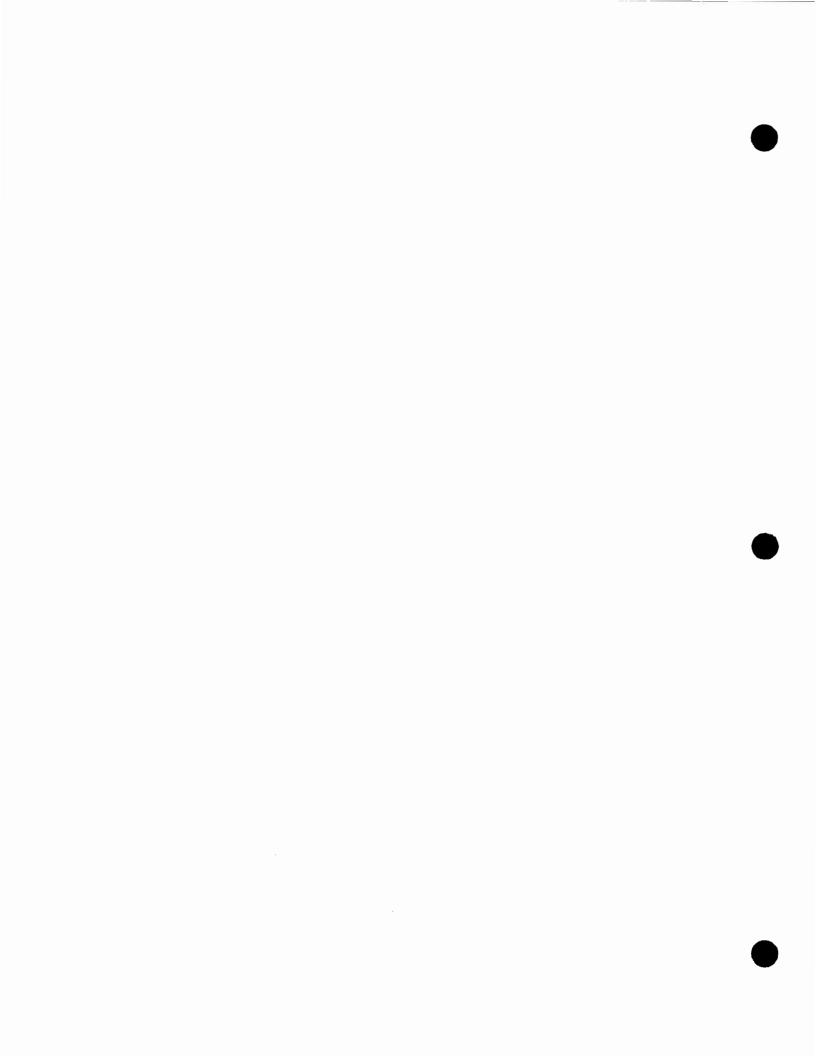
House Comm. on Health

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Phoebe Landon	MWC
Marilyn Avila	Rep Stevens
South wol	de MMC.
Franklin Freem	Ty Muc
Kathy Burksh	



House Comm. on Health

Alex Miller AMGA

03/08/17

Name of Committee

Date

NAME	FIRM OR AGENCY AND ADDRESS
Ann Rodriguez	NC Council of Comm Programs
Kerry Vosel	Kvstrategres
Davice Barn	Tratma Suders
Ken MoHon	K.M.A.
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Robert PASCHIE	NE 202
DEL MAINARO	OFFIN EXSECUT
TJ Buysee	NP
Christine Wegson	ACS CAN
Jon Carr	Jordon Price Can lin
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House Comm. on Health

03/08/17

Name of Committee

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NAME	FIRM OR AGENCY AND ADDRESS
Lori Kroll	Wought Health
Nather Balach	PPAB
Gruge	NMRS
April Calver	Johnson Health
Emily Ziagler	. UN REX
DANIEL VANLIERE	Vidant
Laurie anerio	Walk West
Canager Heise	MUA
Tracy Kimbrell	Parker Poe
Markade M'Correll	Cavolinas-AcaethCare
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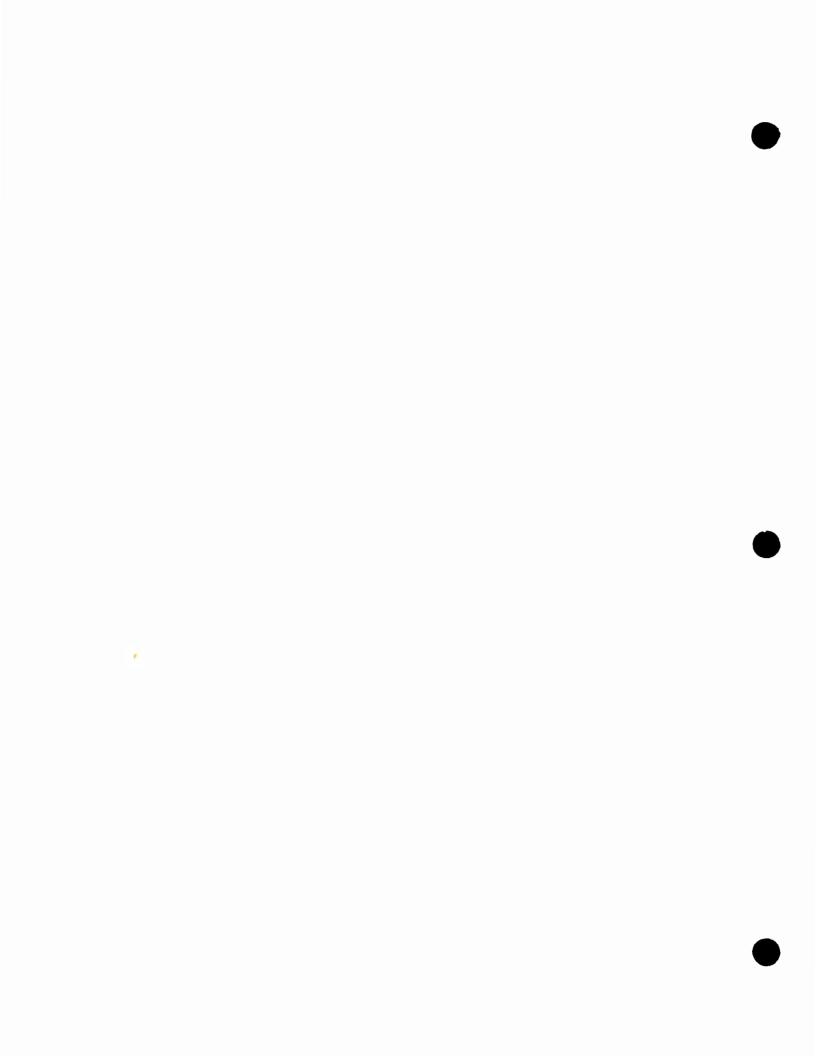
House Comm. on Health

03/08/17

Name of Committee

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House Committee on Health Tuesday, March 14, 2017 at 15 Minutes After Session Room 643 of the Legislative Office Building

MINUTES

The House Committee on Health met at 15 Minutes After Session on March 14, 2017 in Room 643 of the Legislative Office Building. Representatives Adcock, Ball, Blackwell, Boswell, Burr, Carney, Cunningham, Dobson, Dollar, Dulin, Earle, Farmer-Butterfield, Ford, Howard, Hunter, Insko, Bert Jones, Lambeth, Lucas, Malone, Murphy, Potts, Rogers, Setzer, Shepard, White, Wray, Yarborough, and Zachary attended.

Representative Donny Lambeth, Chair, presided.

The following bills were considered:

HB 226 Consultation Requirements for DHHS. (Representatives Rogers, Duane Hall, Destin Hall, John)

Rep. Rogers explained the bill. Rep. Lambeth motioned for a Favorable Report with referral to Appropriations. All in favor, HB 226 passed.

HB 244 Public Participation/Composting Facilities. (Representatives Howard, McElraft, McGrady, Setzer)

Rep. Howard explained the bill, which has a PCS. Rep. Potts motioned for a Unfavorable to original bill, favorable to the PCS, with referral to Environment. All in favor, HB 244 passed.

HB 250 Body Art Regulation Changes. (Representatives Corbin, Bert Jones, Murphy)

Rep. Corbin explained the bill. Joanna Reese, NCACC and several committee members offered comments and questions. Rep. Jones offered a technical amendment to the bill. Rep. Shepard made a motion to accept the amendment. Rep. Adcock motioned for a Favorable Report to be rolled into a PCS, with referral to Finance. The bill then passed.

HB 258 Amend Med. Mal. Health Care Provider Defin. (Representatives Riddell, Fraley, Bert Jones, Clampitt)

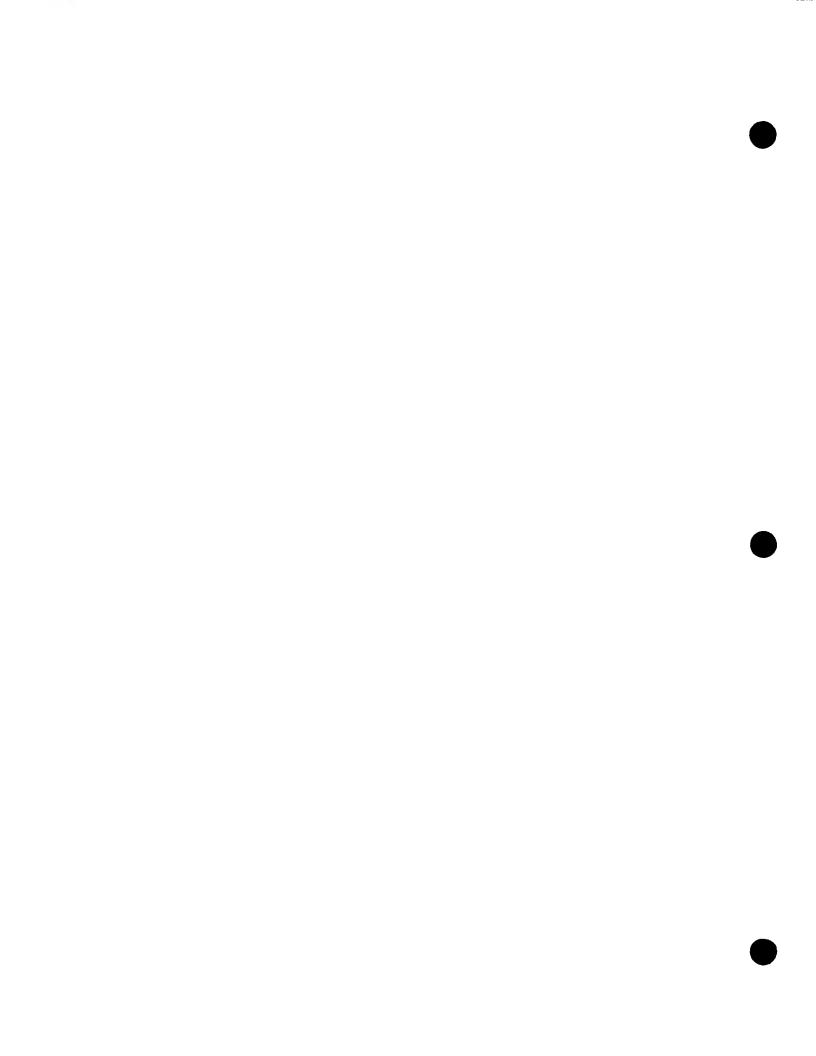
Rep. Riddell explained the bill. Discussion followed. Jason Bates and Joe Faircloth, members of NC Association of Rescue and EMS spoke in favor of HB 258. Rep. Carney motioned for a Favorable Report, with referral to Judiciary I. All in favor, the bill passed.

The meeting adjourned at 3:55.

Representative Donny Lambeth, Chair

Presiding

Brenda Olls, Committee Clerk



NORTH CAROLINA HOUSE OF REPRESENTATIVES COMMITTEE MEETING NOTICE AND BILL SPONSOR NOTIFICATION 2017-2018 SESSION

You are hereby notified that the House Committee on Health will meet as follows:

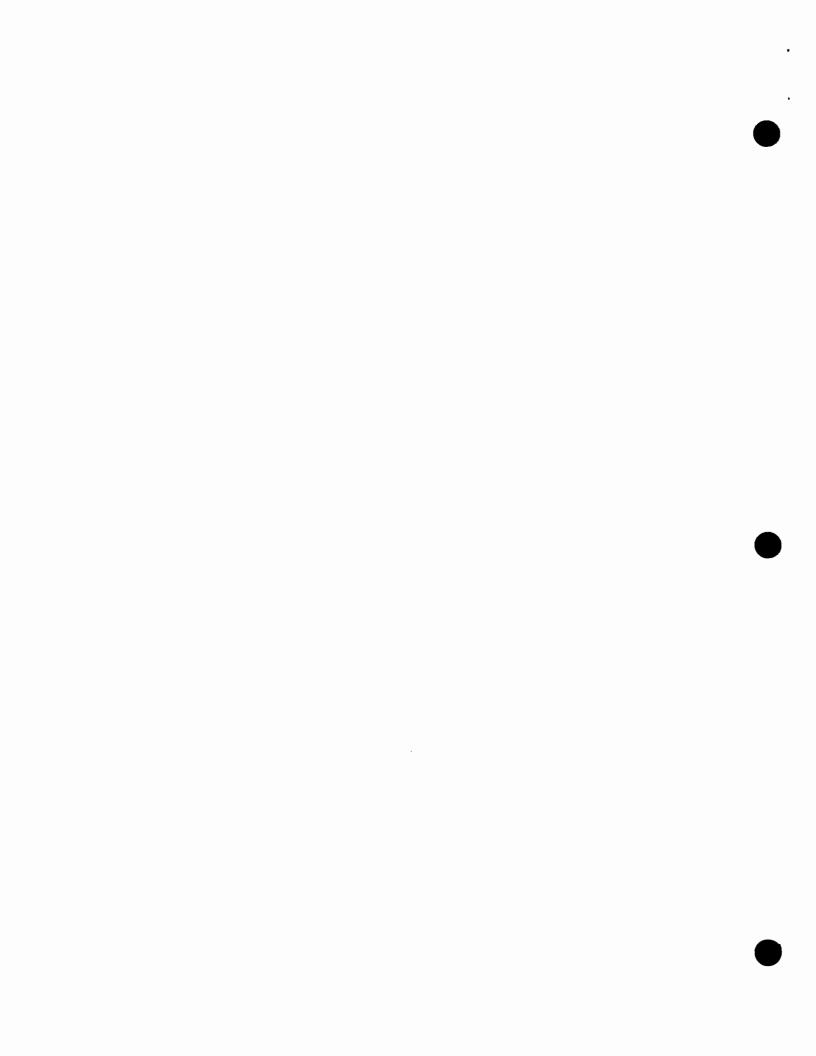
DAY & DATE: Tuesday, March 14, 2017
TIME: 15 Minutes After Session

LOCATION: 643 LOB

COMMENTS: Rep. Lambeth will preside.

The following bills will be considered:

BILL NO.	SHORT TITLE	SPONSOR
HB 226	Consultation Requirements for DHHS.	Representative Rogers
		Representative Duane Hall
		Representative Destin Hall
		Representative John
HB 244	Public Participation/Composting	Representative Howard
	Facilities.	Representative McElraft
		Representative McGrady
		Representative Setzer
HB 250	Body Art Regulation Changes.	Representative Corbin
		Representative Bert Jones
		Representative Murphy
HB 258	Amend Med. Mal. Health Care	Representative Riddell
	Provider Defin.	Representative Fraley
		Representative Bert Jones
		Representative Clampitt



Respectfully,

Representative Justin P. Burr, Co-Chair Representative Josh Dobson, Co-Chair Representative Bert Jones, Co-Chair Representative Donny Lambeth, Co-Chair Representative Gregory F. Murphy, MD, Co-Chair

I hereby certify this notice was filed by the committee assistant at the following offices at 2:22 PM on Monday, March 13, 2017.
Principal Clerk Reading Clerk – House Chamber
Brenda Olls (Committee Assistant)

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House Committee on Health Tuesday, March 14, 2017, 15 Minutes After Session 643 Legislative Office Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

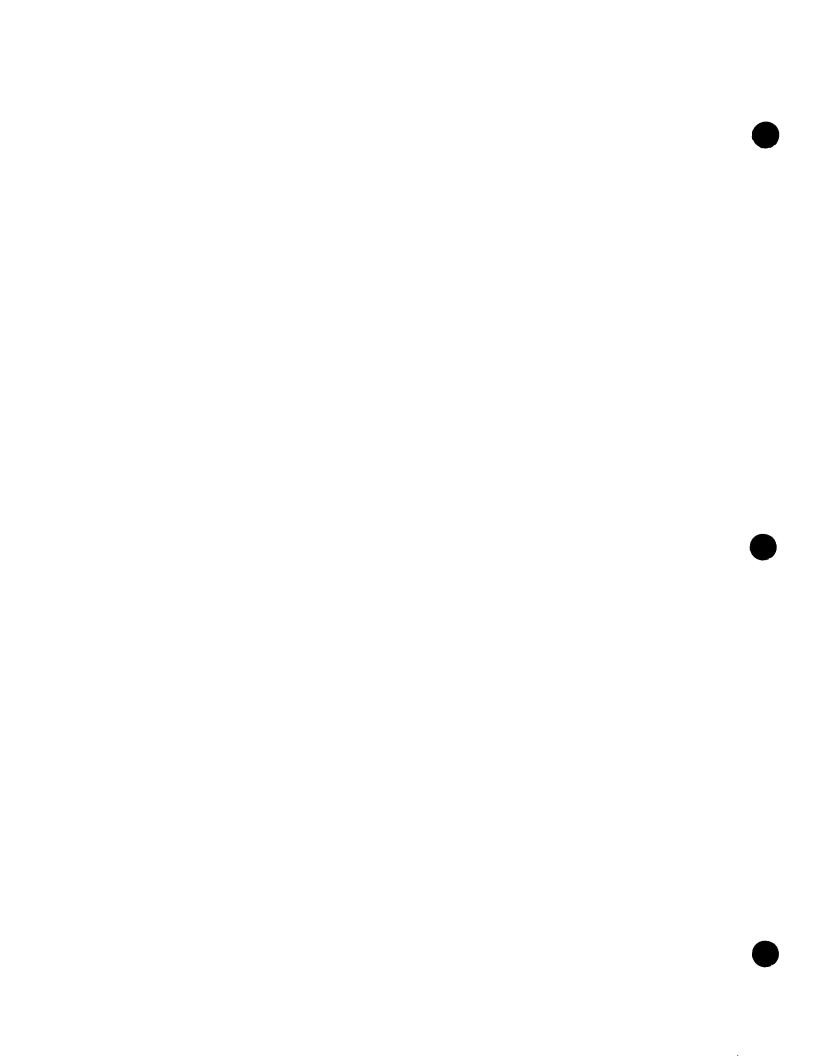
Bills

BILL NO. HB 226	SHORT TITLE Consultation Requirements for DHHS.	SPONSOR Representative Rogers
	•	Representative Duane Hall
		Representative Destin Hall
		Representative John
HB 244	Public Participation/Composting	Representative Howard
	Facilities.	Representative McElraft
		Representative McGrady
		Representative Setzer
HB 250	Body Art Regulation Changes.	Representative Corbin
		Representative Bert Jones
		Representative Murphy
HB 258	Amend Med. Mal. Health Care	Representative Riddell
,	Provider Defin.	Representative Fraley
		Representative Bert Jones
		Representative Clampitt

Presentations

Other Business

Adjournment





HOUSE BILL 226:Consultation Requirements for DHHS.

2017-2018 General Assembly

Committee: House Health. If favorable, re-refer to Date: March 14, 2017

Appropriations

Introduced by: Reps. Rogers, Duane Hall, Destin Hall, John Prepared by: Augustus D. Willis

Analysis of: First Edition Committee Counsel

OVERVIEW: House Bill 226 would require the Department of Health and Human Services to consult with the House and Senate Appropriations Committees on Justice and Public Safety prior to implementing any new Safety Planning Policy regarding Safety Assessments (DSS-5132) and the use of Temporary Parental Safety Agreements.

BACKGROUND: Temporary Parental Safety Agreements are voluntary, short-term agreements made between a parent and a county child welfare agency during the assessment phase of a case when there is a safety threat to a child in the child's home. When a Temporary Parental Safety Agreement requires the need to separate a child from the home and/or restrict a parent's access to their child, a temporary placement option for the child is identified during the time the necessary assessments are being completed. Temporary Parental Safety Agreements that include separation or restriction are allowed only during the assessment phase.

On December 9, 2016, the North Carolina Courts Commission heard a presentation on the Department of Health and Human Services' policy change related to Temporary Parental Safety Agreements, implementing a 45-day timeframe for all assessments absent court involvement. Since this meeting, the Department has agreed to temporarily suspend implementation of the policy changes, which were set to go into effect January 1, 2017. In its January 2017 report, the North Carolina Courts Commission recommended this bill.

BILL ANALYSIS: House Bill 226 would require the Department of Health and Human Services to consult with the House and Senate Appropriations Committees on Justice and Public Safety prior to implementing any new Safety Planning Policy regarding Safety Assessments (DSS-5132) and the use of Temporary Parental Safety Agreements.

EFFECTIVE DATE: This act is effective when it becomes law.





H HOUSE BILL 226

Short Title:	e: Consultation Requirements for DHHS.	
Sponsors:	ponsors: Representatives Rogers, Duane Hall, Destin Hall, and John (Primary Sponsors) For a complete list of sponsors, refer to the North Carolina General Assembly web site.	
Referred to:	Health, if favorable, Appropriations	

March 2, 2017

A BILL TO BE ENTITLED

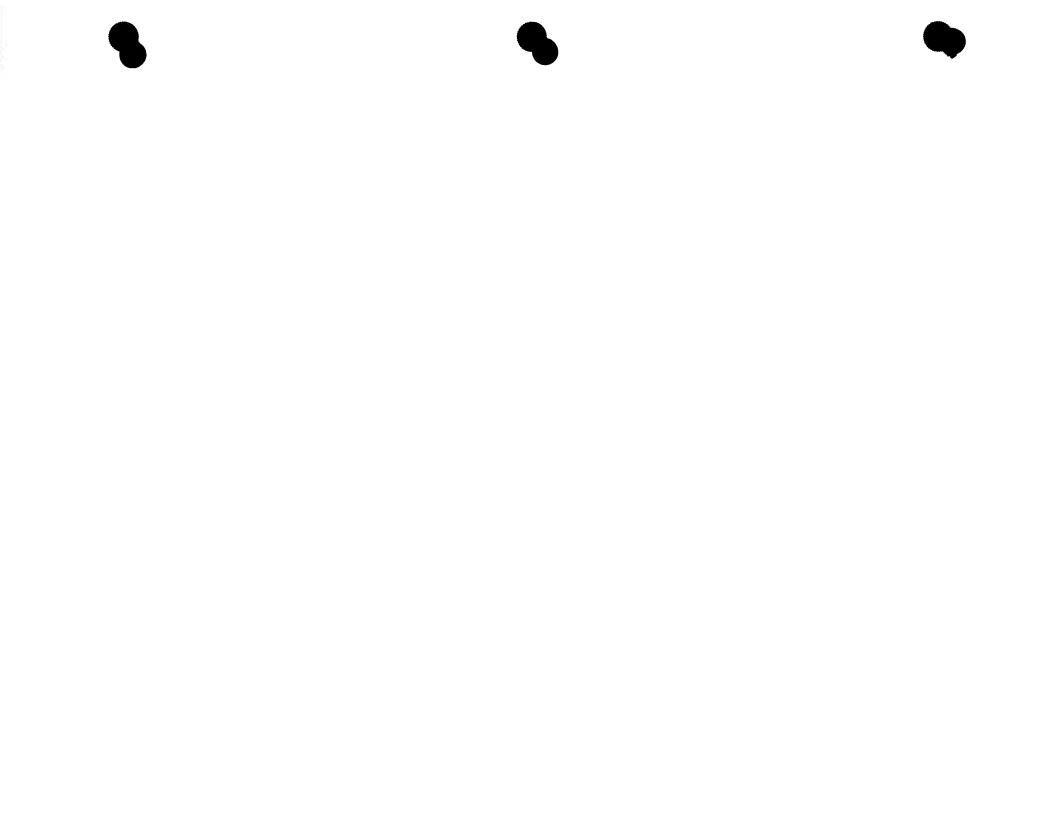
AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO CONSULT WITH THE HOUSE AND SENATE APPROPRIATIONS COMMITTEES ON JUSTICE AND PUBLIC SAFETY PRIOR TO IMPLEMENTING ANY NEW SAFETY PLANNING POLICY REGARDING SAFETY ASSESSMENTS (DSS-5132) AND THE USE OF TEMPORARY PARENTAL SAFETY AGREEMENTS, AS RECOMMENDED BY THE NORTH CAROLINA COURTS COMMISSION.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services shall consult with the House Appropriations Committee on Justice and Public Safety and the Senate Appropriations Committee on Justice and Public Safety prior to implementing any new Safety Planning Policy regarding Safety Assessments (DSS-5132) and the use of Temporary Parental Safety Agreements.

SECTION 2. This act is effective when it becomes law.







HOUSE BILL 244: Public Participation/Composting Facilities.

2017-2018 General Assembly

Committee: House Health. If favorable, re-refer to Date: March 14, 2017

Environment

Introduced by: Reps. Howard, McElraft, McGrady, Setzer Prepared by: Jennifer Mundt

Analysis of: PCS to First Edition Committee Staff

H244-CSMH-1

OVERVIEW: House Bill 244 would (i) broaden the scope of impacts to be considered when evaluating applications for solid waste management permits, (ii) reduce odors from composting facilities, and (iii) require the Department of Environmental Quality to give notice of and hold a public information hearing for composting facilities.

CURRENT LAW and BILL ANALYSIS:

G.S. 130A-294(a)(4)a. directs the Department of Environmental Quality (DEQ or Department) to develop a permit system for solid waste management facilities. Under current law, the Department must evaluate several criteria in applications for solid waste management facility permits including whether the proposed facility would result in significant damage to ecological systems, natural resources, cultural sites, recreation areas, or historic sites of more than a local significance.

Section 1 of the bill would add school grounds or athletic fields and existing community facilities hosting outdoor activities to the statutory list of examples of ecological systems, natural resources, cultural sites, recreation areas, or historic sites of more than a local significance.

G.S. 130A-309.11 sets out the standards by which the Environmental Management Commission (Commission) adopted rules for compost production at solid waste facilities including rules for the production of (1) hygienically safe compost products for various applications and (2) the development of a classification scheme for different composts based on type of trash, maturity of the compost, and levels of inorganic and organic constituents in the compost (15A NCAC 13B .1400 et seq).

Section 2 of the bill would require the Commission to adopt rules to substantially reduce and minimize fugitive emissions and offensive odors from composting facilities that will adversely affect the general health, safety, and welfare of persons beyond the facility's boundary.

The Proposed Committee Substitute (PCS) would amend Section 3 of the bill to direct DEQ to deny the issuance or renewal of a permit for the construction, operation, expansion, or modification of a solid waste management facility that will produce compost from solid waste or solid waste co-composted with other wastes without first conducting a public information hearing in the county where the facility is proposed to be located. The PCS directs DEQ to give notice of the public information hearing and provides that no permit can be issued or renewed less than 90 days following the hearing.

EFFECTIVE DATE: This act would become effective October 1, 2017.

Karen Cochrane-Brown Director



Legislative Analysis Division 919-733-2578

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HOUSE BILL 244 PROPOSED COMMITTEE SUBSTITUTE H244-CSMH-1 [v.3] 03/09/2017 05:46:58 PM

Short Title:	Public Participation/Composting Facilities.	(Public)
Sponsors:		
Referred to:		

March 6, 2017

A BILL TO BE ENTITLED 2

AN ACT TO BROADEN THE SCOPE OF IMPACTS TO BE CONSIDERED IN SOLID WASTE MANAGEMENT FACILITY PERMITTING, TO PROVIDE FOR NOTICE AND PUBLIC HEARING FOR COMPOSTING FACILITIES, AND TO REDUCE ODOR EMISSIONS FROM THOSE FACILITIES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 130A-294(a)(4) reads as rewritten:

"§ 130A-294. Solid waste management program.

The Department is authorized and directed to engage in research, conduct investigations and surveys, make inspections and establish a statewide solid waste management program. In establishing a program, the Department shall have authority to:

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Develop a permit system governing the establishment and operation of (4)solid waste management facilities. A landfill with a disposal area of 1/2 acre or less for the on-site disposal of land clearing and inert debris is exempt from the permit requirement of this section and shall be governed by G.S. 130A-301.1. Demolition debris from decommissioning of manufacturing buildings, including electric generating stations, that is disposed of on the same site as the decommissioned buildings, is exempt from the permit requirement of this section and rules adopted pursuant to this section and shall be governed by G.S. 130A-301.3. The Department shall not approve an application for a new permit, major permit modification, or a substantial amendment to a permit for a sanitary landfill, excluding demolition landfills as defined in the rules of the Commission, except as provided in subdivisions (3) and (4) of subsection (b1) of this section. No permit shall be granted for a solid waste management facility having discharges that are point sources until the Department has referred the complete plans and specifications to the Commission and has received advice in writing that the plans and specifications are approved in accordance with the provisions of G.S. 143-215.1. In any case where the Department denies a permit for a solid waste management facility, it shall state in writing the reason for denial and shall also state its estimate of the changes in the applicant's proposed activities or plans

that will be required for the applicant to obtain a permit.

45 46 this subsection."

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SECTION 3. This act becomes effective October 1, 2017.

local newspaper of general circulation, and by any other method deemed necessary or appropriate

by the Division to give actual notice of the activities to persons potentially affected. No permit

shall be issued or renewed less than 90 days following the public information hearing required by

H **HOUSE BILL 244**

1

Short Title:

Public Participation/Composting Facilities.

(Public)

Sponsors:

Representatives Howard, McElraft, McGrady, and Setzer (Primary Sponsors).

For a complete list of sponsors, refer to the North Carolina General Assembly web site.

Referred to:

Health, if favorable, Environment

March 6, 2017

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A BILL TO BE ENTITLED

AN ACT TO BROADEN THE SCOPE OF IMPACTS TO BE CONSIDERED IN SOLID WASTE MANAGEMENT FACILITY PERMITTING, TO PROVIDE FOR NOTICE AND PUBLIC HEARING FOR COMPOSTING FACILITIES, AND TO REDUCE ODOR EMISSIONS FROM THOSE FACILITIES.

The General Assembly of North Carolina enacts:

(4)

SECTION 1. G.S. 130A-294(a)(4) reads as rewritten:

"§ 130A-294. Solid waste management program.

- The Department is authorized and directed to engage in research, conduct investigations and surveys, make inspections and establish a statewide solid waste management program. In establishing a program, the Department shall have authority to:
 - Develop a permit system governing the establishment and operation of solid waste management facilities. A landfill with a disposal area of 1/2 acre or less for the on-site disposal of land clearing and inert debris is exempt from the permit requirement of this section and shall be governed by G.S. 130A-301.1. Demolition debris from the decommissioning of manufacturing buildings, including electric generating stations, that is disposed of on the same site as the decommissioned buildings, is exempt from the permit requirement of this section and rules adopted pursuant to this section and shall be governed by G.S. 130A-301.3. The Department shall not approve an application for a new permit, major permit modification, or a substantial amendment to a permit for a sanitary landfill, excluding demolition landfills as defined in the rules of the Commission, except as provided in subdivisions (3) and (4) of subsection (b1) of this section. No permit shall be granted for a solid waste management facility having discharges that are point sources until the Department has referred the complete plans and specifications to the Commission and has received advice in writing that the plans and specifications are approved in accordance with the provisions of G.S. 143-215.1. In any case where the Department denies a permit for a solid waste management facility, it shall state in writing the reason for denial and shall also state its estimate of the changes in the applicant's proposed activities or plans that will be required for the applicant to obtain a permit.

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c. The Department shall deny an application for a permit for a solid waste management facility if the Department finds that:
...

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3. Construction or operation of the facility would result in significant damage to ecological systems, natural resources, cultural sites, recreation areas, or historic sites of more than local significance. These areas include, but are not limited to, national or State parks or forests; wilderness areas; historic sites; recreation areas; school grounds or athletic fields; existing community facilities hosting outdoor activities; segments of the natural and scenic rivers system; wildlife refuges, preserves, and management areas; areas that provide habitat for threatened or endangered species; primary nursery areas and critical fisheries habitat designated by the Marine Fisheries Commission; and Outstanding Resource Waters designated by the Commission.

SECTION 2. G.S. 130A-309.11 reads as rewritten:

"§ 130A-309.11. Compost standards and applications.

 (b) The Commission shall adopt rules to establish standards for the production of compost. Rules shall be adopted not later than 24 months after the initiation of rule making. Such rules shall include:

 (1) Requirements necessary to produce hygienically safe compost products for varying applications.

(2) A classification scheme for compost based on:

 The types of waste composted, including at least one type containing only yard trash;

 The maturity of the compost, including at least three degrees of decomposition for fresh, semi-mature, and mature; and

The levels of organic and inorganic constituents in the compost.

 (3) Requirements necessary to substantially reduce and minimize fugitive emissions and offensive odors from the composting facility that will adversely affect the general health, safety, and welfare of persons beyond the facility's boundary.

(f) The Department shall not issue a permit for the construction, operation, expansion, or modification of a solid waste management facility that will produce compost from solid waste or solid waste co-composted with other wastes without first conducting a public information hearing in the county where the proposed facility is to be located. The public information hearing shall be advertised as a legal notice for two consecutive weeks in a newspaper located within the county or, if no newspaper is published in the county, in a newspaper located in adjoining county in closest proximity to the site of the proposed modified facility. The notice shall run no more than 25 days and no less than 10 days before the public information hearing. No permit shall be issued less than 90 days following the public hearing required by this subsection."

SECTION 3. This act becomes effective October 1, 2017.

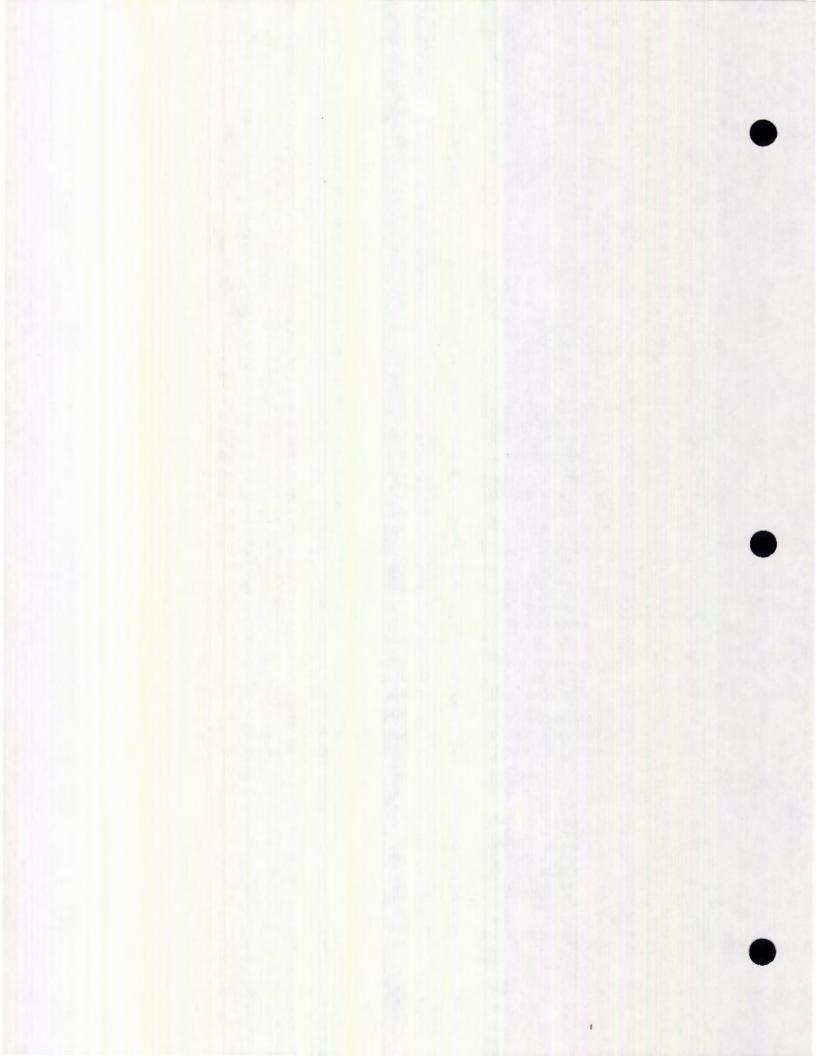




NORTH CAROLINA GENERAL ASSEMBLY **AMENDMENT House Bill 250**

		A	MENDMENT NO)
			(to be filled in by	
	H250-ATA-4 [v.1]		Principal Clerk)	
				Page 1 of 1
	Amends Title [NO] First Edition	Date	3-14	,2017
	Representative			
1 2 3	moves to amend the bill on page 2, lib by rewriting those lines to read:	nes 37 and 38		
4	"SECTION 4. G.S. 90A-	51(2a) reads as requitten:		
5		health practice" means the	he provision of	environmental
6		including administration		
7		ement, and consultation		
8		to or for the public. These		
9		zards and promote and pro		
10	the following are	eas: food, lodging, and	institutional sanit	ation; on-site
11		nent and disposal; publ		
12		isoning prevention; well j		
13		body art establishment sa		
14		lth requiring the delegatio		
15		he Department of Health a		
16 17		tal health professionals to Public Health. The		
18		alth professionals enforcin		
19		ater systems and wells."	g fules of local bo	arus of fleatiff
20	SECTION 5. This act b		1 2018 Permits	for tattooing
21	issued before that date, but not yet ex			o for tattooms
	SIGNED Blone			
		nent Sponsor		
	SIGNED			
	Committee Chair if Sen	ate Committee Amendme	nt	
	ADOPTED FA	AILED	TABLED	







HOUSE BILL 250: Body Art Regulation Changes.

2017-2018 General Assembly

Committee: House Health. If favorable, re-refer to Date: March 14, 2017

Finance

Introduced by: Reps. Corbin, Bert Jones, Murphy Prepared by: Jennifer Muhdt

Analysis of: First Edition Committee Staff

OVERVIEW: House Bill 250 would make changes to the regulation of body art.

CURRENT LAW: Part 11 of Article 8 of Chapter 130A of the General Statutes sets out public health sanitation and permit requirements for tattooing (Part). This Part specifically applies to the practice of tattooing and the requirements for obtaining and renewing a permit from the Department of Health and Human Services or local health department in order to engage in tattooing. The Commission for Public Health adopted a suite of rules to implement this Part (15A NCAC 18A .3200 et seq.).

BILL ANALYSIS: House Bill 250 would:

- Expand and amend Part 11 of Article 8 of Chapter 130A of the General Statutes to define and regulate "body art," to mean procedures conducted for artistic purposes that include body piercing, branding, scarification, subdermal implants, and tattooing.
- Amend the definition of "tattooing" to delete the producing of scar and only refer to the inserting
 of permanent markings or coloration upon or under human skin through puncturing by use of a
 needle or any other method.
- Define the terms "body piercing," "branding," "scarification," and "subdermal implants" for purposes of this Part.
- Provide that any violations of the Part would constitute a Class A1 misdemeanor.
- Provide that this Part does not authorize a person holding a body art permit to treat injuries or disorders of the body by incision or manipulation or otherwise practice medicine as defined Article 1 of Chapter 90 of the General Statutes (Practice of Medicine).

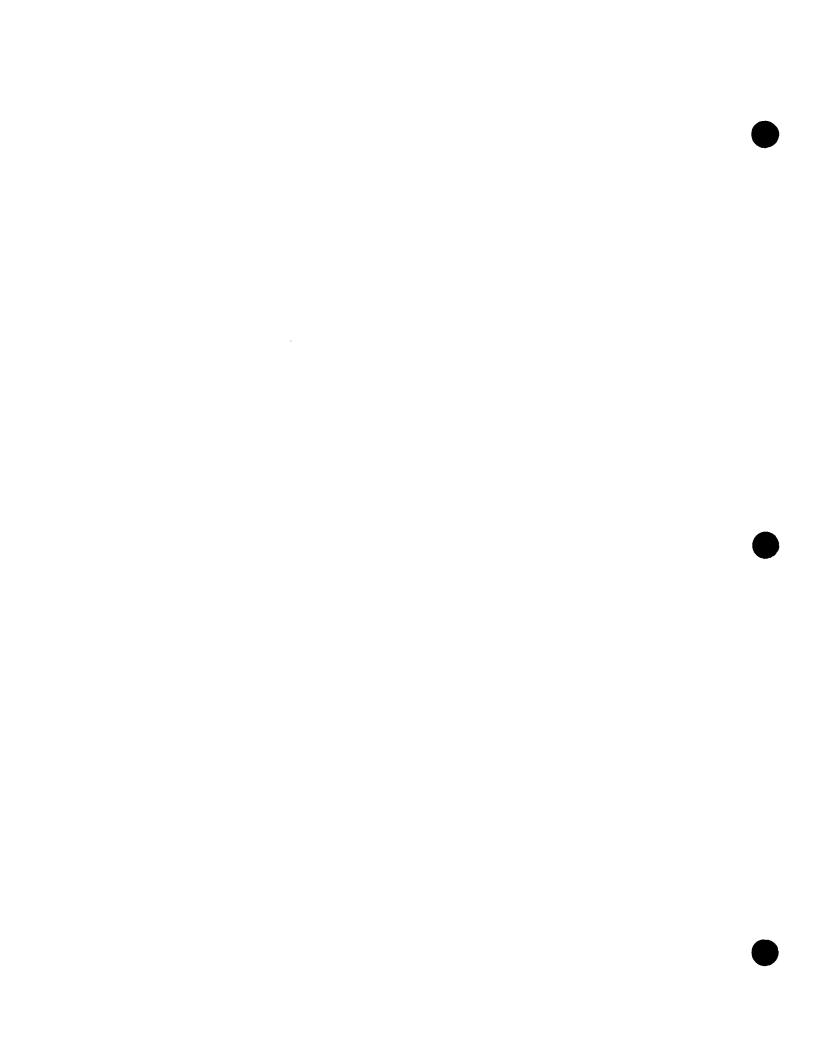
The bill would make conforming changes to the statutes governing the powers and duties of both the Commission for Public Health and local boards of health to reflect the amendments to this Part.

EFFECTIVE DATE: This act would become effective January 1, 2018. Permits for tattooing issued before that date, but not yet expired, must remain valid until expiration.





Legislative Analysis Division 919-733-2578



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HOUSE BILL 250 PROPOSED COMMITTEE SUBSTITUTE H250-PCS40215-TA-4

D

(Public) Body Art Regulation Changes. Short Title: Sponsors: Referred to: March 6, 2017 A BILL TO BE ENTITLED AN ACT TO MAKE CHANGES TO THE REGULATION OF BODY ART. The General Assembly of North Carolina enacts: SECTION 1. Part 11 of Article 8 of Chapter 130A of the General Statutes reads as rewritten: "Part 11. Tattooing. Body Art. "§ 130A-283. Tattooing Body art regulated. Definition. Definitions. - As used in this Part, the term tattooing means the following definitions shall apply: Body art. - Procedures conducted for artistic purposes that include body (1) piercing, branding, scarification, subdermal implants, and tattooing. Body piercing. - The puncturing of the skin of a person by aid of needles (2) designed or used to puncture the skin for the purpose of inserting removable jewelry through the human body. The term does not include the puncturing of the external part of the human earlobe. Branding. - The creation of a permanent mark on human tissue by burning (3) with a hot iron or other similar instrument. Scarification - The injury of the skin involving scratching, etching, or (4) cutting of designs to produce a scar on a human being for ornamentation or decoration. Subdermal implanting. - The insertion of an object under the skin of a (5)person for ornamentation or decoration. Tattooing. -The inserting of permanent markings or coloration, or the (6)producing of sears, coloration upon or under human skin through puncturing by use of a needle or any other method. Prohibited Practice. - No person shall engage in tattooing body art without first obtaining a tattooing body art permit from the Department. Licensed physicians, as well as physician assistants and nurse practitioners working under the supervision of a licensed physician, who perform tattooing body art within the normal course of their professional

practice are exempt from the requirements of this Part.

(c) Application. – To obtain a tattooing—body art permit, a person must apply to the Department. Upon receipt of the application, the Department, acting through the local health department, shall inspect the premises, instruments, utensils, equipment, and procedures of the applicant to determine whether the applicant meets the requirements for a tattooing—body art permit set by the Commission. If the applicant meets these requirements, the Department shall



 issue a permit to the applicant. A permit is valid for one year and must be renewed annually by applying to the Department for a permit renewal.

- (d) Violations. The Department may deny an application for a tattooing body art permit if an applicant does not meet the requirements set by the Commission for the permit. The Department may suspend, revoke, or refuse to renew a permit if it finds that tattooing body art is being performed in violation of this Part. A violation of this Part is a Class A1 misdemeanor. In accordance with G.S. 130A-24(a), Chapter 150B of the General Statutes, the Administrative Procedure Act, governs appeals concerning the enforcement of this Part.
- (e) Limitation. This Part shall not be construed to authorize a person holding a valid body art permit to treat injuries or disorders of the body by incision or manipulation or otherwise practice medicine as defined in Article 1 of Chapter 90 of the General Statutes. A permit issued pursuant to this Part does not authorize a person to remove a tattoo from the body of a human being. Compliance with this Part is not a bar to prosecution for a violation of G.S. 14-400."

SECTION 2. G.S. 130A-29(c) reads as rewritten:

"§ 130A-29. Commission for Public Health – Creation, powers and duties.

17 . 18 (

(c) The Commission shall adopt rules:

(8) Establishing permit requirements for the sanitation of premises, utensils, equipment, and procedures to be used by a person engaged in tattooing, body art, as provided in Part 11 of Article 8 of this Chapter.

SECTION 3. G.S. 130A-39(g) reads as rewritten:

"§ 130.A-39. Powers and duties of a local board of health.
...

(a) A local board of health may impose a fee for s

(g) A local board of health may impose a fee for services to be rendered by a local health department, except where the imposition of a fee is prohibited by statute or where an employee of the local health department is performing the services as an agent of the State. Notwithstanding any other provisions of law, a local board of health may impose cost-related fees for services performed pursuant to Article 11 of this Chapter, "Wastewater Systems," for services performed pursuant to Part 10, Article 8 of this Chapter, "Public Swimming Pools", for services performed pursuant to Part 11, Article 8 of this Chapter, "Tattooing". "Body Art," and for services performed pursuant to G.S. 87-97. Fees shall be based upon a plan recommended by the local health director and approved by the local board of health and the appropriate county board or boards of commissioners. The fees collected under the authority of this subsection are to be deposited to the account of the local health department so that they may be expended for public health purposes in accordance with the provisions of the Local Government Budget and Fiscal Control Act."

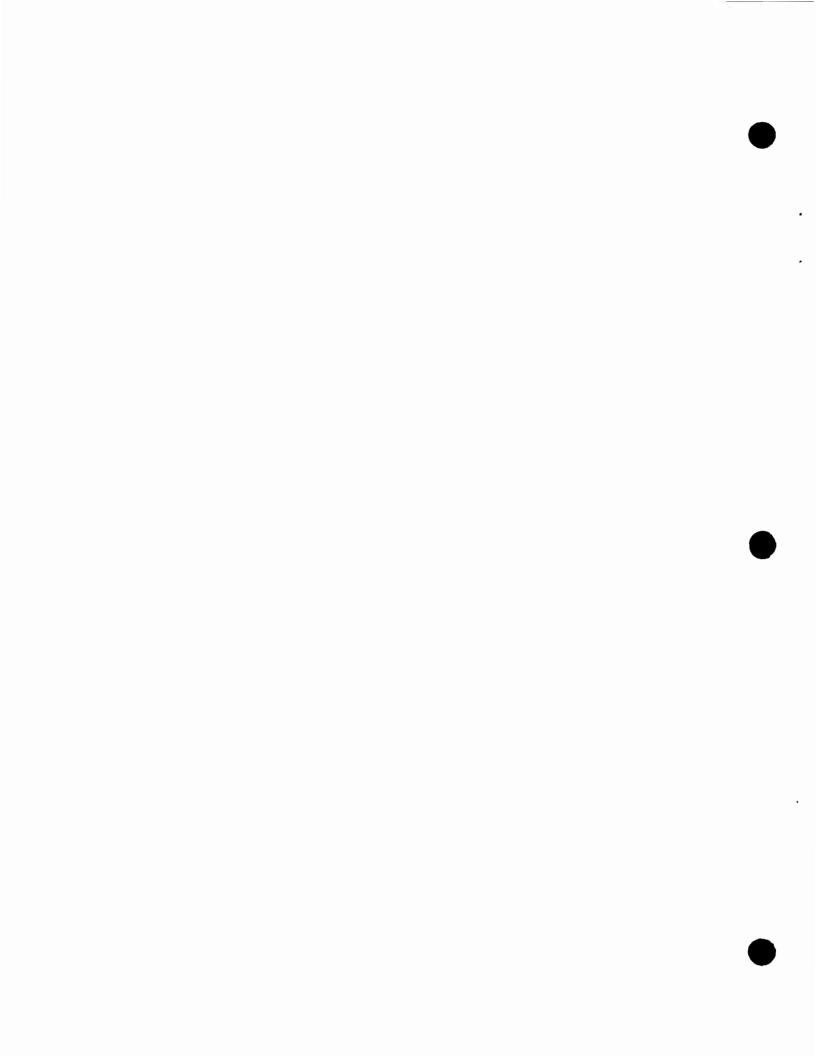
SECTION 4. G.S. 90A-51(2a) reads as rewritten:

 "Environmental health practice" means the provision of environmental health services, including administration, organization, management, education, enforcement, and consultation regarding environmental health services provided to or for the public. These services are offered to prevent environmental hazards and promote and protect the health of the public in the following areas: food, lodging, and institutional sanitation; on-site wastewater treatment and disposal; public swimming pool sanitation; childhood lead poisoning prevention; well permitting and inspection; tattoo parlor sanitation; body art establishment sanitation; and all other areas of environmental health requiring the delegation of authority by the Division of Public Health of the Department of Health and Human Services to State and

	General Assembly Of North Carolina Session 2017
1	local environmental health professionals to enforce rules adopted by the
2	Commission for Public Health. The definition also includes local
3	environmental health professionals enforcing rules of local boards of health
4	for on-site wastewater systems and wells."
5	SECTION 5. This act becomes effective January 1, 2018. Permits for tattooing

SECTION 5. This act becomes effective January 1, 2018. Permits for tattooing issued before that date, but not yet expired, shall remain valid until expiration.

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HOUSE BILL 250

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(Public) Short Title: Body Art Regulation Changes. Sponsors: Representatives Corbin, Bert Jones, and Murphy (Primary Sponsors). For a complete list of sponsors, refer to the North Carolina General Assembly web site. Referred to: Health, if favorable, Finance

March 6 2017

		iviateli 0, 2017
1		A BILL TO BE ENTITLED
2	AN ACT TO !	MAKE CHANGES TO THE REGULATION OF BODY ART.
3	The General A	ssembly of North Carolina enacts:
4	SE	CTION 1. Part 11 of Article 8 of Chapter 130A of the General Statutes reads as
5	rewritten:	
6		"Part 11. Tattooing. Body Art.
7	"§ 130A-283.	Tattooing Body art regulated.
8	(a) De	Finition. Definitions As used in this Part, the term tattooing means following
9	definitions sha	ll apply:
10	(1)	Body art Procedures conducted for artistic purposes that include body
11		piercing, branding, scarification, subdermal implants, and tattooing.
12	(2)	
13		designed or used to puncture the skin for the purpose of inserting removable
14		jewelry through the human body. The term does not include the puncturing of
15		the external part of the human earlobe.
16	(3)	
17		a hot iron or other similar instrument.
18	<u>(4)</u>	
19		of designs to produce a scar on a human being for ornamentation or decoration.
20	(5)	
21		for ornamentation or decoration.
22	<u>(6)</u>	
23		producing of sears, coloration upon or under human skin through puncturing by
24		use of a needle or any other method.
25	(b) Pro	hibited Practice No person shall engage in tattooing body art without first

- Prohibited Practice. No person shall engage in tattooing body art without first obtaining a tattooing body art permit from the Department. Licensed physicians, as well as physician assistants and nurse practitioners working under the supervision of a licensed physician, who perform tattooing body art within the normal course of their professional practice are exempt from the requirements of this Part.
- Application. To obtain a tattooing body art permit, a person must apply to the Department. Upon receipt of the application, the Department, acting through the local health department, shall inspect the premises, instruments, utensils, equipment, and procedures of the applicant to determine whether the applicant meets the requirements for a tattooing body art permit set by the Commission. If the applicant meets these requirements, the Department shall



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issue a permit to the applicant. A permit is valid for one year and must be renewed annually by applying to the Department for a permit renewal.

- (d) Violations. The Department may deny an application for a tattooing body art permit if an applicant does not meet the requirements set by the Commission for the permit. The Department may suspend, revoke, or refuse to renew a permit if it finds that tattooing body art is being performed in violation of this Part. A violation of this Part is a Class A1 misdemeanor. In accordance with G.S. 130A-24(a), Chapter 150B of the General Statutes, the Administrative Procedure Act, governs appeals concerning the enforcement of this Part.
- (e) Limitation. This Part shall not be construed to authorize a person holding a valid body art permit to treat injuries or disorders of the body by incision or manipulation or otherwise practice medicine as defined in Article 1 of Chapter 90 of the General Statutes. A permit issued pursuant to this Part does not authorize a person to remove a tattoo from the body of a human being. Compliance with this Part is not a bar to prosecution for a violation of G.S. 14-400."

SECTION 2. G.S. 130A-29(c) reads as rewritten:

"§ 130A-29. Commission for Public Health – Creation, powers and duties.

- (c) The Commission shall adopt rules:
 - (8) Establishing permit requirements for the sanitation of premises, utensils, equipment, and procedures to be used by a person engaged in tattooing, body art, as provided in Part 11 of Article 8 of this Chapter.

SECTION 3. G.S. 130A-39(g) reads as rewritten: "§ 130A-39. Powers and duties of a local board of health.

(g) A local board of health may impose a fee for services to be rendered by a local health department, except where the imposition of a fee is prohibited by statute or where an employee of the local health department is performing the services as an agent of the State. Notwithstanding any other provisions of law, a local board of health may impose cost-related fees for services performed pursuant to Article 11 of this Chapter, "Wastewater Systems," for services performed pursuant to Part 10, Article 8 of this Chapter, "Public Swimming Pools", for services performed pursuant to Part 11, Article 8 of this Chapter, "Tattooing", "Body Art," and for services performed pursuant to G.S. 87-97. Fees shall be based upon a plan recommended by the local health director and approved by the local board of health and the appropriate county board or boards of commissioners. The fees collected under the authority of this subsection are to be deposited to the account of the local health department so that they may be expended for public health purposes in accordance with the provisions of the Local Government Budget and Fiscal Control Act."

SECTION 4. This act becomes effective January 1, 2018. Permits for tattooing issued before that date, but not yet expired, shall remain valid until expiration.



HOUSE BILL 258: Amend Med. Mal. Health Care Provider Defin.

2017-2018 General Assembly

Committee: House Health. If favorable, re-refer to Date: March 10, 2017

Judiciary I

Introduced by: Reps. Riddell, Fraley, Bert Jones, Clampitt Prepared by: Jason Moran-Bates

Analysis of: First Edition Committee Co-Counsel

OVERVIEW: House Bill 258 would amend Article 1B of Chapter 90 of the General Statutes to include paramedics under the definition of health care providers for purposes of medical malpractice actions.

CURRENT LAW: Article 1B of Chapter 90 sets forth the standards of care and burdens of proof for medical malpractice cases. It also provides a Good Samaritan exception for volunteer providers of emergency health care.

BILL ANALYSIS: House Bill 258 would amend the definition of health care provider in G.S. 90-21.11(1) to include paramedics as defined in G.S. 131E-155(15a). In order to be a paramedic under G.S. 131E-155(15a) an individual must complete education in emergency medical care approved by DHHS and be credentialed as a paramedic by DHHS. Under House Bill 258, a plaintiff would not be able to recover damages from a paramedic unless the plaintiff showed by the preponderance of evidence that the paramedic failed to provide the level of care that would have been provided by a similarly educated and trained paramedic from a similar community under similar circumstances. If the care the paramedic provided was emergency care, the plaintiff's burden of proof would rise to clear and convincing evidence.

Paramedics who provide voluntary medical care without expectation of compensation would be covered by the Good Samaritan exception in G.S. 90-21.14 and could not be found liable in a malpractice action unless they acted with gross negligence, wanton conduct, or intentional wrongdoing.

EFFECTIVE DATE: This act would be effective when it becomes law and would apply to causes of action arising on or after that date.

Karen Cochrane-Brown
Director



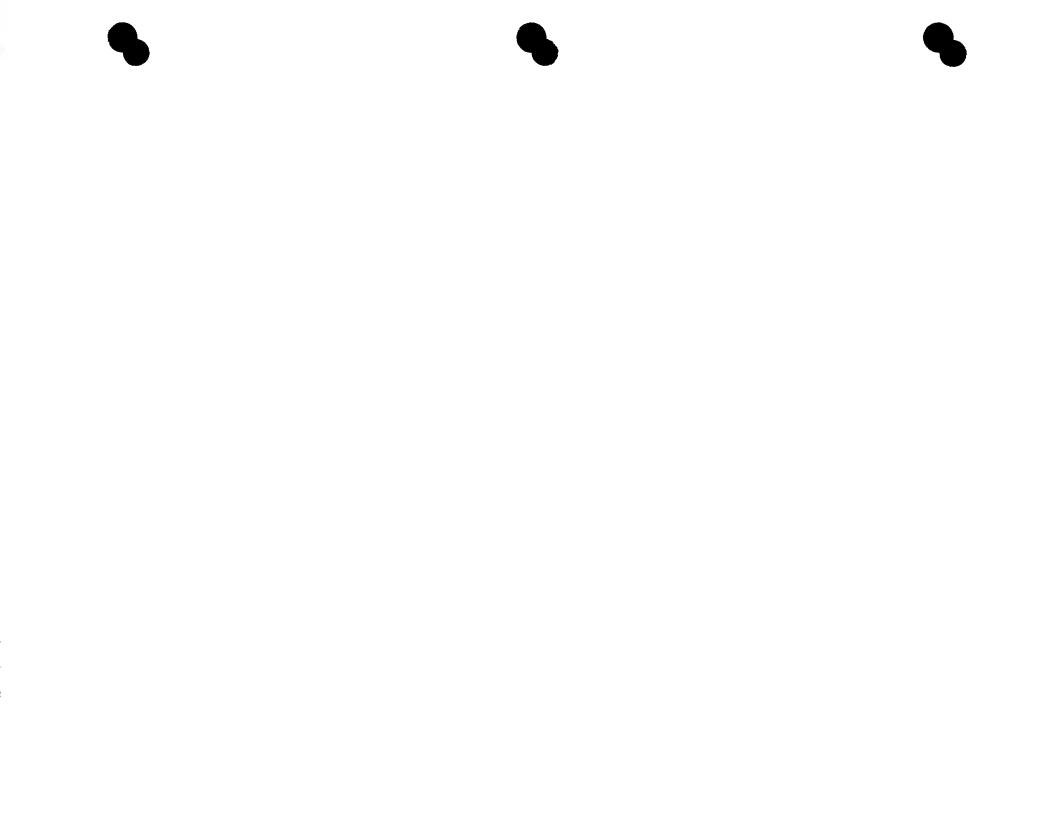
Legislative Analysis Division 919-733-2578

H HOUSE BILL 258

Short Title:	Amend Med. Mal. Health Care Provider Defin.	(Public)	
Sponsors:	Sponsors: Representatives Riddell, Fraley, Bert Jones, and Clampitt (Primary Sponsors). For a complete list of sponsors, refer to the North Carolina General Assembly web site.		
Referred to:	Health, if favorable, Judiciary I		
	March 7, 2017		
A BILL TO BE ENTITLED AN ACT AMENDING THE DEFINITION OF HEALTH CARE PROVIDER IN ARTICLE 1B OF CHAPTER 90 OF THE GENERAL STATUTES TO INCLUDE PARAMEDICS. The General Assembly of North Carolina enacts: SECTION 1. G.S. 90-21.11(1) reads as rewritten: "(1) Health care provider. – Without limitation, any of the following:			
Sl	e. Any paramedic, as defined in G.S. 131E-155(15a)." ECTION 2. This act is effective when it becomes law and applies to come	auses of action	

arising on or after that date.





NORTH CAROLINA GENERAL ASSEMBLY HOUSE OF REPRESENTATIVES

HEALTH COMMITTEE REPORT

Representative Justin P. Burr, Co-Chair Representative Josh Dobson, Co-Chair Representative Bert Jones, Co-Chair Representative Donny Lambeth, Co-Chair Representative Gregory F. Murphy, MD, Co-Chair

FAVORABLE AND RE-REFERRED

HB 226 Consultation Requirements for DHHS.

Draft Number:

None

Serial Referral: **APPROPRIATIONS**

Recommended Referral: None Long Title Amended:

No

Floor Manager:

Rogers

HB 258 Amend Med. Mal. Health Care Provider Defin.

Draft Number:

None

No Riddell

Serial Referral: JUDICIARY I

Recommended Referral: None Long Title Amended: Floor Manager:

FAVORABLE COM SUB, UNFAVORABLE ORIGINAL BILL AND RE-REFERRED

HB 244 Public Participation/Composting Facilities.

> Draft Number: H244-PCS40212-MH-1

Serial Referral: ENVIRONMENT

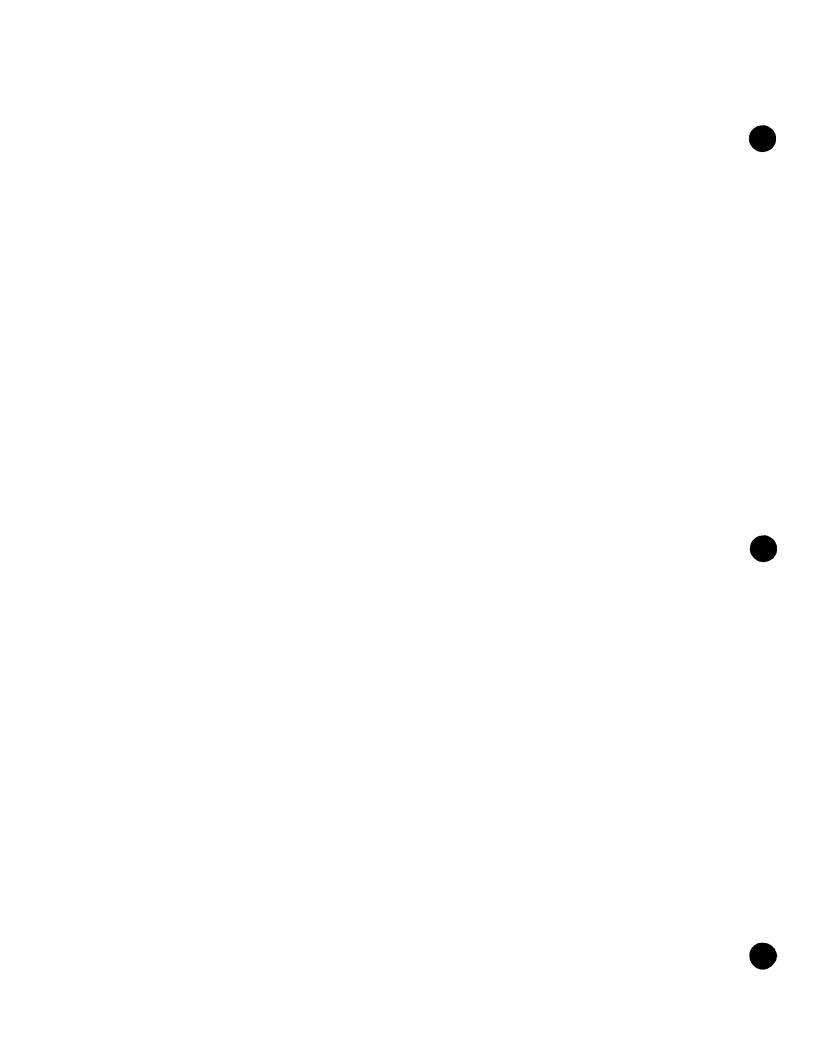
Recommended Referral: None Long Title Amended:

No

Floor Manager: Howard

TOTAL REPORTED: 3





NORTH CAROLINA GENERAL ASSEMBLY HOUSE OF REPRESENTATIVES

HEALTH COMMITTEE REPORT

Representative Justin P. Burr, Co-Chair Representative Josh Dobson, Co-Chair Representative Bert Jones, Co-Chair Representative Donny Lambeth, Co-Chair Representative Gregory F. Murphy, MD, Co-Chair

${\bf FAVORABLE\ COM\ SUB\ ,\ UNFAVORABLE\ ORIGINAL\ BILL\ AND\ RE-REFERRED}$

HB **250** Body Art Regulation Changes.

Draft Number: H250-PCS40215-TA-4

Serial Referral: FINANCE
Recommended Referral: None
Long Title Amended: No
Floor Manager: Corbin

TOTAL REPORTED: 1



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Emerging Public Health Issues: Unnecessary Exposures to Hepatitis-C and Other Blood Borne Pathogens Through Sharing of Needles, Illegal Tattooing and Unregulated Body Art (piercings and implants)

Hepatitis C (Hep-C): Hep-C is classified two ways; Chronic Hep-C and Acute Hep-C. Chronic Hep-C is a slow-progressing se, with symptoms that may not appear for years, if at all. If left untreated, Chronic Hep-C can lead to liver damage, and potentially even liver cancer. Acute Hep-C is a short term viral infection that occurs within the first 6 months after someone is exposed to the Hepatitis C virus. For most people an Acute Hep-C infection will turn into Chronic Hep-C. Hep-C is usually spread when blood from a person infected with the Hep-C virus enters the body of someone who is not infected. Hep-C is the most common bloodborne infection in the US, and there is no vaccine; however, it is treatable condition. Today, most people become infected with the Hep-C virus by sharing of needles or other equipment used for injection purposes. Other ways Hep-C can be spread is through contact with dried blood on equipment or surfaces, and/or blood splashes in the eyes, nose, or mouth.

The number of acute Hep-C cases is on the rise in North Carolina (NC). Between 2010 and 2015 the number of reported cases of acute Hep-C has tripled (close to a 300% increase). Acute Hep-C is a reportable disease under state law; however, it continues to go under-reported and underestimated. It is estimated that there are approximately 110,000 North Carolinians with Chronic Hep-C. Some Facts about Hep-C:

- Hep-C virus is *IOX* more infectious then HIV;
- 50% of cases are more than likely unaware they've been infected;
- 41% of cases are between the ages of 21 and 30;
- 75% of adults with Hep-C are Baby Boomers (born between 1945 & 1965);
- 37% of those infected reported injection drug use; and
- 75% to 85% of people infected with Hep-C will develop chronic illness."

Hep-C in Western North Carolina (WNC): In Macon County and many surrounding counties, Hep-C has become a significant health concern. A recent Center for Disease Control and Prevention (CDC) study identified five counties in NC, e of which are in WNC: Graham, Clay and Cherokee as being in the top 220 counties in the United States as having a high revalence of Acute Hep-C infections: Macon County shares a border with these counties.

Tattoos, Piercings and other forms of Body Modifications (all referred to as "body art") are prevalent in today's society including here in WNC. While it used to be uncommon to encounter someone with a tattoo or piercing outside of certain groups, one can hardly go about their day without encountering someone who has been tattooed or pierced.

Research studies show that in the informal, unregulated tattooing and piercing settings, where poor infection-control practices are used that the transmission of Hep-C is possible.^{iv} These same studies show that when tattooing and piercing are properly regulated Hep-C is not spread.

Tattooing in NC: The tattoo industry in NC is currently regulated and enforced at the local level by the county health department. These laws are in place to protect the health and safety of both artist and the client due to the potential ease of transmission of bloodborne pathogens during the tattooing process. Improper (and illegal) tattooing techniques lead to the transmission of diseases (including Hep-C, Hep-B and HIV) that are serious and have a lifelong impact on the individual and could create significant increases in cost of health care for everyone. Proper tattooing techniques ensure that those who do receive tattoos do so in a safe manner. In addition to the techniques used, the use of proper equipment (such as an autoclave and disposable needles), and the proper treatment of inks are important to prevent bloodborne pathogens/disease from being spread.

There are consequences to those found to be tattooing without a permit in NC law. However, these consequences are not proving to be severe enough to discourage those who tattoo illegally (class I misdemeanor), and enforcing these consequences has even to be difficult (not viewed by the legal system as a significant crime).

In recent months, we have seen a rise in the number of illegal tattoo artists operating in Macon County. This department has invested a significant number of work hours to ensure these individuals cease and desist from tattooing. Additionally, we have had to invest significant time in investigating this illegal operation in an effort to identify the people this individual tattooed so as to make sure they were appropriately tested for Hep-C, Hep-B and HIV as these viruses can make them sick and possibly their families sick. This is not just a Macon County problem. As the department has been working to address this issue, we have determined that other county health departments are experiencing a similar problem. Given how common body art is today, and due to the high prevalence of Hep-C in WNC, an examination of the impacts on health and possible further regulation of these industries should be considered.

Piercings and Body Modifications in NC: Piercing and other body modifications (such as dermal implants) are currently unregulated in NC; however, there is mention in General Statute I4-400 that body piercing of a minor is prohibited. Professional organizations (such as Association of Professional Piercers) that support safe piercing techniques and practices exist; however, membership is voluntary and uncommon.

Piercing and body modification have their own set of issues in the spread of bloodborne pathogens. The use of equipment similar to what is found in a permitted tattoo establishment along with procedures to minimize the risk of spreading infection such as Hep-C to those who wish to be pierced are lacking or non-existent in most of these establishments.

Piercing and body modification also presents other health risks. For example individuals with diabetes, hemophilia, autoimmune disorders, cardiac issues, skin conditions or who are or may be pregnant may experience serious complications from the procedure (i.e. bleeding, skin rashes or lesions, scars, viral or bacterial infections, etc.).

The Following are Areas of Concern Regarding Tattooing, Piercing and Body Modification in Relation to Hep-C:

- Penalties for tattooing without a permit do not discourage individuals from practicing without a permit.
- The act of piercing or body modifications is not regulated or inspected even though many times these procedures require
 the insertion of a needle and/or in some cases a surgical incision with a scalpel to place rings, plugs, eyelets, gauges, and
 other articles of jewelry.
- Piercing and tattooing, done improperly, pose a risk for infection; training in prevention of bloodborne pathogen exposure for those practitioners would minimize these risks for them and their clients.
- Occupational Safety and Health Administration Bloodborne Pathogens Standards that address accidental needle sticks
 do apply to these is industry and they are required to maintain an OSHA Exposure Control Plan for accidental needle
 sticks, but these standards are generally not followed or enforced.
- Food and Drug Administration recently became aware of tattoo inks that had confirmed bacterial contamination in unopened bottles available for purchase online: neither tattoo inks nor tattoo equipment are regulated by the FDA.
- Non-sterile water used to dilute concentrated inks can contaminate the ink with harmful germs which can lead to infections when deposited under the skin and spread to the bloodstream.
- Though Hep-C is a treatable disease, the cost of treatment is extremely expensive and in many cases out of reach for the average person.

Sharing of Needles: The sharing of needles by intravenous (IV) drug users is a primary contributor to the spread of HIV and Hep-C in NC. We commend the NC General Assembly for passing legislation which was signed into law and with an effective date of July II, 2016. The new law allows any governmental or nongovernmental organization, including health departments, to establish and operate a needle and hypodermic syringe exchange program.

^{iv} Bloodborne pathogen risk reduction activities in the body piercing and tattooing industry. Lehman, EJ; Huy, J; Levy, E; Viet, SM; Mobley, A; McCleery, TZ, American Journal of Infect Control 2010 Mar; 38(2):130-138. http://dx.doi.org/10.1016/j.ajic.2009.07.008.



¹Center for Disease Control and Prevention: http://www.cdc.gov/hepatitis/hcv/cfaq.htm 8/5/2016

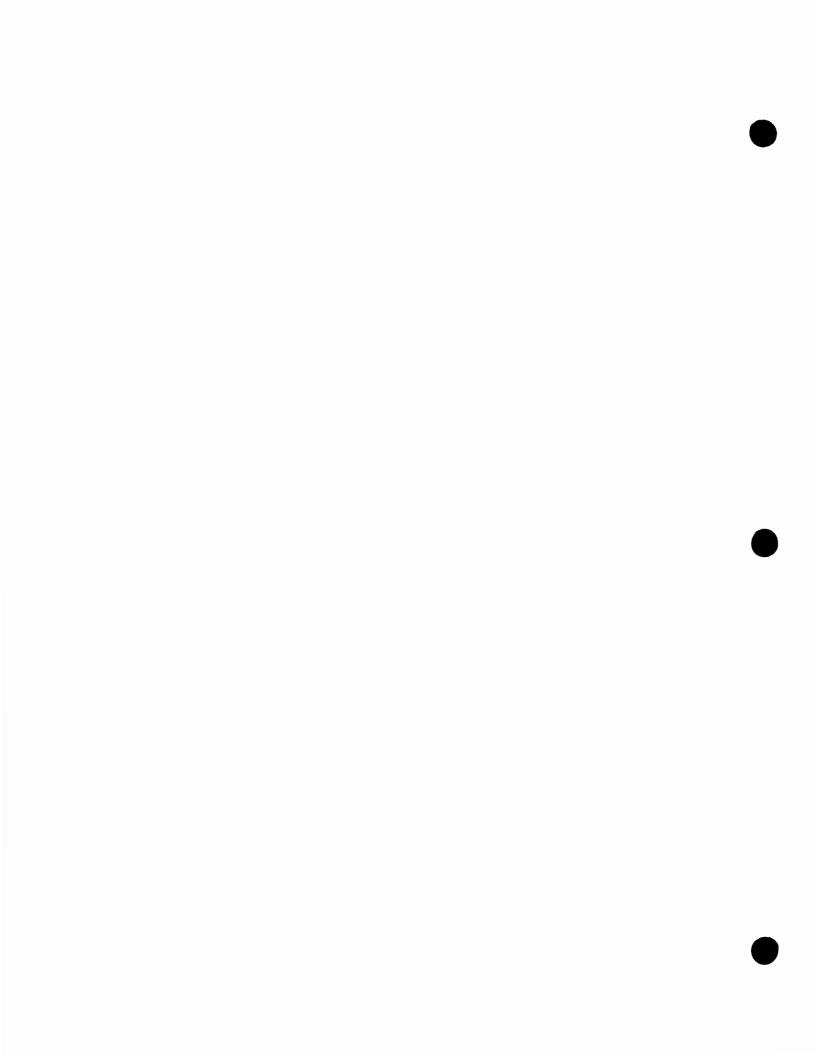
[&]quot; NC DHHS, DHP, Communicable Disease Branch, Hepatitis-C In NC 2016 Fact Sheet 05/13/2016

Center for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention,

County-level Vulnerability to Rapid Dissemination of HIV/HCV Infection Among Persons who Inject Drugs 3/8/2016

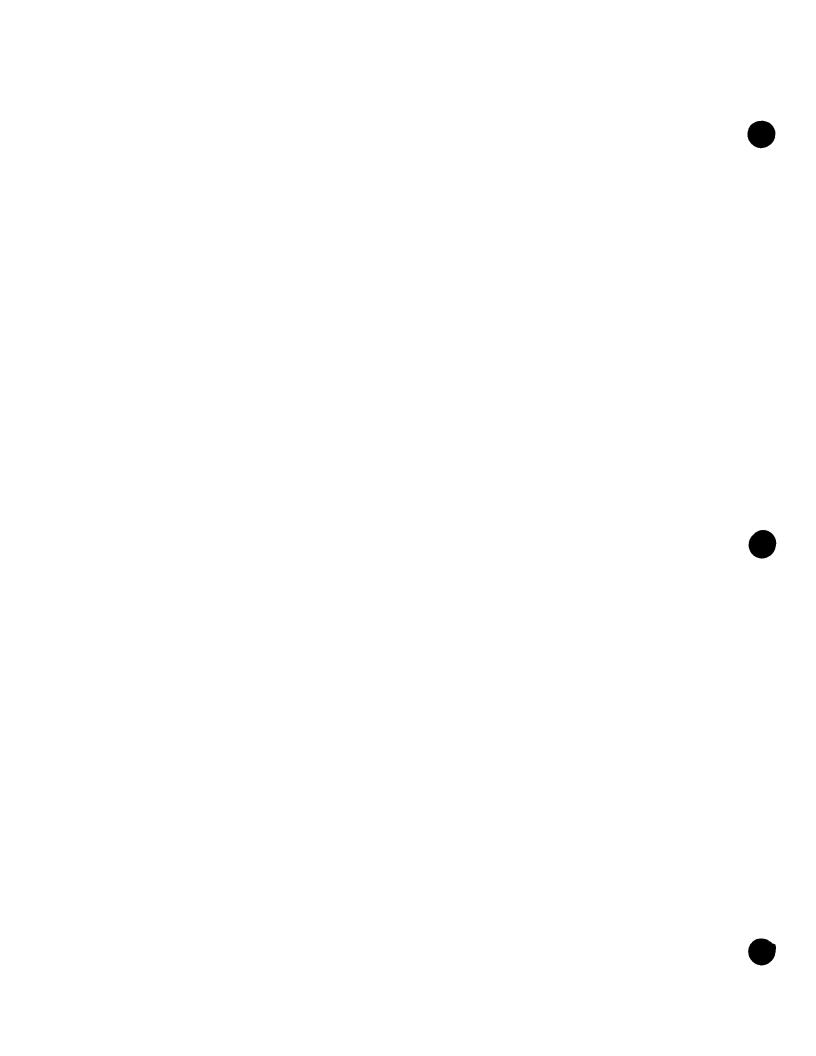
Committee Sergeants at Arms

NAME O	e committee H	ouse Comr	<u>n. on Healt</u>
DATE:	03/14/17	Room:	643
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		House Sgt-At Arr	ns:
1. Name:	Young Bae	-	
2. Name:	Jim Moran		BAFAN V VANADOR
3. Name:	Warren Haw	kins	
4. Name:	David Linthic	cum	•
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House Pages Assignments Tuesday, March 14, 2017 Session: 2:00 PM

Committee	Room	Time	Staff	Comments	Member
HEALTH	643	15 MIN.	Hannah Lewis		Rep. Speaker Tim Moore
		AFTER	7		
		SESSION			
			Yasmeen Ayesh		Rep. Speaker Tim Moore
			Yara Mahmoud		Rep. Speaker Tim Moore
			Brooke Reutinger		Rep. Speaker Tim Moore
Rules, Calendar, and	1228	15 MIN	Hannah Bethea		Rep. Garland Pierce
Operations of the House		AFTER SESSION			
			Marissa Huggins		Rep. Mike Clampitt
			Sophia Sload		Rep. Speaker Tim Moore



VISITOR REGISTRATION SHEET

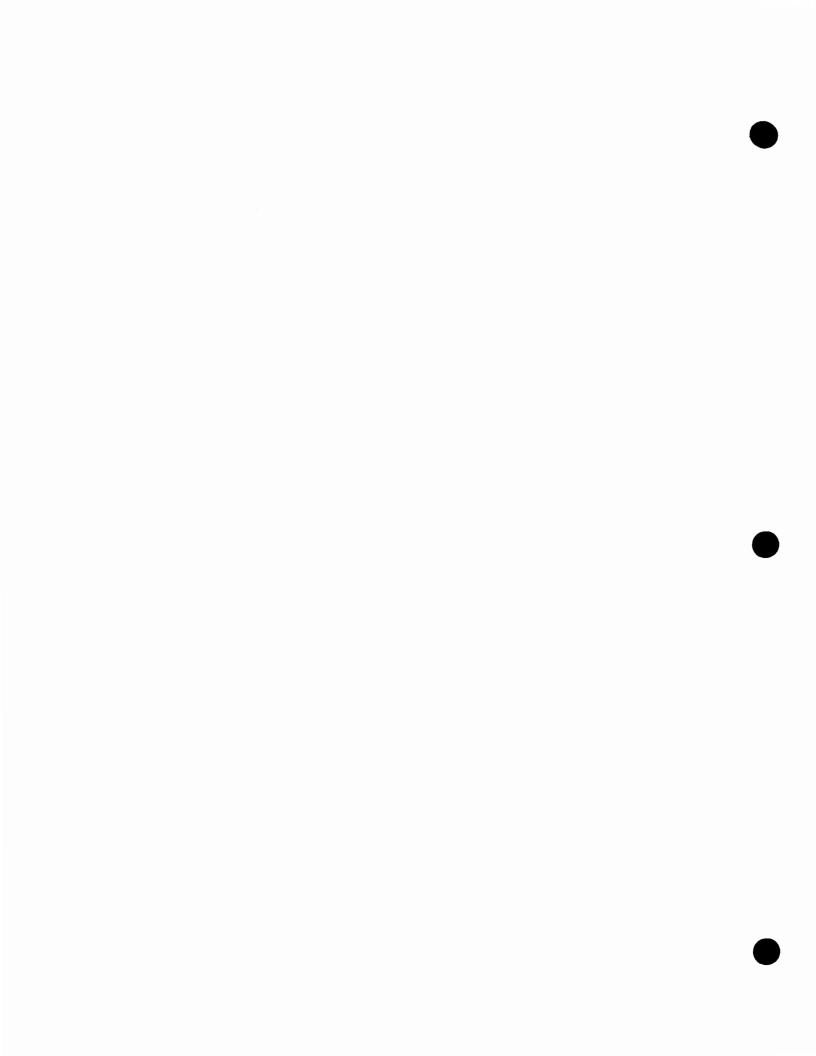
House Comm. on Health

03/14/17

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS	
Dodu Renfer	CCR	
Fred Bore	Bone: A350,	
Joel Fariloth	NC Assoc of Rescue & EMS	
Blair Borny	RA-Pours	



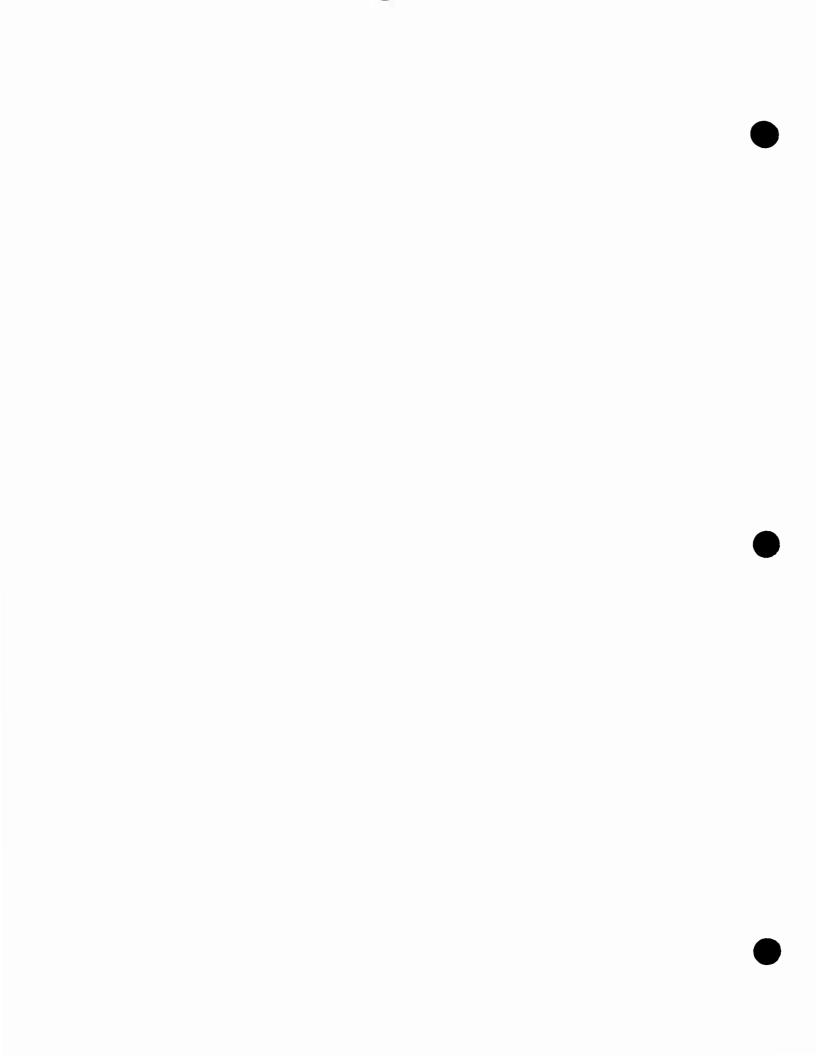
VISITOR REGISTRATION SHEET

House Comm. on Health

03/14/17

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS	
Pen Buff	5°G	
McLean Pires	Inter	
Chris Broughton	MWC	
Keltykrissburg	3P	X .
caroline Miller	·AMGA	
Henry Jones	Jordon Frice	
And miller	DEQ.	
This M'cline	86	
Lepensin	CSS.	
Livi Owner	MIRMA	
Bu Glager	CaroMont	



VISITOR REGISTRATION SHEET

House Comm. on Health 03/14/17

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS			
Anna Martina	Oak City Government	Relations		
Julia Adams -	Oak City Government	Relations		
High Johnson	NCACC			
John Rease	NCACC			
Michelle Frazier	. SML			
Josh Lanca	SML			
LT Mc Crimmon	DHHS			
BenPopken	DHHS .			
	Gateway Health			



House Committee on Health Wednesday, March 15, 2017 at 11:00 AM Room 643 of the Legislative Office Building

MINUTES

The House Committee on Health met at 11:00 AM on March 15, 2017 in Room 643 of the Legislative Office Building. Representatives Adcock, Ball, Blackwell, Boswell, Burr, Carney, Cunningham, Dobson, Dollar, Dulin, Earle, Farmer-Butterfield, Ford, Hunter, Insko, Jackson, Bert Jones, Lambeth, Lucas, Malone, Murphy, Potts, Rogers, Setzer, Shepard, Szoka, White, Wray, Yarborough, and Zachary attended.

Representative Justin Burr presided.

The following bill was considered:

HB 88 Modernize Nursing Practice Act. (Representatives Dobson, Lambeth, Stevens, Adcock)

The meeting was FOR DISCUSSION ONLY. Representatives Dobson and Lambeth explained the bill.

Public comments were offered by supporters and opponents of the bill with each having a total of 15 minutes to speak.

After the speakers concluded, members of the committee responded with questions for sponsors and the supporters and opponents of the bill.

Handouts and speaker names are included and made a part of these Minutes.

The meeting adjourned at 12:00 P.M.

Representative Justin P. Burr

Presiding

Dina Long, Committee Clerk

Jan Pann

NORTH CAROLINA HOUSE OF REPRESENTATIVES COMMITTEE MEETING NOTICE AND BILL SPONSOR NOTIFICATION 2017-2018 SESSION

You are hereby notified that the House Committee on Health will meet as follows:

TIME: LOCATION	N:	Wednesday, March 15, 201 11:00 AM 643 LOB Rep. Burr will preside.	7		
The followin	The following bills will be considered:				
BILL NO. HB 88	Mo	ORT TITLE dernize Nursing Practice Act DISCUSSION ONLY.	SPONSOR Representative Dobson Representative Lambeth Representative Stevens Representative Adcock Respectfully,		
			Representative Justin P. Burr, Co-Chair Representative Josh Dobson, Co-Chair Representative Bert Jones, Co-Chair Representative Donny Lambeth, Co-Chair Representative Gregory F. Murphy, MD, Co-Chair		
I hereby cert Monday, Ma	-	•	nmittee assistant at the following offices at 2:30 PM or		
		Principal Clerk Reading Clerk – House Char	nber		
Brenda Olls	(Con	nmittee Assistant)			

	_

House Committee on Health Wednesday, March 15, 2017, 11:00 AM 643 Legislative Office Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

BILL NO. SHORT TITLE

HB 88 Modernize Nursing Practice Act.

DISCUSSION ONLY.

SPONSOR

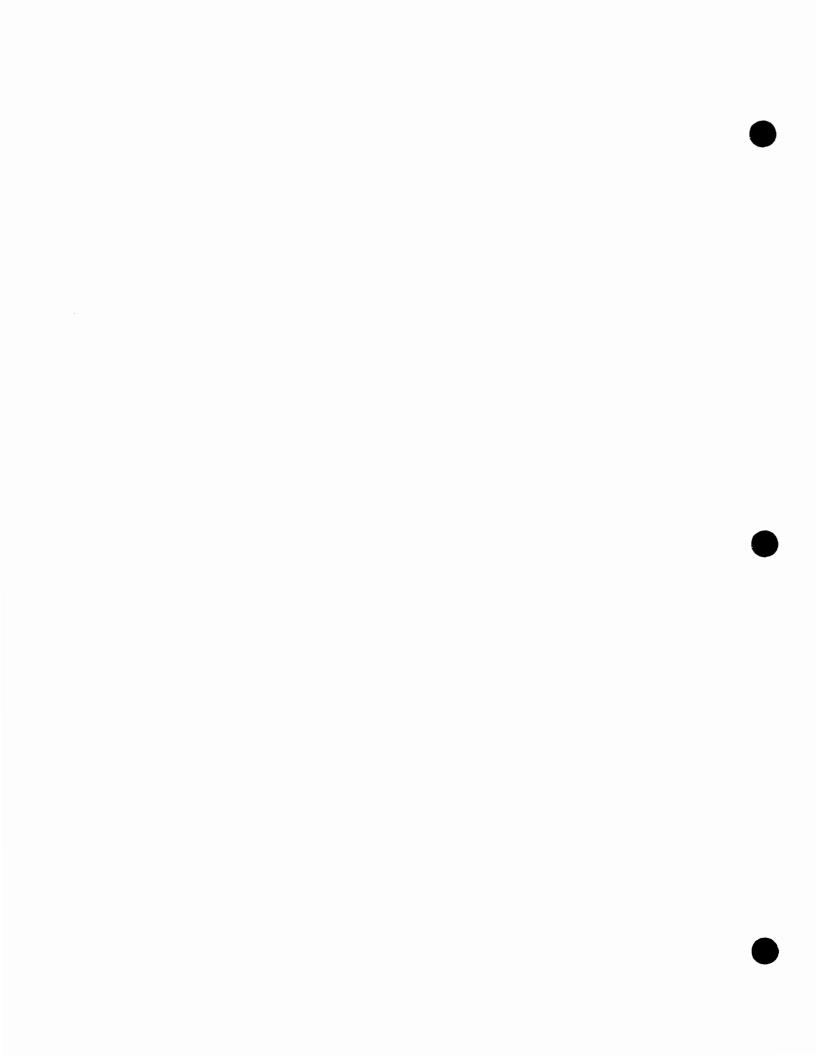
Representative Dobson Representative Lambeth Representative Stevens Representative Adcock

Presentations

The meeting will be FOR DISCUSSION ONLY, with each side having a total of 15 minutes to express their support or opposition to the bill.

Other Business

Adjournment





HOUSE BILL 88: Modernize Nursing Practice Act.

2017-2018 General Assembly

Committee: House Health. If favorable, re-refer

February 20, 2017

Insurance. If favorable, re-refer to Finance

Introduced by: Reps. Dobson, Lambeth, Stevens, Adcock

Prepared by: Jason Moran-Bates

Analysis of: First Edition

Committee Co-Counsel

OVERVIEW: House Bill 88 would amend the Nursing Practice Act to create a category of nursing license for Advance Practice Registered Nurses (APRN). APRNs can practice in any of four roles: Nurse Practitioner, Certified Nurse Midwife, Clinical Nurse Specialist, or Certified Registered Nurse Anesthetist. The bill would also give the North Carolina Board of Nursing (Board) the authority to regulate APRNs as well as establish eligibility requirements and licensing renewal and reinstatement rules. In addition, the bill modifies the composition of the Board to add an APRN, expands the Board's disciplinary powers, clarifies rules regarding public records, and makes numerous technical changes.

CURRENT LAW: The Nursing Practice Act is Article 9A of Chapter 90 of the General Statutes. Currently, it does not contain any provisions regarding APRNs, which are governed by Title 21, Chapter 36 of the North Carolina Administrative Code.

BILL ANALYSIS: Section 1 of the bill would amend G.S. 90-171.20 to add definitions for advanced assessments; APRN; Nurse anesthesia activities; Population focus; and the practice of nursing as an APRN, certified nurse midwife (CNM), certified registered nurse anesthetist (CRNA), clinical nurse specialist (CNS), and Nurse Practitioner (NP). It would also make conforming changes to the remaining definitions in G.S. 90-171.20.

Section 2 would amend G.S. 90-18(c) to clarify that the practice of nursing as a CRNA does not constitute the practice of medicine or surgery.

Section 3 would amend G.S. 90-29(b)(6) to clarify that the practice of nursing as a CRNA does not constitute the practice of dentistry.

Section 4 would amend G.S. 90-171.21 to create a slot for an APRN on the Board, allow all APRNs to vote for the APRN member, and establish eligibility criteria for the APRN member. It would also allow the Board to select the person who received the second-highest number of votes in an election to fill the remainder of the unexpired term for a vacancy of a registered nurse or licensed practical nurse and modify the eligibility criteria for the remaining Board members who are nurses but not APRNs. Section 4(b) makes Section 4 applicable to all Board members appointed after the bill becomes law.

Section 5 would amend G.S. 90-171.23(b), outlining the duties and powers of the Board, to remove the requirement that the Board appoint and maintain a subcommittee to work with the North Carolina Medical Board to develop rules and regulations governing the performance of medical acts by nurses. Instead, the Board would have sole power to grant prescribing, ordering, dispensing, and furnishing authority to APRNs. This section would also allow the Board to establish programs to monitor the treatment, recovery, and safe practice of nurses with substance abuse, mental, or physical disorders that





Legislative Analysis Division 919-733-2578

House Bill 88

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may impact their ability to deliver safe care. Section 5 would also to allow the Board to subpoena patient records, but require the Board to withhold any patient identifying information from public disclosure. It would also make several technical, clarifying changes to the powers granted to the Board.

Section 6 would amend G.S. 90-171.24 to require the Executive Director of the Board to hold an active North Carolina registered nurse license, be a North Carolina resident, have a minimum of five years' experience, and have no disciplinary history or criminal convictions related to nursing.

Section 7 would amend 90-171.27(b) to establish fees for APRNs and make other technical changes.

Section 8 would make technical changes to G.S. 90-171.29

Section 9 would add a new section to Article 9A of Chapter 90 allowing the Board to require applicants for a nursing license to submit to mental and physical examinations.

Section 10 would amend G.S. 90-171.30 by eliminating the requirement that the nursing examination be held at least twice a year.

Section 11 would amend G.S. 90-171.33 to eliminate temporary licenses for applicants seeking licensure through examination.

Sections 12 and 13 clarify that the license renewal and reinstatement procedures set forth in Article 9A apply to both registered nurses and licensed practical nurses.

Section 14 would amend G.S. 90-171.36 to clarify that licensees who have been on inactive status for less than five years can re-activate their licenses by paying a fee and submitting an application, while licensees who have been on inactive status for more than five years must complete a refresher course before returning to active status.

Section 15 would amend G.S. 90-171.36A to clarify the rules for designating retirement status.

Section 16 would amend Article 9A by adding new sections relating to the licensure of APRNs.

- G.S. 90-171.36B would require all nurses who practice as APRNs to be licensed as an APRN by the Board.
- G.S. 90-171.36C would require the Board to issue an APRN license to nurses who do not meet the new education requirements, provided that they are approved to practice as APRNs as of December 31, 2017, submit an application, and are otherwise qualified.
- G.S. 90-171.36D would set forth the rules for renewal and reinstatement of the APRN license.

Section 17 would amend G.S. 90-171.37 to clarify the Board's power to discipline nurses who 1) are convicted or plead guilty to crimes of moral turpitude, crimes involving the practice of medicine, or crimes which are felonies; 2) are unable to practice safely due to substance abuse or any other mental or physical abnormality; 3) have acted immorally or dishonorably; 4) have acted unprofessionally or failed to adhere to the standards of practice; 5) have had a license revoked, suspended, restricted, or acted against in any other jurisdiction; and 6) have failed to respond to the Board's inquiries. It would also grant the Board the authority to revoke the dispensing authority of any APRN who prescribes or dispenses drugs in an unsafe manner, sells drugs, prescribes drug for non-therapeutic purposes, or gives drugs to individuals who are not the APRN's patients.

Section 18 would make a technical change to G.S. 90-171.37A

Section 19 would add new sections to Article 9A relating to public records.

House Bill 88

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- G.S. 90-171.37B(a) would make the Board's investigative files exempt from Chapter 132 of the General Statutes and not subject to discovery or subpoena
- G.S. 90-171.37B(b) would require the Board to provide all information in its possession to a nurse being investigated or complained of, except for the Board's investigative report, the identity of non-testifying complainants, and materials privileged by the Rules of Civil procedure or Rules of Evidence.
- G.S. 90-171.37B(c) would provide that any notice or statement of charges is a public record
- . G.S. 90-171.37B(d) would permit the Board to report information indicating the commission of a crime to the appropriate authority.
- G.S. 90-171.37B(e) would require the Board to cooperate with any law enforcement agency or district attorney conducting an investigation.
- G.S. 90-171.37B(f) would require all licensees to report any felony arrests or indictments, arrest for DWI, or any arrest or indictment for the use possession, or sale of controlled substances to the Board within 30 days.
- G.S. 90-171.37B(g) would allow the Board to transmit information regarding the issuance, denial, annulment, suspension, or revocation of a license to the DHHS or any health care licensure board. It would require the Board to notify the licensee of this transmission and provide a summary of the information transmitted.
- G.S. 90-171.37C would require service of notice under Article 9A to be made personally or by registered or certified mail.

Section 20 would make technical changes to G.S. 90-171.39

Section 21 would amend G.S. 90-171.40 to require the Board to review all nursing programs in the state every ten years instead of every eight years. If the Board finds a nursing program is deficient, it may take appropriate action, including withdrawal of approval for that program.

Section 22 would make a technical change to G.S. 90-171.42.

Section 23 would amend G.S. 90-171.43 to require individuals who practice as APRNs to be licensed as APRNs and to prevent those who are not licensed from using the designations "APRN," "CNM," "CNS," "CRNA," and "NP."

Section 24 would require health care facilities to verify individuals are licensed as APRNs before hiring them as APRNs.

Section 25 would amend G.S. 90-171.44 to prohibit individuals from calling themselves APRNs, CNMs, CNSs, NPs, RNs, or LPNs.

Section 26 would amend G.S. 90-171.47 to make conforming changes to the requirement for the Board to investigate misconduct in a timely manner.

Section 27 would amend G.S. 90-171.48 to require background checks for individuals seeking renewal or reinstatement of an APRN license.

Section 28 would add a section to Article 9A allowing the Governor to waive the requirements of the Nursing Practice Act in order to permit the provision of health care during a state of emergency.

Section 29 would repeal G.S. 90-171.28, which allowed nurses who held licenses from a competent authority pursuant to state law as of June 30, 1981, to be licensed under Article 9A.

House Bill 88

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EFFECTIVE DATE: This bill would become effective January 1, 2017.

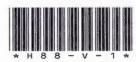
BACKGROUND: APRN is an umbrella term for registered nurses who are certified as Nurse Practitioners, Certified Nurse Midwives, Certified Registered Nurse Anesthetists, or Clinical Nurse Specialists in the North Carolina Administrative Code. All four practice areas require credentialing by a national board and education beyond that required for a registered nurse.

GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2017

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HOUSE BILL 88*

Short Title:	Modernize Nursing Practice Act. (Public)
Sponsors:	Representatives Dobson, Lambeth, Stevens, and Adcock (Primary Sponsors). For a complete list of sponsors, refer to the North Carolina General Assembly web site.
Referred to:	Health, if favorable, Finance
	February 14, 2017
The General	A BILL TO BE ENTITLED DATING AND MODERNIZING THE NURSING PRACTICE ACT. Assembly of North Carolina enacts: CTION 1. G.S. 90-171.20 reads as rewritten: Definitions
0	this Article, unless the context requires otherwise:
(1	
(<u>1</u> (<u>1</u> (<u>2</u>	the history, physical, and psychological assessment of a patient's signs symptoms, pathophysiologic status, and psychosocial variations in the determination of differential diagnoses and treatment. Advanced practice registered nurse or APRN. – An individual licensed by the Board as an advanced practice registered nurse within one of the following four roles: a. Nurse practitioner or NP. b. Certified nurse midwife or CNM. c. Clinical nurse specialist or CNS. d. Certified registered nurse anesthetist or CRNA. "Board" means the Board. – The North Carolina Board of Nursing.
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Identifying, responding to, and managing emergency situations,

including initiating and participating in cardiopulmonary

Providing consultation related to respiratory and ventilator care

and implementing such care according to established policies

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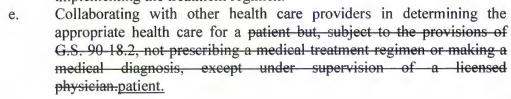
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resuscitation.

within the practice setting.



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Genera	l Assemb	oly Of North Carolina	Session 2017
		f. Implementing the treatment and pharmaceutical reg ordered by any person authorized by State law to pre-	
		regimen.	1 1.1
		g. Providing teaching and counseling about the patient's	
		h. Reporting and recording the plan for care, nursing	care given, and the
		patient's response to that care.	6
		 Supervising, teaching, and evaluating those who preparing to perform nursing functions and adn programs and nursing services. 	
		j. Providing for the maintenance of safe and effect whether rendered directly or indirectly.	etive nursing care,
	(8)	The "practice of nursing by a licensed practical nurse"	consistsPractice of
	(0)	nursing by a licensed practical nurse. – Consists of the	
		components:	e tono mig bevon
		a. Participating in the assessment of the patient's pl	vsical and mental
		health, including the patient's reaction to illnes regimens.	
		 Recording and reporting the results of the nursing ass 	sessment.
		c. Participating in implementing the health care plan	
		registered nurse and/or prescribed by any person a	
		law to prescribe such a plan, by performing tasks as	
		by and performed under the supervision or under ord	_
		a registered nurse, physician licensed to practice m	
		other person authorized by State law to provide the si	
		cl. Assigning or delegating nursing interventions	
		personnel under the supervision of the registered nurs	
		d. Participating in the teaching and counseling of patien	
		registered nurse, physician, or other qualified profe practice in North Carolina.	
		e. Reporting and recording the nursing care rendere response to that care.	d and the patient's
		f. Maintaining safe and effective nursing care, whether or indirectly."	er rendered directly
	SECT	FION 2. G.S. 90-18(c) reads as rewritten:	
"(c)		following shall not constitute practicing medicine or surgery	as defined in this
Article:		O Francisco Provincia de San Bara,	
	•••		
	(7)	The practice of midwifery as defined in G.S. 90-178.2.	
	•••		
	(14a)	The practice of nursing by a certified registered nurse anes	thetist or CRNA as
		defined in G.S. 90-171.20.	

	SECT	FION 3. G.S. 90-29(b) reads as rewritten:	
"(b)		son shall be deemed to be practicing dentistry in this State w	no does, undertakes
or atten	npts to do	, or claims the ability to do any one or more of the following a	cts or things which,
for the	purposes o	of this Article, constitute the practice of dentistry:	
	(6)	Administers an anesthetic of any kind in the treatment of de	ntal or oral diseases
	,	or physical conditions, or in preparation for or incident to a	
		the oral cavity; provided, however, that this subsection s	• -
		lawfully qualified certified registered nurse anesthetist wh	

1 anesthetic unde 2 dentist or physic

anesthetic under the supervision and direction of <u>in collaboration with</u> a licensed dentist or <u>physician</u>; <u>physician pursuant to G.S. 90-171.20(6d)</u>;

SECTION 4.(a) G.S. 90-171.21 reads as rewritten:

"§ 90-171.21. Board of Nursing; composition; selection; vacancies; qualifications; term of office; compensation.

- (a) The Board shall consist of 14 members. Eight members shall be registered nurses. Three members shall be licensed practical nurses. Three members shall be representatives of the public.
- Selection. The North Carolina Board of Nursing shall conduct an election each year (b) to fill vacancies of nurse members of the Board scheduled to occur during the next year. Nominations of candidates for election of registered nurse members shall be made by written petition signed by not less than 10 registered nurses eligible to vote in the election. Nominations of candidates for election of licensed practical nurse members shall be made by written petition signed by not less than 10 licensed practical nurses eligible to vote in the election. Every registered nurse holding an active advanced practice registered nurse license shall be eligible to vote in the election of the advanced practice registered nurse Board member. Every licensed registered nurse holding an active license shall be eligible to vote in the election of registered nurse board members. Every licensed practical nurse holding an active license shall be eligible to vote in the election of licensed practical nurse board members. The list of nominations shall be filed with the Board after January 1 of the year in which the election is to be held and no later than midnight of the first day of April of such year. Before preparing ballots, the Board shall notify each person who has been duly nominated of the person's nomination and request permission to enter the person's name on the ballot. A member of the Board who is nominated for reelection and who does not withdraw the member's name from the ballot is disqualified to participate in conducting the election. Elected members shall begin their term of office on January 1 of the year following their election.

Nominations of persons to serve as public members of the Board may be made to the Governor or the General Assembly by any citizen or group within the State. The Governor shall appoint one public member to the Board, and the General Assembly shall appoint two public members to the Board. Of the public members appointed by the General Assembly, one shall be appointed by the General Assembly upon the recommendation of the President Pro Tempore of the Senate, and one shall be appointed by the General Assembly upon the recommendation of the Speaker of the House of Representatives.

Board members shall be commissioned by the Governor upon their election or appointment.

- Assembly shall be filled within 45 days after the term is vacated. The Governor shall fill all other unexpired terms on the Board within 30 days after the term is vacated. For vacancies of registered nurse or licensed practical nurse members, the Governor shall appoint the person who received the next highest number of votes to those elected members at the most recent election for board members. Board shall notify the person who received the next highest number of votes in the election when the vacating member was elected in order to fulfill the remainder of the unexpired term. If the replacement Board member no longer meets the qualifications under subsection (d) of this section, the Board shall notify the person receiving the next highest number of votes in the election when the vacating member was elected. Appointees shall serve the remainder of the unexpired term and until their successors have been duly elected or appointed and qualified.
- (d) Qualifications. Of the eight registered nurse members on the Board, one shall be a nurse administrator employed by a hospital or a hospital system, who shall be accountable for the administration of nursing services and not directly involved in patient care; one shall be an individual who meets the requirements to practice as a certified registered nurse anesthetist, a certified nurse midwife, a clinical nurse specialist, or a nurse practitioner; an APRN; two shall be

House Bill 88*-First Edition

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staff nurses, defined as individuals who are primarily involved in direct patient care regardless of practice setting; one shall be an at-large registered nurse who meets the requirements of sub-subdivisions (1) b., e., f., and g. of this subsection, but is not currently an educator in a program leading to licensure or any other degree-granting program; and three shall be nurse educators. Minimum ongoing employment requirements for every registered nurse and licensed practical nurse shall include continuous employment equal to or greater than fifty percent (50%) of a full-time position that meets the criteria for the specified Board member position. Of the three nurse educators, one shall be a practical nurse educator, one shall be an associate degree or diploma nurse educator, and one shall be a baccalaureate or higher degree nurse educator. All nurse educators shall meet the minimum education requirement as established by the Board's education program standards for nurse faculty. Candidates eligible for election to the Board as nurse educators are not eligible for election as the at-large member.

- (1) Except for the at-large member, every registered nurse member shall meet the following criteria:
 - a. Hold a current, an active, unencumbered license to practice as a registered nurse in North Carolina.
 - al. Be a resident of North Carolina.
 - b. Have a minimum of five years of experience as a registered nurse.
 - c. Have been engaged continuously in a position that meets the criteria for the specified Board position for at least three years immediately preceding election.
 - d. Show evidence that the employer of the registered nurse is aware that the nurse intends to serve on the Board.
 - e. Have no disciplinary history with the Board or any other licensing board in this State or another state within the 10 years preceding the nurse's appointment to the Board.
 - f. Have no history of felony convictions of any kind.
 - g. Have no misdemeanor convictions related to the practice of nursing.
- (2) Every licensed practical nurse member shall meet the following criteria:
 - a. Hold a current, an active, unencumbered license to practice as a licensed practical nurse in North Carolina.
 - a1. Be a resident of North Carolina.
 - c. Have a minimum of five years of experience as a licensed practical nurse.
 - d. Have been engaged continuously in the position of a licensed practical nurse for at least three years immediately preceding election.
 - e. Show evidence that the employer of the licensed practical nurse is aware that the nurse intends to serve on the Board.
 - f. Have no disciplinary history with the Board or any other licensing board in this State or another state within the 10 years preceding the nurse's appointment to the Board.
 - g. Have no history of felony convictions of any kind.
 - h. Have no misdemeanor convictions related to the practice of nursing.
- (3) A public member appointed by the Governor-shall not be a provider of health services-licensed nurse or licensed health care professional or employed in the health services field. No by a health care institution, health care insurer, or health care professional school. Additionally, no public member appointed by the Governor or person in the public member's immediate family as defined by G.S. 90-405(8) shall be currently employed as a licensed nurse or been previously employed as a licensed nurse.

The nurse practitioner, nurse anesthetist, nurse midwife, or clinical nurse 1 2 specialist advanced practice registered nurse member shall be recognized licensed by the Board as a registered nurse an advanced practice registered 3 nurse who meets the following criteria: 4 Has graduated from or completed a graduate level advanced practice 5 nursing education program accredited by a national accrediting body. 6 7 b. Maintains current certification or recertification from a national credentialing body approved by the Board or meets other requirements 8 established by rules adopted by the Board. 9 Practices in a manner consistent with rules adopted by the Board and 10 C. other applicable law. 11 12 Holds an active, unencumbered license to practice as an advanced d. practice registered nurse in North Carolina. 13 Is a resident of North Carolina. 14 <u>e.</u> 15 <u>f.</u> Has a minimum of five years of experience as an advanced practice registered nurse. 16 17 Has been engaged continuously in the position of an advanced practice g. registered nurse for at least three years immediately preceding election. 18 Provides evidence that the employer of the advanced practice registered 19 <u>h.</u> nurse is aware that the nurse intends to serve on the Board. 20 Has no disciplinary history with the Board or any other licensing board 21 <u>i.</u> in this State or another state within the 10 years preceding the nurse's 22 appointment to the Board. 23 24 į. Has no history of felony convictions of any kind. Has no misdemeanor convictions related to the practice of nursing. 25 k. Term. – Members of the Board shall serve four-year staggered terms. No member shall 26 serve more than two consecutive four-year terms or eight consecutive years after January 1, 27 28 2005.years. Removal. - The Board may remove any of its members for neglect of duty. 29 incompetence, or unprofessional conduct. A member subject to disciplinary proceedings shall be 30 disqualified from Board business until the charges are resolved. 31 Reimbursement. - Board members are entitled to receive compensation and 32 reimbursement as authorized by G.S. 93B-5." 33 SECTION 4.(b) G.S. 90-171.21(a), as amended by this act, applies to members newly 34 appointed to the Board of Nursing after the effective date of this act. 35 36 **SECTION 5.** G.S. 90-171.23(b) reads as rewritten: Duties, powers. The Board is empowered to: 37 "(b) Administer this Article. 38 (1) (2) Issue its interpretations of this Article. 39 Adopt, amend or repeal rules and regulations as may be necessary to carry out 40 (3) the provisions of this Article. 41 Establish qualifications of, employ, and set the compensation of an executive 42 (4) officer who shall be a registered nurse and who holds an active North Carolina 43 license and who shall not be a member of the Board. 44 Employ and fix the compensation of other personnel that the Board determines 45 (5) are necessary to carry into effect this Article and incur other expenses necessary 46 to effectuate this Article. 47 Examine, license, and renew the licenses of duly qualified applicants for 48 (6)49 licensure.

Cause the prosecution of all persons violating this Article.

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experience chemical addiction or abuse or mental or physical disabilities and programs for monitoring such nurses for safe practice.monitoring the treatment, recovery, and safe practice of nurses experiencing substance use disorders, mental health disorders, or physical conditions impacting the ability to deliver safe care.

(18a) Establish programs for aiding in the remediation of nurses who experience practice deficiencies.

(19) Request that the Department of Public Safety conduct criminal history record checks of applicants for licensure pursuant to G.S. 143B-940.

(20) Adopt rules requiring an applicant to submit to the Board evidence of the applicant's continuing competence in the practice of nursing at the time of license renewal or reinstatement.

(21) Proceed in accordance with G.S. 90-171.37A, notwithstanding G.S. 150B-40(b), when conducting a contested case hearing in accordance with Article 3A of Chapter 150B of the General Statutes.

(22) Designate one or more of its employees to serve papers or subpoenas issued by the Board. Service under this subdivision is permitted in addition to any other methods of service permitted by law.

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- (23) Acquire, hold, rent, encumber, alienate, and otherwise deal with real property in the same manner as a private person or corporation, subject only to approval of the Governor and the Council of State. Collateral pledged by the Board for an encumbrance is limited to the assets, income, and revenues of the Board.
- Order the production of any records concerning the practice of nursing relevant (24)to a complaint received by the Board or an inquiry or investigation conducted by or on behalf of the Board Order or subpoena the production of any patient records, documents, or other material concerning any matter to be heard before or inquired into by the Board, notwithstanding any other provision of law providing for the application of any health care provider-patient privilege with respect to such records, documents, or other material. All records, documents, or other material compiled by the Board are subject to the provisions of G.S. 90-171.37B. Notwithstanding the provisions of G.S. 90-171.37B, in any proceeding before the Board, in any record of any hearing before the Board, and in the notice of charges against any licensee, the Board shall withhold from public disclosure the identity of a patient, including information relating to dates and places of treatment, or any other information that would tend to identify the patient, unless the patient or the representative of the patient expressly consents to the disclosure. Upon written request, the Board shall revoke a subpoena if, upon a hearing, it finds that the evidence the production of which is required does not relate to a matter in issue, or if the subpoena does not describe with sufficient particularity the evidence the production of which is required, or if for any other reason in law the subpoena is invalid."

SECTION 6. G.S. 90-171.24 reads as rewritten:

"§ 90-171.24. Executive director.

The executive director shall perform the duties prescribed by the Board and serve as secretary/treasurer to the Board. Additionally, the executive director shall hold an active North Carolina registered nurse license and shall meet the criteria set forth in G.S. 90-171.21(d)(1)a., a1., b., e., f., and g. The executive director shall also serve as the Administrator of the Nurse Licensure Compact."

SECTION 7. G.S. 90-171.27(b) reads as rewritten:

"§ 90-171.27. Expenses payable from fees collected by Board.

90-1/1.2/. Expenses payable from fees confected by Board.
(b) The schedule of fees shall not exceed the following rates:
Application for license as advanced practice registered nurse
Renewal of license to practice as advanced practice registered nurse
(two-year period)
Reinstatement of lapsed license to practice as advanced practice registered
nurse and renewal fee
Application for examination leading to certificate and license as registered
nurse
Application for certificate and license as registered nurse by endorsement
Application for each re-examination leading to certificate and license as
registered nurse
Renewal of license to practice as registered nurse (two-year period)
Reinstatement of lapsed license to practice as a registered nurse and
renewal fee
Application for examination leading to certificate and license as licensed
practical nurse by examination
Application for eertificate and license as licensed practical nurse by
endorsement



Application for each re-examination leading to certificate and license as licensed practical nurse	75.00
Renewal of license to practice as a licensed practical nurse (two-year period)	
Reinstatement of lapsed license to practice as a licensed practical nurse and renewal fee	
Application fee for retired registered nurse status or retired licensed practical nurse status	50.00
Reinstatement of retired registered nurse to practice as a registered nurse or a retired licensed practical nurse to practice as a licensed practical	
nurse (two-year period)	100.00

A fee for an item listed in this schedule shall not increase from one year to the next by more than twenty percent (20%)."

SECTION 8. G.S. 90-171.29 reads as rewritten:

"§ 90-171.29. Qualifications of applicants for examination.

In order to be eligible for licensure <u>as a registered nurse or a licensed practical nurse</u> by examination, the applicant shall <u>make a written application to the Board on forms furnished by the Board-submit an application in the manner prescribed by the Board and shall submit to the Board an application fee and written evidence, verified by oath, sufficient to satisfy the Board that the applicant has graduated from a course of study approved by the Board and is mentally and physically competent to practice nursing."</u>

SECTION 9. Article 9A of Chapter 90 of the General Statutes is amended by adding a new section to read:

"§ 90-171,29A. Mental or physical exam to establish competence.

In considering whether an applicant or licensee is mentally or physically capable of practicing nursing with reasonable skill and safety, the Board may require an applicant or licensee to submit to a mental examination by a licensed mental health professional designated by the Board and to a physical examination by a physician or other licensed health care professional designated by the Board. The Board may order an applicant or licensee to be examined before or after charges are presented against the applicant or licensee. The results of the examination shall be reported directly to the Board and shall be admissible in evidence in a hearing before the Board."

SECTION 10. G.S. 90-171.30 reads as rewritten:

"§ 90-171.30. Licensure by examination.

At least twice each year the The Board shall give an examination, at the time and place it determines, to applicants for licensure to practice as a registered nurse or licensed practical nurse. The Board shall adopt rules, not inconsistent with this Article, governing qualifications of applicants, the conduct of applicants during the examination, and the conduct of the examination. The applicants shall be required to pass the examination required by the Board. The Board shall adopt rules which identify the criteria which must be met by an applicant in order to be issued a license. When the Board determines that an applicant has met those criteria, passed the required examination, submitted the required fee, and has demonstrated to the Board's satisfaction that he or she is mentally and physically competent to practice nursing, the Board shall issue a license to the applicant."

SECTION 11. G.S. 90-171.33 reads as rewritten:

"§ 90-171.33. Temporary license.

(a) Until the implementation of the computer adaptive licensure examination, the Board may issue a nonrenewable temporary license to persons who are applying for licensure under G.S. 90-171.30, and who are scheduled for the licensure examination at the first opportunity after graduation, for a period not to exceed the lesser of nine months or the date of applicant's notification of the results of the licensure examination. The Board shall revoke the temporary

 license of any person who does not take the examination as scheduled, or who has failed the examination for licensure as provided by this act.

- (b) Upon implementation of the computer adaptive licensure examination, no temporary licenses will be issued to persons who are applying for licensure under G.S. 90-171.30.
- (e) The Board may issue a nonrenewable temporary license to persons applying for licensure under G.S. 90-171.32 for a period not to exceed the lesser of six months or until the Board determines whether the applicant is qualified to practice nursing in North Carolina. Temporary licensees may perform patient-care services within limits defined by the Board. In defining these limits, the Board shall consider the ability of the temporary licensee to safely and properly carry out patient-care services. Temporary licensees shall be held to the standard of care of a fully licensed nurse."

SECTION 12. G.S. 90-171.34 reads as rewritten:

"§ 90-171.34. Licensure renewal.

Every unencumbered <u>registered nurse and licensed practical nurse</u> license, except <u>for a temporary license</u>, issued under this Article shall be renewed for two years. On or before the date the current license expires, every person who desires to continue to practice nursing shall apply for licensure renewal to the <u>Board on forms furnished by the Board in the manner prescribed by the Board and shall also file the required fee. Failure to renew the license before the expiration date shall result in automatic forfeiture of the right to practice nursing in North Carolina until such time that the license has been reinstated."</u>

SECTION 13. G.S. 90-171.35 reads as rewritten:

"§ 90-171.35. Reinstatement.

A registered nurse or licensed practical nurse licensee who has allowed his or her license to lapse by failure to renew as herein provided may apply for reinstatement on a form provided in a manner prescribed by the Board. The Board shall require the applicant to return the completed application with the required fee and to furnish a statement of the reason for failure to apply for renewal prior to the deadline. If the license has lapsed for at least five years, the Board shall require the applicant to complete satisfactorily complete a refresher course approved by the Board, or provide proof of active licensure within the past five years in another jurisdiction. The Board may require any applicant for reinstatement to satisfy the Board that the license should be reinstated. If, in the opinion of the Board, the applicant has so satisfied the Board, it shall issue a renewal of license to practice nursing, or it shall issue a license to practice nursing for a limited time."

SECTION 14. G.S. 90-171.36 reads as rewritten:

"§ 90-171.36. Inactive list.status.

- (a) When a licensee submits a request for inactive status, the Board shall issue to the licensee a statement of inactive status and shall place <u>designate</u> the licensee's name on the inactive <u>list.status</u> as inactive. While on the inactive <u>list.inactive</u>, the person shall not be subjected to renewal requirements and shall not practice nursing in North Carolina.
- (b) When If, within five years of being placed on inactive status, such person desires to be removed from the inactive list and returned to the active list within five years of being placed on inactive status, change their status from inactive to active, that person shall submit an application shall be submitted to the Board on a form furnished by the Board and the fee shall be paid for license renewal. Board, along with payment of the license reinstatement fee. The Board shall require evidence of competency to resume the practice of nursing before returning the applicant to active status. If the person has been on the inactive list for more than five years, the applicant must satisfactorily complete a refresher course approved by the Board or provide proof of active licensure within the past five years in another jurisdiction."

SECTION 15. G.S. 90-171.36A reads as rewritten:

"§ 90-171.36A. Retired nurse status; reinstatement.



- (a) After a registered nurse or a licensed practical nurse has retired, upon payment of the one-time fee required by G.S. 90-171.27(b), the Board may issue a special license to a registered nurse or licensed practical nurse in recognition of the nurse's retired status. shall designate the nurse's status as retired.
- (b) If a retired registered nurse or licensed practical nurse wishes to return to the practice of nursing, the retired nurse shall apply for reinstatement on a form provided in a manner prescribed by the Board and satisfy any requirements the Board deems necessary to reinstate the license."

SECTION 16. Article 9A of Chapter 90 of the General Statutes is amended by adding new sections to read:

"§ 90-171.36B. Advanced practice registered nurse licensure.

- (a) No advanced practice registered nurse shall practice as an advanced practice registered nurse unless the nurse is licensed by the Board under this section.
- (b) An applicant for a license to practice as an APRN shall apply to the Board in a format prescribed by the Board and pay a fee in an amount determined under G.S. 90-171.27.
 - (c) To be eligible for licensure, an applicant shall meet all of the following criteria:
 - (1) Must hold a current North Carolina registered nurse license.
 - (2) Must not hold an encumbered license as a registered nurse or advanced practice registered nurse in any state or territory.
 - Must have completed a graduate level APRN program accredited by a nursing or nursing-related accrediting body that is recognized by the United States Secretary of Education or the Council for Higher Education Accreditation as acceptable to the Board. The education must be in one of the four APRN roles and at least one population focus.
 - Must be currently certified by a national certifying body recognized by the Board in the APRN role and population focus appropriate to educational preparation.
 - (5) Must report any criminal conviction, nolo contendere plea, Alford plea, or other plea arrangement in lieu of conviction.
 - (6) Must not have committed any acts or omissions that are grounds for disciplinary action in another jurisdiction or, if these acts have been committed and would be grounds for disciplinary action in this State, the Board has found, after investigation, that sufficient restitution has been made.

"§ 90-171.36C. Advanced practice registered nurse licensure; grandfathering exceptions.

- (a) The Board shall issue an APRN license to an applicant who does not meet the education requirements of G.S. 91-171.36B(c)(3) if the applicant is recognized by the Board or approved to practice as an APRN in this State on December 31, 2017.
- (b) The Board shall issue a license to an applicant who meets the education requirements of G.S. 90-171.36B(c)(3) but who is unable to meet the certification requirements of G.S. 90-171.36B(c)(4) if the applicant's education and certification are substantially similar to the requirements set forth in G.S. 90-171.36B.
- (c) An advanced practice registered nurse licensed under this section shall maintain all practice privileges provided to licensed advanced practice registered nurses under this Chapter.

"§ 90-171.36D. Advanced practice registered nurse licensure renewal; reinstatement.

- (a) APRN licenses issued under this Article shall be renewed according to the frequency and schedule established by the Board. An applicant for APRN license renewal shall:
 - (1) Submit a renewal application in the manner prescribed by the Board and remit the required fee.
 - (2) Maintain national certification in the appropriate APRN role and at least one population focus, authorized by licensure, through an ongoing certification

General Assembly Of North Carolina maintenance program nationally recognized by the Board unless subject to the 1 grandfather provision in G.S. 90-171.36C. 2 3 Meet all other requirements as set forth in statute and rule. Failure to renew the APRN license before the expiration date shall result in automatic 4 forfeiture of the right to practice nursing as an APRN in North Carolina until such time as the 5 6 license has been reinstated. An APRN licensee who has allowed his or her license to lapse by failure to renew as 7 (b) herein provided may apply for reinstatement in a manner prescribed by the Board. The Board shall 8 require the applicant to return the completed application along with the required fee and a 9 statement of the reason for failure to apply for renewal prior to the deadline." 10 11 SECTION 17. G.S. 90-171.37 reads as rewritten: Revocation, discipline, suspension, probation, or denial of 12 90-171.37. 118 licensure. Disciplinary authority. 13 The Board may initiate an investigation upon receipt of information about any practice 14 that might violate any provision of this Article or any rule or regulation promulgated by the Board. 15 In accordance with the provisions of Chapter 150B of the General Statutes, the Board shall have 16 the power and authority to: (i) refuse to issue a license to practice nursing; (ii) refuse to issue a 17 certificate of renewal of a license to practice nursing; (iii) revoke or suspend a license to practice 18 nursing; and (iv) invoke other such disciplinary measures, censure, or probative terms against a 19 20 licensee as it deems fit and proper; in any instance or instances in which the Board is satisfied that the applicant or licensee: to place on probation with or without conditions, impose limitations and 21 conditions on, accept voluntary surrender, publicly reprimand, issue public letters of concern, 22 require satisfactory completion of treatment programs or remedial or educational training, refuse 23 to issue a certificate of renewal, fine, deny, suspend, or revoke a license or privilege to practice 24 25 nursing in this State, issued by the Board to any person who has been found by the Board to have committed any of the following acts or conduct, or for any of the following reasons: 26

> Has given false information or has withheld material information from the (1) Board in procuring or attempting to procure a license to practice nursing.

> Has been convicted of or pleadedpled guilty or-nolo contendere to any crime (2) which indicates that the nurse is unfit or incompetent to practice nursing or that the nurse has deceived or defrauded the public.or guilty in accordance with State v. Alford to a crime involving moral turpitude, or the violation of a law involving the practice of medicine, or a conviction of a felony; provided that a felony conviction shall be treated as provided in subsection (c) of this section.

- Has a mental or physical disability or uses any drug to a degree that interferes (3) with his or her fitness to practice nursing. Is unable to practice nursing with reasonable skill and safety to patients by reason of illness, excessive use of alcohol, drugs, chemicals, or any other type of material, or by reason of any physical or mental abnormality. The Board is empowered and authorized to require a nurse licensed by it to submit to mental or physical examination by physicians designated by the Board before or after charges may be presented against the nurse, and the results of the examination shall be admissible in evidence in a hearing before the Board.
- Engages in conduct that endangers the public health. (4)
- Is unfit or incompetent to practice nursing by reason of deliberate or negligent (5)acts or omissions regardless of whether actual injury to the patient is established.
- Engages in conduct that deceives, defrauds, or harms the public in the course of (6)professional activities or services.
- Immoral or dishonorable conduct or acts involving moral turpitude. (6a)



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- Unprofessional conduct, including, but not limited to, departure from, or the (6b)failure to conform to, the standards of acceptable and prevailing nursing practice, or the ethics of the nursing profession, irrespective of whether or not a patient is injured thereby, or the committing of any act contrary to honesty, justice, or good morals, whether the same is committed in the course of the licensee's practice or otherwise, and whether committed within or without North Carolina.
- Having a license to practice nursing or a privilege to practice nursing revoked, (6c)suspended, restricted, or acted against or having a license to practice nursing denied by the licensing authority of any jurisdiction. For purposes of this subdivision, the licensing authority's acceptance of a license to practice nursing voluntarily relinquished by a nurse or relinquished by stipulation, consent order, or other settlement in response to or in anticipation of the filing of administrative charges against the nurse's license, is an action against a license to practice nursing.
- The failure to respond, within a reasonable period of time and in a reasonable (6d)manner as determined by the Board, to inquiries from the Board concerning any matter affecting the license to practice nursing.
- Has violated any provision of this Article Article or any provision of the rules (7) adopted by the Board pursuant to this Article.
- Has willfully violated any rules enacted by the Board. (8)

The Board may take any of the actions specified above in this section when a registered nurse approved to perform medical acts has violated rules governing the performance of medical acts by a registered nurse; provided this shall not interfere with the authority of the North Carolina Medical Board to enforce rules and regulations governing the performance of medical acts by a registered nurse.

- In addition to the disciplinary powers listed above, the Board may limit, restrict, deny, suspend, or revoke prescriptive or dispensing authority of any advanced practice registered nurse who holds prescriptive authority who has been found by the Board to have committed any of the following acts or conduct, or for any of the following reasons:
 - Prescribing, dispensing, administering, or distributing drugs in an unsafe (1) manner or without adequate instructions to patients according to acceptable and prevailing standards.
 - Selling, purchasing, trading, or offering to sell, purchase, or trade drug samples. (2)
 - Prescribing, dispensing, administering, or distributing drugs for other than (3) therapeutic or prophylactic purposes.
 - Prescribing or distributing drugs to individuals who are not patients of the (4) advanced practice registered nurse or who are not within that nurse's role and population focus.
- The Board may reinstate a revoked license, revoke censure or probative (c) terms, probation, or remove other licensure restrictions when it finds that the reasons for revocation, censure or probative terms, or other licensure restrictions no longer exist and that the nurse or applicant can reasonably be expected to safely and properly practice nursing.
- (d) A felony conviction shall result in the automatic revocation of a license issued by the Board, unless the Board orders otherwise or receives a request for a hearing from the person within 60 days of receiving notice from the Board, after the conviction, of the provisions of this subsection. If the Board receives a timely request for a hearing in such a case, the provisions of G.S. 90-14.2 shall be followed.
- The Board and its members and staff shall not be held liable in any civil or criminal (e) proceeding for exercising, in good faith, the powers and duties authorized by law.

The Board may reinstate a revoked license, revoke censure or probative terms, or remove other licensure restrictions when it finds that the reasons for revocation, censure or probative terms, or other licensure restrictions no longer exist and that the nurse or applicant can reasonably be expected to safely and properly practice nursing."

SECTION 18. G.S. 90-171.37A(a) reads as rewritten:

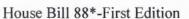
"§ 90-171.37A. Use of hearing committee and depositions.

(a) The Board, in its discretion, may designate in writing three or more of its members to conduct hearings as a hearing committee to takereceive evidence. A majority of the hearing committee shall be licensed nurses."

SECTION 19. Article 9A of Chapter 90 of the General Statutes is amended by adding new sections to read:

"§ 90-171.37B. Board to keep public records.

- (a) All records, papers, investigative files, investigative reports, other investigative information, and other documents containing information in the possession of or received or gathered by the Board, or its members or employees or consultants as a result of investigations, inquiries, assessments, or interviews conducted in connection with a licensing, complaint, assessment, potential impairment matter, or disciplinary matter, shall not be considered public records within the meaning of Chapter 132 of the General Statutes and are privileged, confidential, and not subject to discovery, subpoena, or other means of legal compulsion for release to any person other than the Board, its employees, or consultants involved in the application for license, impairment assessment, or discipline of a license holder, except as provided in subsection (b) of this section. For purposes of this subsection, investigative information includes information relating to the identity of, and a report made by, a physician or other person performing an expert review for the Board and transcripts of any deposition taken by Board counsel in preparation for or anticipation of a hearing held pursuant to this Article but not admitted into evidence at the hearing.
- (b) The Board shall provide the licensee or applicant with access to all information in its possession that the Board intends to offer into evidence in presenting its case in chief at the contested hearing on the matter, subject to any privilege or restriction set forth by rule, statute, or legal precedent, upon written request from a licensee or applicant who is the subject of a complaint or investigation, or from the licensee's or applicant's counsel, unless good cause is shown for delay. The Board shall not be required to provide any of the following:
 - (1) A Board investigative report.
 - (2) The identity of a nontestifying complainant.
 - (3) Attorney-client communications, attorney work product, or other materials covered by a privilege recognized by the Rules of Civil Procedure or the Rules of Evidence.
- (c) Any notice or statement of charges against any licensee, or any notice to any licensee of a hearing in any proceeding, shall be a public record within the meaning of Chapter 132 of the General Statutes, notwithstanding that it may contain information collected and compiled as a result of any such investigation, inquiry, or interview; and provided, further, that if any such record, paper, or other document containing information theretofore collected and compiled by the Board, as hereinbefore provided, is received and admitted in evidence in any hearing before the Board, it shall thereupon be a public record within the meaning of Chapter 132 of the General Statutes.
- (d) If investigative information in the possession of the Board, its employees, or agents indicates that a crime may have been committed, the Board may report the information to the appropriate law enforcement agency or district attorney of the district in which the offense was committed. Such information shall be confidential under G.S. 132-1.4.
- (e) The Board shall cooperate with and assist a law enforcement agency or district attorney conducting a criminal investigation or prosecution of a licensee by providing information that is relevant to the criminal investigation or prosecution to the investigating agency or district



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attorney. Information disclosed by the Board to an investigative agency or district attorney remains confidential and may not be disclosed by the investigating agency except as necessary to further the investigation.

(f) All persons licensed under this Article shall self-report to the Board within 30 days of arrest or indictment any of the following:

(1) Any felony arrest or indictment.

(2) Any arrest for driving while impaired or driving under the influence.

(3) Any arrest or indictment for the possession, use, or sale of any controlled substance.

The Board, its members, and staff may release confidential or nonpublic information to any health care licensure board in this State or another state or authorized Department of Health and Human Services personnel with enforcement or investigative responsibilities about the issuance, denial, annulment, suspension, or revocation of a license, or the voluntary surrender of a license by a licensee of the Board, including the reasons for the action, or an investigative report made by the Board. The Board shall notify the licensee within 60 days after the information is transmitted. A summary of the information that is being transmitted shall be furnished to the licensee. If the licensee requests in writing within 30 days after being notified that the information has been transmitted, the licensee shall be furnished a copy of all information so transmitted. The notice or copies of the information shall not be provided if the information relates to an ongoing criminal investigation by any law enforcement agency or authorized Department of Health and Human Services personnel with enforcement or investigative responsibilities.

"§ 90-171.37C. Service of notices.

Any notice required by this Article may be served either personally by an employee of the Board or by an officer authorized by law to serve process, or by registered or certified mail, return receipt requested, directed to the licensee or applicant at his or her last known address as shown by the records of the Board. If notice is served personally, it shall be deemed to have been served at the time when the officer or employee of the Board delivers the notice to the person addressed or delivers the notice at the licensee's or applicant's last known address as shown by records of the Board with a person of suitable age and discretion then residing therein. Where notice is served in a manner authorized by Rule 4(j) of the N.C. Rules of Civil Procedure, it shall be deemed to have been served on the date borne by the return receipt showing delivery of the notice to the licensee's or applicant's last known address as shown by the records of the Board, regardless of whether the notice was actually received or whether the notice was unclaimed or undeliverable for any reason."

SECTION 20. G.S. 90-171.39 reads as rewritten:

"§ 90-171.39. Approval.

The Board shall designate persons to surveyreview proposed nursing programs, including the clinical facilities programs. The persons designated by the Board shall submit a written report of the surveyreview to the Board in the manner prescribed by the Board. If in the opinion of the Board the standards for approved nursing education are met, the program shall be given approval."

SECTION 21. G.S. 90-171.40 reads as rewritten:

"§ 90-171.40. Ongoing approval.

The Board shall review all nursing programs in the State at least every eight10 years or more often as considered necessary. If the Board determines that any approved nursing program does not meet or maintain the standards required by the Board, the Board shall give written notice specifying the deficiencies to the institution responsible for the program. The Board shall withdrawevaluate and take appropriate action, up to and including withdrawing approval from a program that fails to correct deficiencies within a reasonable time. The Board shall publish annually-a list of nursing programs in this State showing their approval status."

SECTION 22. G.S. 90-171.42(a) reads as rewritten:



"§ 90-171.42. Continuing education programs.

(a) Upon request, the The Board shall grant approval to continuing education programs upon a finding that the program offers an educational experience designed to enhance the practice of nursing."

SECTION 23. G.S. 90-171.43 reads as rewritten:

"§ 90-171.43. License required.

- (a) No person shall practice or offer to practice as an advanced practice registered nurse, registered nurse, or licensed practical nurse, or use the word "nurse" as a title for herself or himself, or use an abbreviation to indicate that the person is an advanced practice registered nurse, registered nurse, or licensed practical nurse, unless the person is currently licensed as an advanced practice registered nurse, registered nurse, or licensed practical nurse as provided by this Article. If the word "nurse" is part of a longer title, such as "nurse's aide", a person who is entitled to use that title shall use the entire title and may not abbreviate the title to "nurse". This Article shall not, however, be construed to prohibit or limit the following:
 - (1) The performance by any person of any act for which that person holds a license issued pursuant to North Carolina law;
 - (2) The clinical practice by students enrolled in approved nursing programs, continuing education programs, or refresher courses under the supervision of qualified faculty;
 - (3) The performance of nursing performed by persons who hold a temporary license issued pursuant to G.S. 90-171.33;
 - (4) The delegation to any person, including a member of the patient's family, by a physician licensed to practice medicine in North Carolina, a licensed dentist or registered nurse of those patient-care services which are routine, repetitive, limited in scope that do not require the professional judgment of a registered nurse or licensed practical nurse;
 - (5) Assistance by any person in the case of emergency.

Any person permitted to practice nursing without a license as provided in subdivision (2) or (3) of this section shall be held to the same standard of care as any licensed nurse.

- (b) The abbreviations for the APRN designation of a certified nurse midwife, a clinical nurse specialist, a certified registered nurse anesthetist, and a nurse practitioner shall be APRN, plus the role title, i.e. CNM, CNS, CRNA, and NP.
- (c) It shall be unlawful for any person to use the title "APRN" or "APRN" plus their respective role titles, the role title alone, authorized abbreviations, or any other title that would lead a person to believe the individual is an APRN, unless permitted by this act.
- (d) The Board shall have the authority to promulgate rules to enforce the provisions of this section."

SECTION 24. G.S. 90-171.43A reads as rewritten:

"§ 90-171.43A. Mandatory employer verification of licensure status.

- (a) Before hiring <u>an advanced practice registered nurse</u>, a registered <u>nurse</u>, or a licensed practical nurse in North Carolina, a health care facility shall verify that the applicant has a current, valid license to practice nursing pursuant to G.S. 90-171.43.
 - (b) For purposes of this section, "health care facility" means:
 - (1) Facilities described in G.S. 131E-256(b).
 - (2) Public health departments, physicians' offices, ambulatory care facilities, and rural health clinics."

SECTION 25. G.S. 90-171.44 reads as rewritten:

"§ 90-171.44. Prohibited acts.

It shall be a violation of this Article, and subject to action under G.S. 90-171.37, for any person to:



House Bill 88*-First Edition

- (1) Sell, fraudulently obtain, or fraudulently furnish any nursing diploma or aid or abet therein.
- (2) Practice nursing under cover of any fraudulently obtained license.
- Practice nursing without a license. This subdivision shall not be construed to prohibit any licensed registered nurse who has successfully completed a program established under G.S. 90-171.38(b) from conducting medical examinations or performing procedures to collect evidence from the victims of offenses described in that subsection.
- Refer to himself or herself as an advanced practice registered nurse; or refer to himself or herself as any of the four roles of advanced practice registered nurses, a registered nurse, or a licensed practical nurse; or use the abbreviations "APRN", "CNM", "CNS", "CRNA", "NP", "RN", and "LPN".
- (4) Conduct a nursing program or a refresher course for activation of a license, that is not approved by the Board.
- (5) Employ unlicensed persons to practice nursing."

SECTION 26. G.S. 90-171.47 reads as rewritten:

"§ 90-171.47. Reports: immunity from suit.

Any person who has reasonable cause to suspect misconduct or incapacity of a licensee or who has reasonable cause to suspect that any person is in violation of this Article, including those actions specified in G.S. 90-171.37(1) through (8), G.S. 90-171.43, and G.S. 90-171.44, shall report the relevant facts to the Board-Board in a timely manner. Upon receipt of such charge information or upon its own initiative, the Board may give notice of an administrative hearing or may, after diligent investigation, dismiss unfounded charges.shall conduct an investigation and prosecute all persons violating this Article pursuant to G.S. 90-171.23(b)(7). Any person making a report pursuant to this section shall be immune from any criminal prosecution or civil liability resulting therefrom unless such person knew the report was false or acted in bad faith or reckless disregard of whether the report was false."

SECTION 27. G.S. 90-171.48 reads as rewritten:

"§ 90-171.48. Criminal history record checks of applicants for licensure.

- (a) Definitions. The following definitions shall apply in this section:
 - (1) Applicant. A person applying for initial-licensure as aan advanced practice registered nurse, registered nurse, or licensed practical nurse either by examination pursuant to G.S. 90-171.29 or G.S. 90-171.30 or without examination pursuant to G.S. 90-171.32. The term "applicant" shall also include a person applying for renewal of licensure pursuant to G.S. 90-171.34, reinstatement of licensure pursuant to G.S. 90-171.35 or returning to active status pursuant to G.S. 90-171.36 as a registered nurse or licensed practical nurse. Additionally, the term "applicant" shall also apply to a person applying for licensure pursuant to G.S. 90-171.36B, renewal for licensure, or reinstatement for licensure pursuant to G.S. 90-171.36C as an advanced practice registered nurse.
 - (2) Criminal history. A history of conviction of a State crime, whether a misdemeanor or felony, that bears on an applicant's fitness for licensure to practice nursing. The crimes include the criminal offenses set forth in any of the following Articles of Chapter 14 of the General Statutes: Article 5, Counterfeiting and Issuing Monetary Substitutes; Article 5A, Endangering Executive and Legislative Officers; Article 6, Homicide; Article 7A, Rape and Other Sex Offenses; Article 8, Assaults; Article 10, Kidnapping and Abduction; Article 13, Malicious Injury or Damage by Use of Explosive or Incendiary Device or Material; Article 14, Burglary and Other Housebreakings; Article 15, Arson and Other Burnings; Article 16, Larceny; Article 17, Robbery; Article

18, Embezzlement; Article 19, False Pretenses and Cheats; Article 19A, Obtaining Property or Services by False or Fraudulent Use of Credit Device or Other Means; Article 19B, Financial Transaction Card Crime Act; Article 20, Frauds; Article 21, Forgery; Article 26, Offenses Against Public Morality and Decency; Article 26A, Adult Establishments; Article 27, Prostitution; Article 28, Perjury; Article 29, Bribery; Article 31, Misconduct in Public Office; Article 35, Offenses Against the Public Peace; Article 36A, Riots, Civil Disorders, and Emergencies; Article 39, Protection of Minors; Article 40, Protection of the Family; Article 59, Public Intoxication; and Article 60, Computer-Related Crime. The crimes also include possession or sale of drugs in violation of the North Carolina Controlled Substances Act in Article 5 of Chapter 90 of the General Statutes and alcohol-related offenses including sale to underage persons in violation of G.S. 18B-302 or driving while impaired in violation of G.S. 20-138.1 through G.S. 20-138.5.

(b) All applicants for licensure shallshall, if requested by the Board, consent to a criminal history record check. Refusal to consent to a criminal history record check may constitute grounds for the Board to deny licensure to an applicant. The Board shall ensure that the State and national criminal history of an applicant applying for initial licensure as a registered nurse or licensed practical nurse either by examination pursuant to G.S. 90-171.29 or G.S. 90-171.30 or without examination pursuant to G.S. 90-171.32 is checked. The Board may request a criminal history record check for applicants applying for reinstatement of licensure pursuant to G.S. 90-171.35 or returning to active status pursuant to G.S. 90-171.36 as a registered nurse or licensed practical nurse.

The Board shall be responsible for providing to the North Carolina Department of Public Safety the fingerprints of the applicant to be checked, a form signed by the applicant consenting to the criminal record check and the use of fingerprints and other identifying information required by the State or National Repositories, and any additional information required by the Department of Public Safety. The Board shall keep all information obtained pursuant to this section confidential.

- (c) If an applicant's criminal history record check reveals one or more convictions listed under subsection (a)(2) of this section, the conviction shall not automatically bar licensure. The Board shall consider all of the following factors regarding the conviction:
 - (1) The level of seriousness of the crime.
 - (2) The date of the crime.
 - (3) The age of the person at the time of the conviction.
 - (4) The circumstances surrounding the commission of the crime, if known.
 - (5) The nexus between the criminal conduct of the person and the job duties of the position to be filled.
 - (6) The person's prison, jail, probation, parole, rehabilitation, and employment records since the date the crime was committed.
 - (7) The subsequent commission by the person of a crime listed in subsection (a) of this section.

If, after reviewing the factors, the Board determines that the grounds set forth in subsections (1), (2), (3), (4), (5), or (6) of G.S. 90-171.37 exist, the Board may deny licensure of the applicant. The Board may disclose to the applicant information contained in the criminal history record check that is relevant to the denial. The Board shall not provide a copy of the criminal history record check to the applicant. The applicant shall have the right to appear before the Board to appeal the Board's decision. However, an appearance before the full Board shall constitute an exhaustion of administrative remedies in accordance with Chapter 150B of the General Statutes.

(d) Limited immunity. – The Board, its officers and employees, acting in good faith and in compliance with this section, shall be immune from civil liability for denying licensure to an applicant based on information provided in the applicant's criminal history record check."





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SECTION 28. Article 9A of Chapter 90 of the General Statutes is amended by adding a new section to read:

"§ 90-171.49. Disasters and emergencies.

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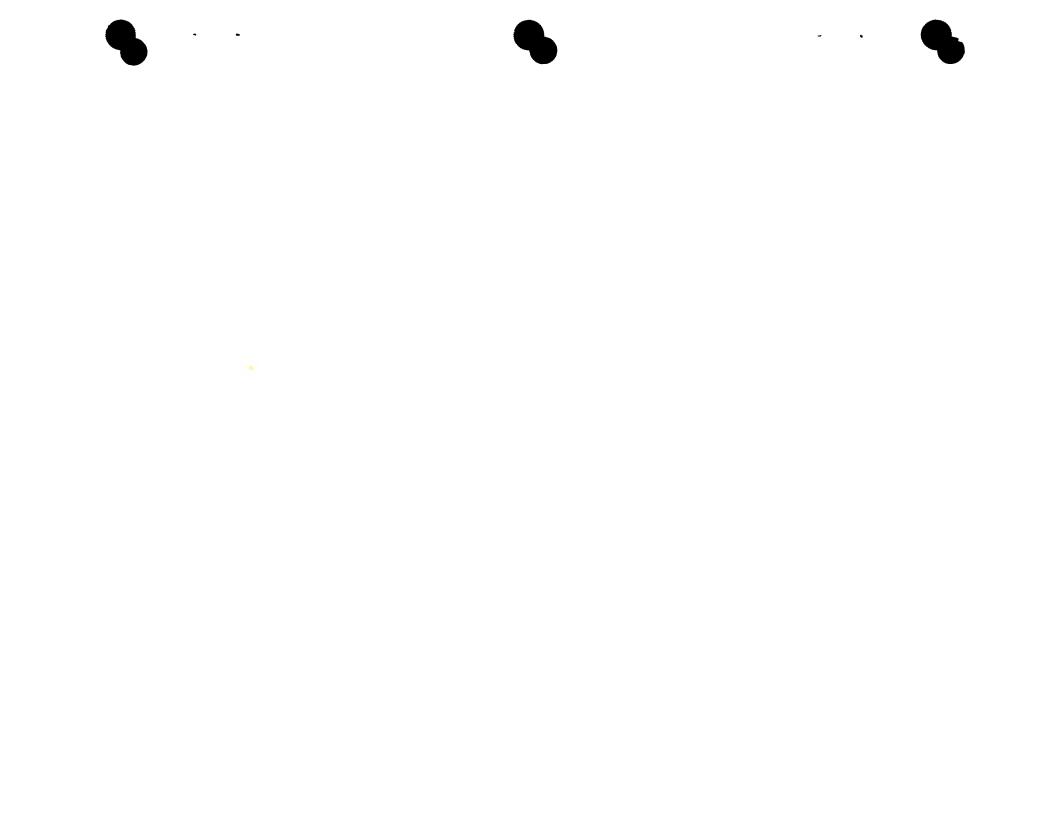
In the event of an occurrence that the Governor of the State of North Carolina has declared a state of emergency, or in the event of an occurrence for which a county or municipality has enacted an ordinance to deal with states of emergency under G.S. 166A-19.31, or to protect the public health, safety, or welfare of its citizens under Article 22 of Chapter 130A of the General Statutes, G.S. 160A-174(a) or G.S. 153A-121(a), as applicable, the Board may waive the requirements of this Article in order to permit the provision of emergency health services to the public."

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SECTION 29. G.S. 90-171.28 and Article 10A of Chapter 90 of the General Statutes are repealed.

12 13

SECTION 30. This act becomes effective January 1, 2018.



HB 88 Modernize Nursing Practice Act – For Discussion Only

I. Presentation of the Bill by the Bill Sponsor

Segments II-V will be timed by the Sgt-at-Arms

II. 10 Minutes for the Supporters of the Bill

- Julie George, Executive Director, NC Board of Nursing
- Patrick Ballantine, Lobbyist for NC Nurses Association (NCNA) and NC Association of Nurse Anesthetists (NCANA)

III. 10 Minutes for Opponents of the Bill

- Dr. Paul Rieker (pronounced Reeker), Past-President of the NC Society of Anesthesiologists.
- Dr. Conrad Flick, MD, Past President, NC Academy of Family Physicians

IV. 5 Minutes for Supporters of the Bill

 Patrick Ballantine, Lobbyist for NC Nurses Association (NCNA) and NC Association of Nurse Anesthetists (NCANA)

V. 5 Minutes for Opponents of the Bill

Dr. Bill Ferrell, MD, Legislative Cabinet Chair, NC Medical Society

VI. Committee Questions During Remaining Time



Julie George

Support House Bill 88

Facts and Evidence Tell the Real Story

The facts support that Advanced Practice Nurses (APRNs) are vital to the future health care workforce in North Carolina and removing barriers to their license to practice in NC can address primary care workforce shortages while sustaining quality of care.

Claim: "Quality of care will be reduced by the removal of the collaborative practice agreement requirement (HB 88) between the nurse practitioner and clinical nurse midwife from the physician."

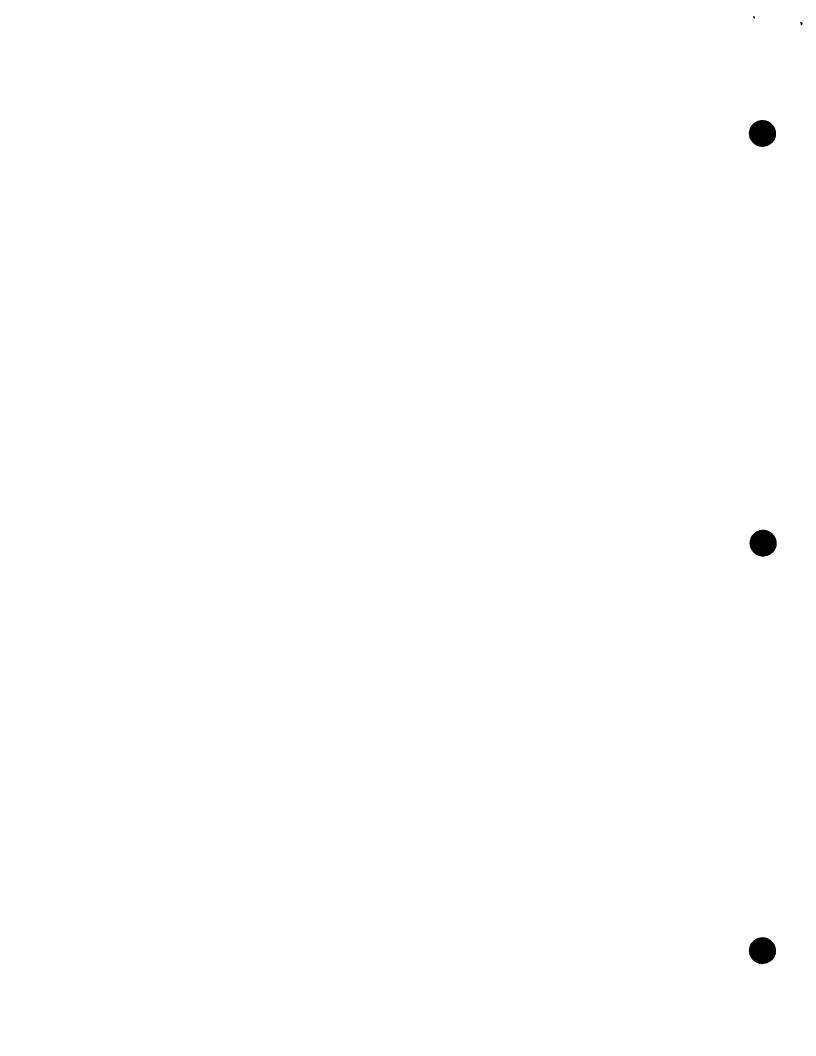
Fact: Quality of care is comparable between Advanced Practice Nurses and primary care physicians.

- Studies have shown that primary care provided by nurse practitioners and nurse
 midwives has been as safe and effective as care provided by primary care
 doctors. A 2010 report from the Institute of Medicine points to 50 years of
 evidence confirming that conclusion.
- The National Governor's Association reviewed the literature and state rules
 governing nurse practitioner scope of practice and found that NPs can perform
 many primary care services as well as physicians do and achieve equal or higher
 patient satisfaction rates. (NGA Paper: The Role of Nurse Practitioners in
 Meeting Increasing Demand for Primary Care, 2012)
- The Federal Trade Commission has weighed in on several state battles over scope of practice, arguing that physician groups have no valid reason for blocking such laws other than to thwart competition. (Federal Trade Commission Policy Perspectives: Competition and Regulation of Advanced Practice Nurses, 2014;2015)

Claim: "Removing the collaborative practice agreement requirement (HB 88) won't improve access to care... or reduce the shortage of primary care practitioners."

Fact: APRNs are a key workforce strategy to address primary care access.

- In North Carolina, Nurse Practitioners already practice in 99 out of 100 counties.
 They are already in the rural areas. HB 88 will reduce barriers to recruit more practitioners to our state.
- Expanded APRN practice is widely regarded as a key strategy to alleviate provider shortages, especially in primary care, in medically underserved areas, and for medically underserved populations. Regulatory constraints on APRN practice limit the ability of APRNs to expand access to primary care services. (Federal Trade Commission 2016 Staff Comment to West Virginia Senate Bill 516)



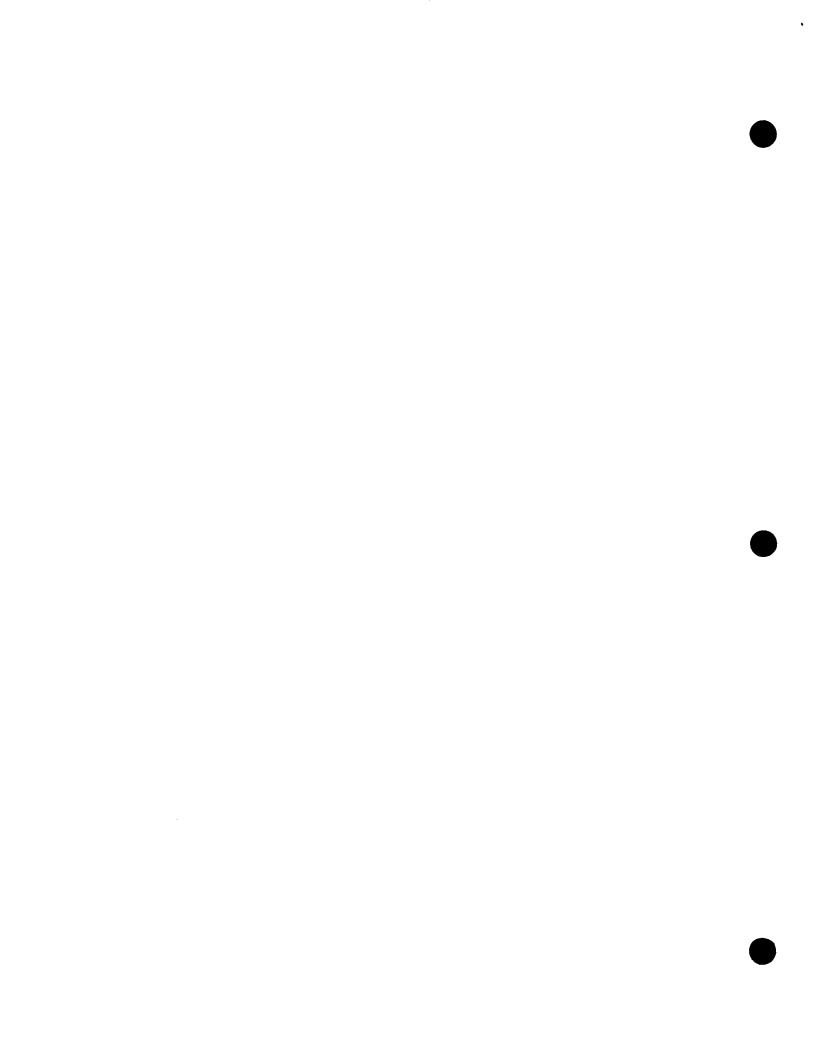
Support House Bill 88

- In 2012, nationwide, 117,000 physicians practiced family medicine according to the Kaiser Family Foundation, while 134,000 nurse practitioners practiced primary care, according to the American Association of Nurse Practitioners.
- The National Resident Matching Program reported in 2014, that only 1,938
 U.S. medical school graduates, or about 12% of the total, went into primary care
 residency programs. Nursing school graduates who went into primary care
 totaled 11,764 in 2012 or about 84% of all NP graduates.
- NPs have played a vital role in improving access to primary care for vulnerable adults according to Morgan et al, 2015. NPs are key providers in 1,202 federally funded community health centers.
- Kaplan et al, 2012, examined the distribution of NPs in urban and rural areas
 observing a trend that NPs were 1.5 times more likely to practice in rural areas in
 states with full practice authority compared with states with restrictive regulations.

Claim: "Team-based protocols would be eliminated."

Fact: In states without collaborative practice agreement restrictions, collaboration occurs between providers.

- Nurse Practitioners and Certified Nurse Midwives routinely function in teams, have referral and transfer relationships independent of the collaborative agreement license requirement. "Rigid supervision and collaborative agreement requirements may impede, rather than foster, development of effective models of team-based care." (Federal Trade Commission Policy Perspectives: Competition and the Regulation of Advanced Practice Nurses, 2014;2015)
- "Health care providers that employ or contract with APRNs typically develop and implement their own practice protocols and their own team-based collaboration and supervision protocols...they do so independent of the question of whether their states imposed particular supervision or "collaboration" structures."
 (Federal Trade Commission Policy Perspectives: Competition and the Regulation of Advanced Practice Nurses, 2014;2015)
- Team based care assumes all members of the team would be available to perform the tasks for which they were trained, freeing up physicians to perform the tasks that only physicians have been trained to perform. (NGA Paper: The Role of Nurse Practitioners in Meeting Increased Demand for Primary Care, 2012)
- Removing the collaborative practice agreement, allowing the nurse practitioner and certified nurse midwife to practice to the full extent of their education, certification and licensure.



North Carolina's Nurse Practitioners & Nurse Midwives

Qualified Health Care Providers

Nurse Practitioners (NP) and Certified Nurse Midwives (CNM) provide comprehensive health services. They have advanced education with master's or doctorate degrees and advanced clinical training beyond initial professional RN preparation.



Population Focus of NPs



NPs Approved to Practice in NC

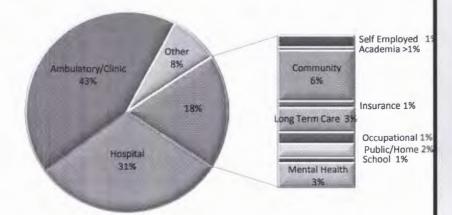


CNMs Approved to Practice in NC



Prepared to Meet Patient Needs

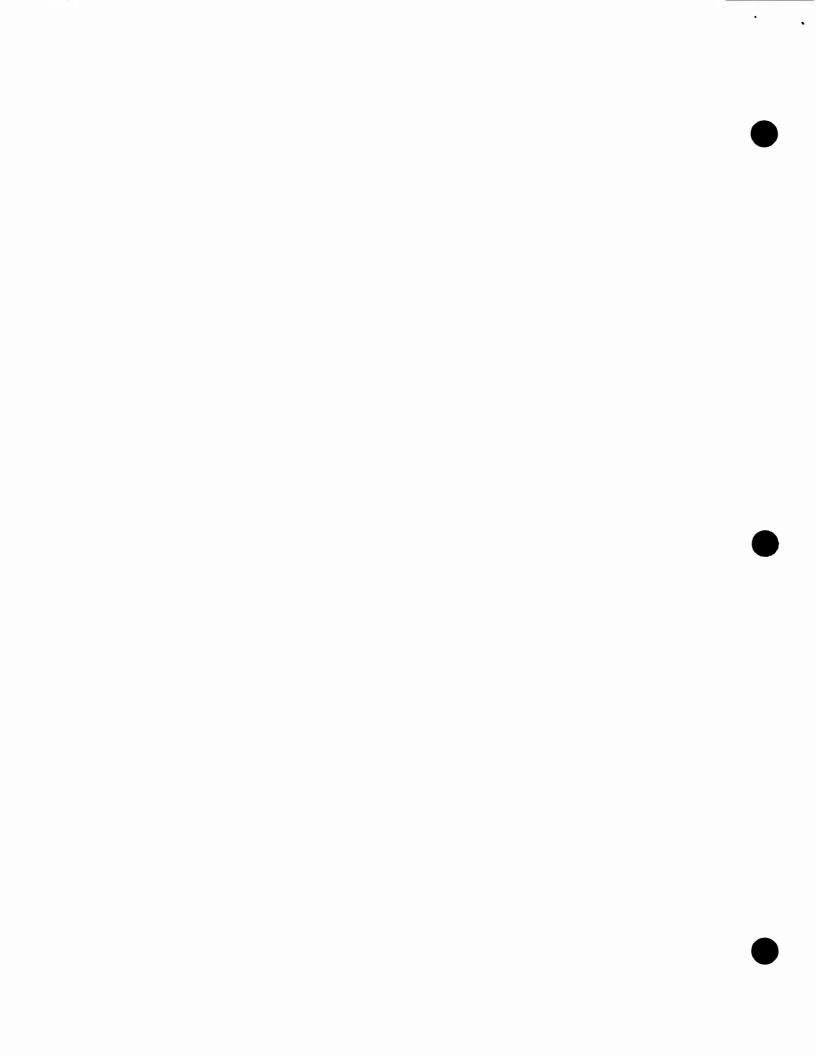
NPs and CNMs work in rural and urban locations in North Carolina in various practice settings as depicted on the graph.

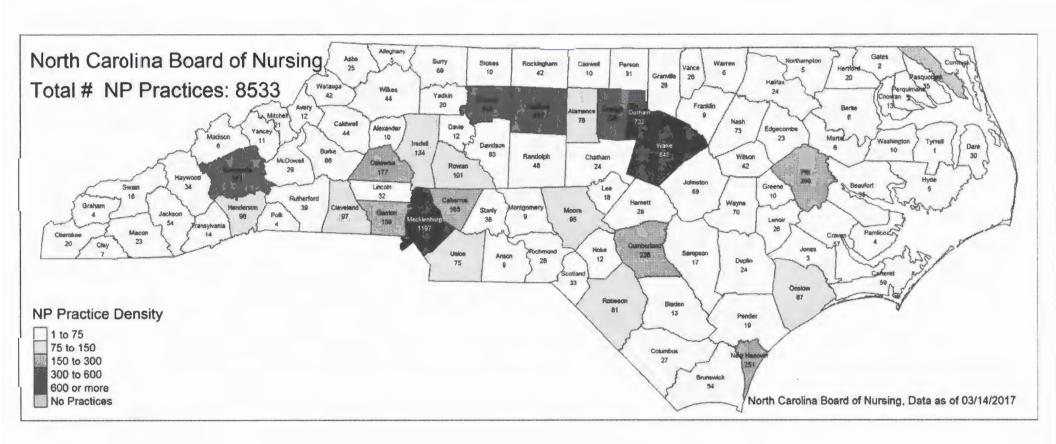


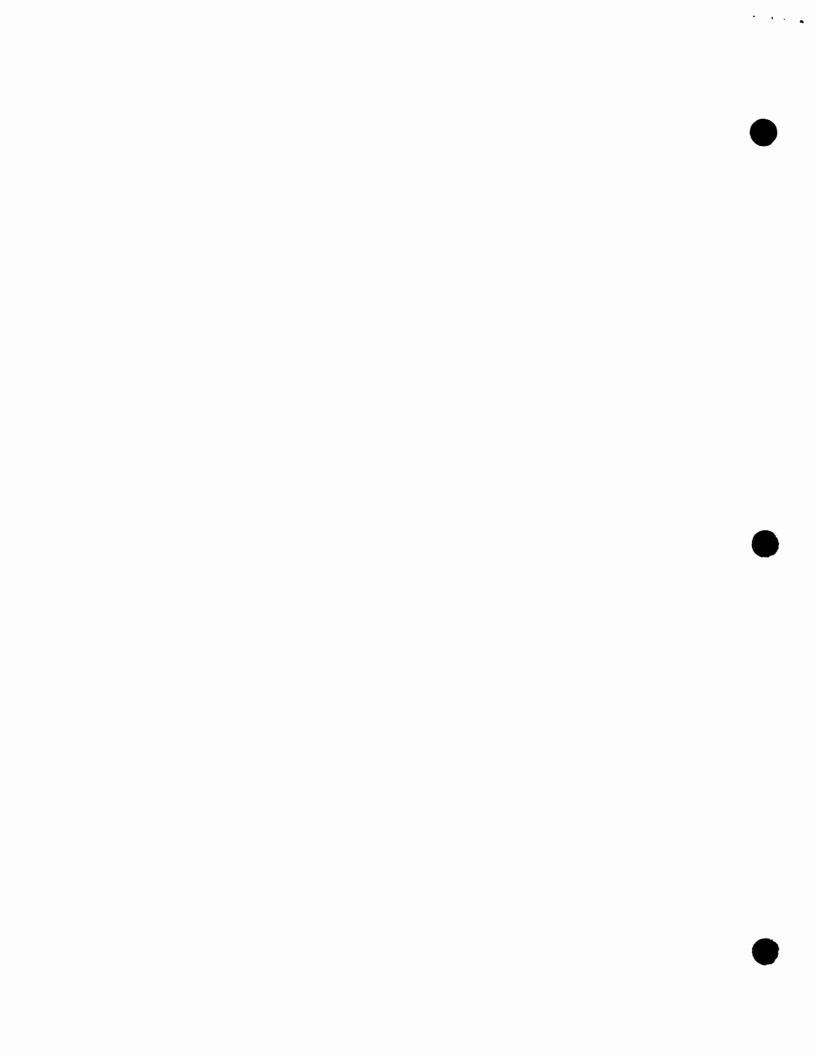
Consistent with Education & Certification, NPs and CNMs:

- Manage a patient's care, diagnose, and treat within scope of licensure;
- Order, perform and interpret diagnostic tests such as lab work and x-rays;
- Prescribe medications and other treatments
- ✓ Collaborate and refer patients
- Focus on health promotion, disease prevention, health education and counseling to guide patients in making informed health and lifestyle choices.

Source: NC Board of Nursing Licensure Data. Accessed: March 2017







NC House Health Committee Hearing House Bill 88, Nursing Modernization Practice Act Wednesday, 15 March, 2017 643 Lob

My name is Dr. Robert Paul Rieker and I am a private practice anesthesiologist from Wake County. I represent the NC Society of Anesthesiologists as Director and a past president.

I am here today to speak in opposition to HB 88 because it eliminates long standing NC law that protects patients and the public by ensuring that a physician supervises a nurse anesthetist when providing anesthesia care to patients.

I work daily with nurse anesthetists providing care to patients in an anesthesia care team model. Because of my own professional career as a physician, I probably know more nurses than any other working professional. My own mother is a Registered Nurse. I do not intend in any way to speak out against nurses or the nursing profession. But I do have to speak against nurses practicing medicine.

Despite what is being said that HB 88 proposes only minor or subtle changes to the Nursing

March 13, 2017

House Health Committee North Carolina General Assembly Legislative Building 16 West Jones Street Raleigh, NC 27601

Dear House Health Committee Members:

As a native North Carolinian, I am writing in strong opposition to House Bill 88 (HB 88). This alarming legislation would remove the long-standing safety standard for physician supervision of anesthesia administration. Eliminating this important law would directly impact the safety of every patient receiving surgical and procedural anesthesia in North Carolina.

As both a practicing physician anesthesiologist, Professor and Department Chair, and Past President of the American Society of Anesthesiologists, I work daily to ensure patients' medical needs are being met safely and effectively. In my hospital as well as in much of the United States, we practice in the model known as the Anesthesia Care Team¹ which includes the delegation of appropriate medical tasks to non-physicians. In each of those circumstances, the responsibility for those tasks remains with the supervising physician. Since the advent of modern anesthesia in the 19th century, the Anesthesia Care Team has safely and effectively delivered anesthesia care with either an anesthesiologist assistant or nurse anesthetist as the non-physician anesthetist member of the team.

Removing physician supervision of anesthesia care makes no more sense than removing it from any other critical care location. Prior to becoming a physician anesthesiologist, I was a nurse anesthetist. As one who has completed education and training in both medicine and nursing, I can tell you true differences exist between a nurse anesthetist and a physician. Those differences warrant continued physician supervision because they directly impact one's ability to comprehensively manage the medical care and emergent needs of patients.

In my experience, there are two main differences in the education and training of a physician anesthesiologist and a nurse anesthetist:

1. Length of Training: Nurse anesthesia education and training ranges from 4-6 years after high school. Nurse anesthetists trained in the past two decades have obtained a baccalaureate degree in nursing (four years), worked a minimum of one year in an intensive care setting, and then participated in an approximately 30-month anesthesia training program, graduating with a master's degree. However, there are still those practicing who never even graduated from college. Nurse anesthetists average about 1,650–2,000 hours of patient care training in their curriculum.

¹ ASA Standards, Guidelines and Statements: Statement on the Anesthesia Care Team available at http://www.asahq.org/~/media/Sites/ASAHQ/Files/Public/Resources/standards-guidelines/statement-on-the-anesthesia-care-team.pdf

Conversely, a physician's education and training is at least 12-14 years after high school. For example, to become a physician anesthesiologist, one must complete a bachelor's degree with a pre-medicine curriculum (four years), medical school (four more years), as well as an additional year of hospital based training in general medicine, pediatrics, surgery, or combination (internship year). Only *then* does a physician begin their specialty residency training in anesthesiology (three years). After residency, many physician anesthesiologists also complete subspecialty training (1-2 additional years after residency) in areas including: pain medicine, cardiac anesthesia, pediatric anesthesia, neuroanesthesia, obstetric anesthesia, or critical care medicine. Altogether, physicians have anywhere from 12,000 – 16,000 hours of patient care training in their curriculum.

2. Depth of Medical and Surgical Knowledge: Equally important as the difference in education and training is the difference in depth of knowledge. Physicians complete all courses relevant to the practice of medicine, including associated laboratory courses. The breadth of courses plus the duration and hours of course work allow for detailed, comprehensive medical knowledge. Nurse anesthetists take selected courses related to anesthesia. The limited number of courses plus the shorter duration and fewer hours do not allow for detailed, comprehensive medical knowledge.

The administration of anesthesia is a complex and technically demanding medical procedure that requires physician supervision. An independent outcomes study published in the peer-reviewed journal *Anesthesiology* found that the presence of a physician anesthesiologist prevented 6.9 excess deaths per 1,000 cases in which an anesthesia or surgical complication occurred. Nurse anesthetists often advocate that substituting nurses for physicians cuts costs without increasing patient deaths or complications. However, there are no definitive, independent studies that confirm nurse anesthetists can ensure the same quality of care, patient safety, and outcomes at less cost when working without physician supervision. Surveys also repeatedly show patients *want* physicians in charge. In a recent American Medical Association survey, 77 percent of consumer respondents said they believed *only* a physician should administer and monitor anesthesia levels before and after surgery, and eighty-four percent said that they prefer a physician to have primary responsibility for the diagnosis and management of their health care.

Physician anesthesiologists are keenly aware of the challenges to surgical care in rural areas. As a profession, however, our first priority is to patient care and safety. Based on the differences in education and training between physicians and nurse anesthetists, we feel strongly that – for the sake of patient safety – in the absence of a physician anesthesiologist, a physician should retain responsibility for the patient when a non-physician anesthesia provider administers anesthesia. It would be a disservice to legislate a lower standard of care for North Carolina patients.

Based on my completion of nurse anesthesia training and medical school and anesthesiology residency, nurse anesthetists are not educated or trained in medical decision making, differential diagnoses, medical diagnostic interpretations, or medical interventions. Physician supervision, whether by a physician anesthesiologist or surgeon, is key to patient safety, as most of the patient related problems encountered in the perioperative period relate to underlying medical illnesses or to the surgical procedure rather than to a specific anesthesia-related problem.

Because of the aging population and increasingly complex medical and surgical procedures, the need for physician supervision has never been greater. Nurse anesthetists are valuable members of the healthcare team; however, the surgically-based medical practice of anesthesiology is far too critical to not have physician supervision. I can attest from personal experience, the medical education and training process best serves the interests of our patients. As one who relies on her training as a physician each day in the operating room, I respectfully request that the House Health Committee maintain the safety that our patients deserve and that the public demands for their anesthesia care by continuing physician supervision of nurse anesthetists. I want the peace of mind knowing that any of my or my husband's relatives living in North Carolina will have the benefit of having physician supervision of nurse anesthetists in the event they need surgery and anesthesia, or a medical procedure requiring anesthesia.

Respectfully yours,

Jane C.K. Fitch, M.D.

Past President, American Society of Anesthesiologists, 2014

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Past President, Society of Academic Anesthesiology Associations, 2014 - 2016

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March 15, 2017

House Health Committee North Carolina General Assembly Legislative Building 16 West Jones Street Raleigh, NC 27601

Dear House Health Committee Members:

On behalf of the American Academy of Anesthesiologist Assistants (AAAA), I write today to oppose House Bill 88 – Modernize Nursing Practice Act. Anesthesia care is the most efficient and highest quality when physicians remain at the helm and responsible for the medical treatment by the anesthesia care team.

The State of North Carolina began licensing Certified Anesthesiologist Assistants (CAAs) to practice in 2007. CAAs are highly skilled health professionals who work under the supervision and direction of physician anesthesiologists to implement anesthesia care plans. CAAs receive anesthesia-specific training and education in a Master's degree program after having received an undergraduate degree.

As CAAs, we support the anesthesia care team model (ACT), which includes a physician anesthesiologist supervising CAAs and/or nurse anesthetists. This long-standing team approach offers the safest and most efficient delivery method of anesthesia care.

CAAs work alongside and interchangeably with nurse anesthetists as members of the physician-led anesthesia care team. Members of the anesthesia care team each bring distinct and valuable skills to the group and work together to provide the best possible anesthesia care for the patient. House Bill 88 would eliminate the role of the physician as the leader of the anesthesia care team, excluding the medical professional with the highest level of education and training to develop and supervise a safe anesthesia plan for a patient. Eliminating supervision puts patients at an unnecessary risk. As CAAs, we value working with physician anesthesiologists and welcome the leadership role they play in the care team model.

The current standard of care in North Carolina requires physician supervision of anesthesiologist assistants and nurse anesthetists. This patient safety requirement and the team-based care it encourages works well for patients and should be maintained. AAAA urges committee members to oppose HB 88 and protect patient safety. If you have any additional question, please feel free to contact Jeremy Betts, AAAA Director of State Affairs at jeremy.betts@politics.org.

Sincerely,

Gina Scarboro, CAA

Olim Scarlow

President

American Academy of Anesthesiologist Assistants

March 13, 2017

House Health Committee North Carolina General Assembly Legislative Building 16 West Jones Street Raleigh, NC 27601

Dear House Health Committee Members:

As a native North Carolinian, I am writing in strong opposition to House Bill 88 (HB 88). This alarming legislation would remove the long-standing safety standard for physician supervision of anesthesia administration. Eliminating this important law would directly impact the safety of every patient receiving surgical and procedural anesthesia in North Carolina.

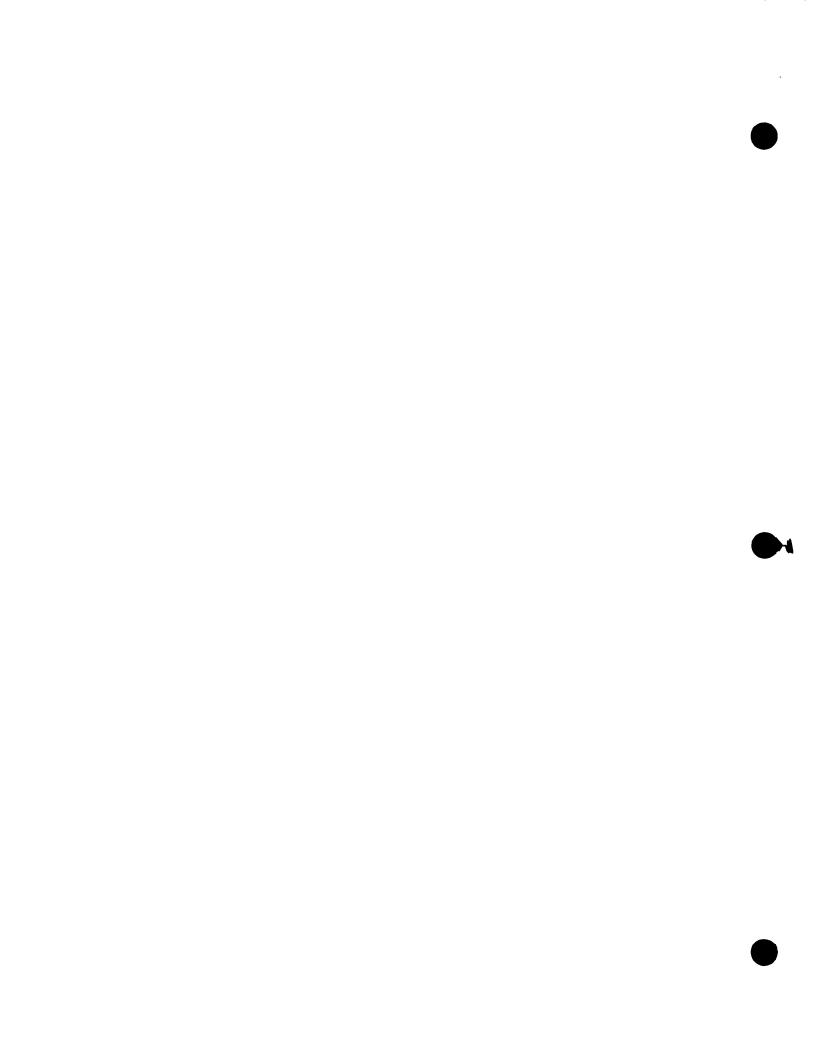
As both a practicing physician anesthesiologist, Professor and Department Chair, and Past President of the American Society of Anesthesiologists, I work daily to ensure patients' medical needs are being met safely and effectively. In my hospital as well as in much of the United States, we practice in the model known as the Anesthesia Care Team¹ which includes the delegation of appropriate medical tasks to non-physicians. In each of those circumstances, the responsibility for those tasks remains with the supervising physician. Since the advent of modern anesthesia in the 19th century, the Anesthesia Care Team has safely and effectively delivered anesthesia care with either an anesthesiologist assistant or nurse anesthetist as the non-physician anesthetist member of the team.

Removing physician supervision of anesthesia care makes no more sense than removing it from any other critical care location. Prior to becoming a physician anesthesiologist, I was a nurse anesthetist. As one who has completed education and training in both medicine and nursing, I can tell you true differences exist between a nurse anesthetist and a physician. Those differences warrant continued physician supervision because they directly impact one's ability to comprehensively manage the medical care and emergent needs of patients.

In my experience, there are two main differences in the education and training of a physician anesthesiologist and a nurse anesthetist:

1. Length of Training: Nurse anesthesia education and training ranges from 4-6 years after high school. Nurse anesthetists trained in the past two decades have obtained a baccalaureate degree in nursing (four years), worked a minimum of one year in an intensive care setting, and then participated in an approximately 30-month anesthesia training program, graduating with a master's degree. However, there are still those practicing who never even graduated from college. Nurse anesthetists average about 1,650–2,000 hours of patient care training in their curriculum.

¹ ASA Standards, Guidelines and Statements: Statement on the Anesthesia Care Team available at http://www.asahq.org/~/media/Sites/ASAHQ/Files/Public/Resources/standards-guidelines/statement-on-the-anesthesia-care-team.pdf



Conversely, a physician's education and training is at least 12-14 years after high school. For example, to become a physician anesthesiologist, one must complete a bachelor's degree with a pre-medicine curriculum (four years), medical school (four more years), as well as an additional year of hospital based training in general medicine, pediatrics, surgery, or combination (internship year). Only *then* does a physician begin their specialty residency training in anesthesiology (three years). After residency, many physician anesthesiologists also complete subspecialty training (1-2 additional years after residency) in areas including: pain medicine, cardiac anesthesia, pediatric anesthesia, neuroanesthesia, obstetric anesthesia, or critical care medicine. Altogether, physicians have anywhere from 12,000 – 16,000 hours of patient care training in their curriculum.

2. Depth of Medical and Surgical Knowledge: Equally important as the difference in education and training is the difference in depth of knowledge. Physicians complete all courses relevant to the practice of medicine, including associated laboratory courses. The breadth of courses plus the duration and hours of course work allow for detailed, comprehensive medical knowledge. Nurse anesthetists take selected courses related to anesthesia. The limited number of courses plus the shorter duration and fewer hours do not allow for detailed, comprehensive medical knowledge.

The administration of anesthesia is a complex and technically demanding medical procedure that requires physician supervision. An independent outcomes study published in the peer-reviewed journal *Anesthesiology* found that the presence of a physician anesthesiologist prevented 6.9 excess deaths per 1,000 cases in which an anesthesia or surgical complication occurred. Nurse anesthetists often advocate that substituting nurses for physicians cuts costs without increasing patient deaths or complications. However, there are no definitive, independent studies that confirm nurse anesthetists can ensure the same quality of care, patient safety, and outcomes at less cost when working without physician supervision. Surveys also repeatedly show patients *want* physicians in charge. In a recent American Medical Association survey, 77 percent of consumer respondents said they believed *only* a physician should administer and monitor anesthesia levels before and after surgery, and eighty-four percent said that they prefer a physician to have primary responsibility for the diagnosis and management of their health care.

Physician anesthesiologists are keenly aware of the challenges to surgical care in rural areas. As a profession, however, our first priority is to patient care and safety. Based on the differences in education and training between physicians and nurse anesthetists, we feel strongly that – for the sake of patient safety – in the absence of a physician anesthesiologist, a physician should retain responsibility for the patient when a non-physician anesthesia provider administers anesthesia. It would be a disservice to legislate a lower standard of care for North Carolina patients.

Based on my completion of nurse anesthesia training and medical school and anesthesiology residency, nurse anesthetists are not educated or trained in medical decision making, differential diagnoses, medical diagnostic interpretations, or medical interventions. Physician supervision, whether by a physician anesthesiologist or surgeon, is key to patient safety, as most of the patient related problems encountered in the perioperative period relate to underlying medical illnesses or to the surgical procedure rather than to a specific anesthesia-related problem.

Because of the aging population and increasingly complex medical and surgical procedures, the need for physician supervision has never been greater. Nurse anesthetists are valuable members of the healthcare team; however, the surgically-based medical practice of anesthesiology is far too critical to not have physician supervision. I can attest from personal experience, the medical education and training process best serves the interests of our patients. As one who relies on her training as a physician each day in the operating room, I respectfully request that the House Health Committee maintain the safety that our patients deserve and that the public demands for their anesthesia care by continuing physician supervision of nurse anesthetists. I want the peace of mind knowing that any of my or my husband's relatives living in North Carolina will have the benefit of having physician supervision of nurse anesthetists in the event they need surgery and anesthesia, or a medical procedure requiring anesthesia.

Respectfully yours,

Jane C.K. Fitch, M.D.

Past President, American Society of Anesthesiologists, 2014

Jane CK like mo

Past President, Society of Academic Anesthesiology Associations, 2014 – 2016

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EDUCATION of PHYSICIANS and ADVANCED NURSE PRACTITIONERS

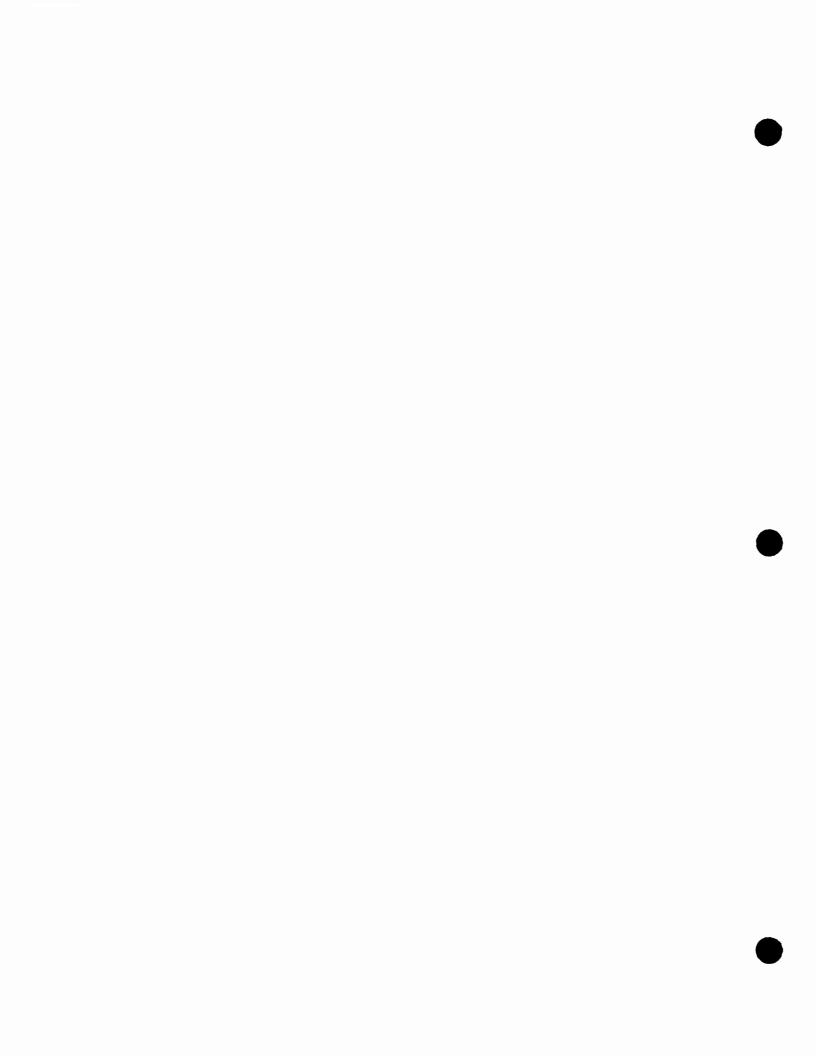
	Undergraduate degree	Entrance exam	Post-graduate schooling	Residency and duration	TOTAL TIME FOR COMPLETION
Family physician (M.D. or D.O.)	Standard 4-year BA/BS	Medical College Admissions Test (MCAT)	4 years, doctoral program (M.D. or D.O.)	REQUIRED, 3 years minimum	11 years
Nurse practitioner	Standard 4-year BA/BS*	Graduate Record Examination (GRE) & National Council Licensure Exam for Registered Nurses (NCLEX-RN) required for MSN programs	1.5 – 3 years, master's program (MSN)	NONE	5.5 – 7 years

TRAINING HOURS of PHYSICIANS and ADVANCED NURSE PRACTITIONERS

	Lecture hours (pre-clinical years)	Study hours (pre-clinical years)	Combined hours (clinical years)	Residency hours	TOTAL HOURS
Family physician	2,700	3,000**	6,000	9,000 – 10,000	20,700 – 21,700
Doctor of Nursing Practice	800 – 1,600	1,500 – 2,250**	500 – 1,500	0	2,800 - 5,350
Difference between FP and NP hours of professional training	1,100 – 1,900 more for FPs	750 – 1,500 more for FPs	4,500 – 5,500 more for FPs	9,000 - 10,000 more for FPs	15,350 – 18,900 more for FPs

^{*} While a standard 4-year degree, preferably a BSN, is recommended, alternate pathways exist for an RN without a bachelor's degree to enter some master's programs.

^{**} Estimate based on 750 hours of study dedicated by a student per year.





March 15, 2017

House Health Committee North Carolina General Assembly Legislative Building 16 West Jones Street Raleigh, NC 27601

Dear House Health Committee Members:

On behalf of the American Academy of Anesthesiologist Assistants (AAAA), I write today to oppose House Bill 88 – Modernize Nursing Practice Act. Anesthesia care is the most efficient and highest quality when physicians remain at the helm and responsible for the medical treatment by the anesthesia care team.

The State of North Carolina began licensing Certified Anesthesiologist Assistants (CAAs) to practice in 2007. CAAs are highly skilled health professionals who work under the supervision and direction of physician anesthesiologists to implement anesthesia care plans. CAAs receive anesthesia-specific training and education in a Master's degree program after having received an undergraduate degree.

As CAAs, we support the anesthesia care team model (ACT), which includes a physician anesthesiologist supervising CAAs and/or nurse anesthetists. This long-standing team approach offers the safest and most efficient delivery method of anesthesia care.

CAAs work alongside and interchangeably with nurse anesthetists as members of the physician-led anesthesia care team. Members of the anesthesia care team each bring distinct and valuable skills to the group and work together to provide the best possible anesthesia care for the patient. House Bill 88 would eliminate the role of the physician as the leader of the anesthesia care team, excluding the medical professional with the highest level of education and training to develop and supervise a safe anesthesia plan for a patient. Eliminating supervision puts patients at an unnecessary risk. As CAAs, we value working with physician anesthesiologists and welcome the leadership role they play in the care team model.

The current standard of care in North Carolina requires physician supervision of anesthesiologist assistants and nurse anesthetists. This patient safety requirement and the team-based care it encourages works well for patients and should be maintained. AAAA urges committee members to oppose HB 88 and protect patient safety. If you have any additional question, please feel free to contact Jeremy Betts, AAAA Director of State Affairs at jeremy.betts@politics.org.

Sincerely,

Gina Scarboro, CAA

Mina Scarboro

President

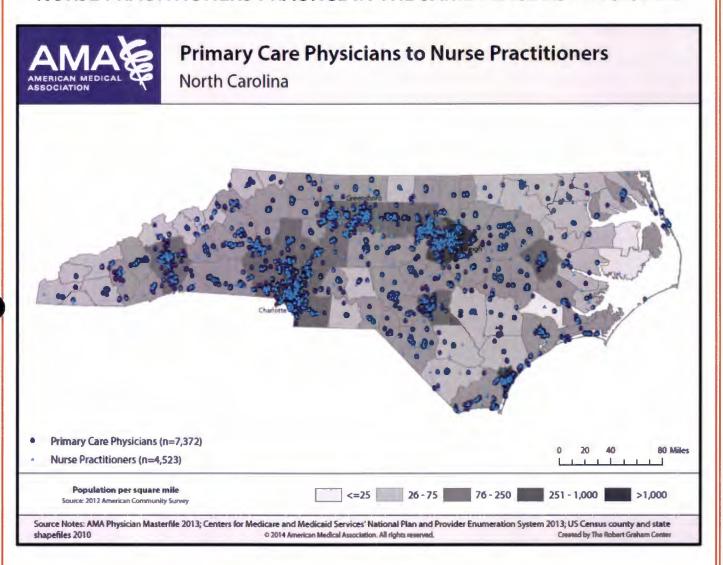
American Academy of Anesthesiologist Assistants



Oppose the Nurse Modernization Act

HB 88 does not fix our rural healthcare access problem.

NURSE PRACTITIONERS PRACTICE IN THE SAME PLACE AS PHYSICIANS



A 2013 assessment found states
that eliminated Physician Supervision
did not see dramatically improved rural access.

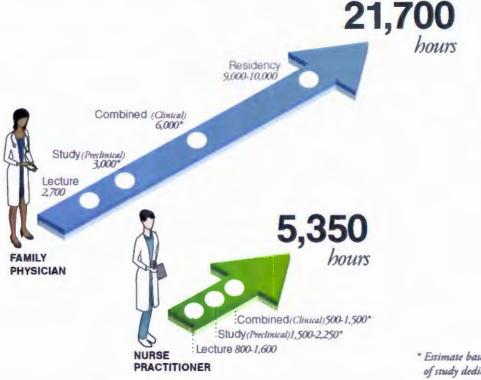
North Carolina Medical Society - 222 N Person St. Raleigh, NC - 919-833-3836

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Oppose HB 88

PHYSICIAN SUPERVISION

maximizes Nurse Practitioner individualized training



* Estimate based on 750 hours of study dedicated by a student per year.

NC factors allowing NPs to practice to the top of their training

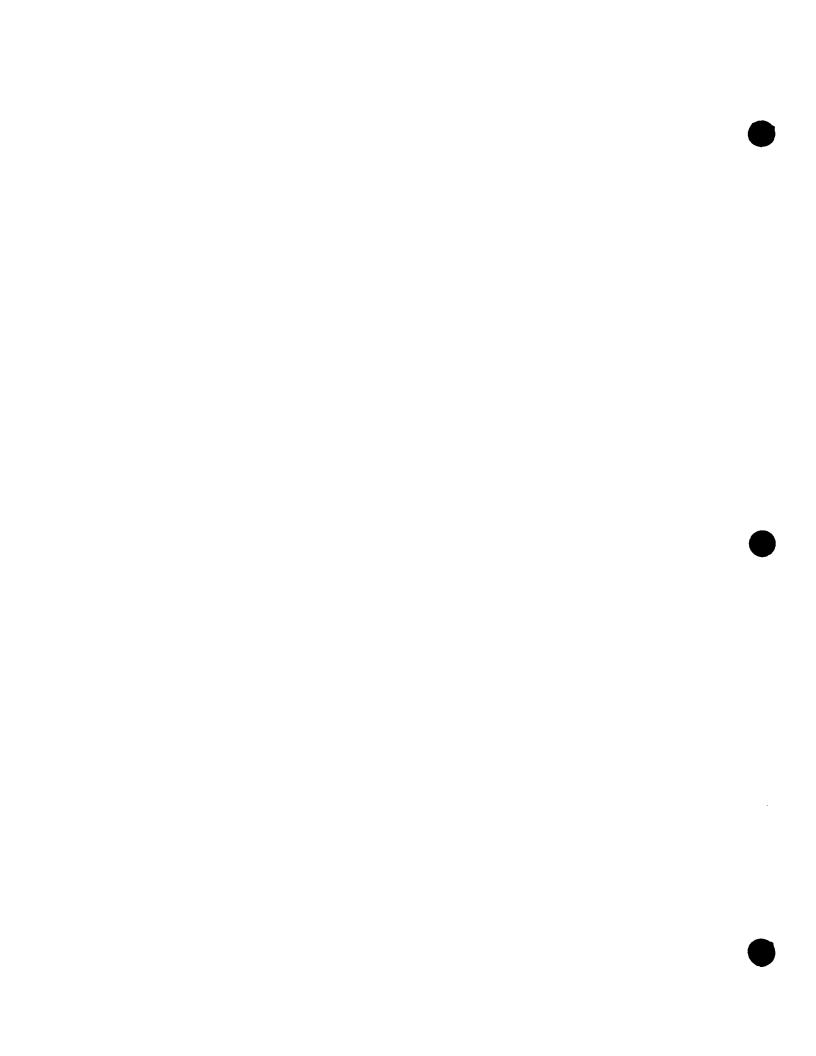
- · Geographic location of both
- · Practice setting of the NP
- Length of affiliation with their supervising physician
- Medical specialty of both
- Frequency, quality and type of the NP's ongoing education

- Level of the NP's training
- Experience of the NP
- Quality of the written agreement & protocols
- NP's scope of practice compared to supervisor
- Number supervised



Committee Sergeants at Arms

NAME O	F COMMITTEE	ouse <u>Comm.</u>	on Health
DATE: _	03/15/17	Room:	643
		House Sgt-At Arms:	
1. Name:	Young Bae		
2. Name:	Jim Moran		· ving spirit i controlleration and controlleration.
3. Name:	David Linthic	cum	
4. Name:	Russell Salis	sbury	
5. Name: _	Joe Crook		
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House Pages Assignments Wednesday, March 15, 2017

Session: 2:00 PM

Committee	Room	Time	Staff	Comments	Member
Alcoholic Beverage	Other	11:00 AM	Savannah Barnes		Rep. Speaker Tim Moore
Control					
			Hannah Bethea		Rep. Garland Pierce
			Mariah Pride		Rep. Speaker Tim Moore
Health	643	11:00 AM	Eliza Hilton	_	Rep. Speaker Tim Moore
			Marissa Huggins		Rep. Mike Clampitt
			Wilson Moore		Rep. Speaker Tim Moore
			Emily Pennington	,	Rep. Speaker Tim Moore
			^		
Pensions and Retirement	415	12:00 PM	Yasmeen Ayesh		Rep. Speaker Tim Moore
			Hannah Lewis		Rep. Speaker Tim Moore
			Brooke Reutinger		Rep. Speaker Tim Moore

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House Comm. on Health

03/15/17

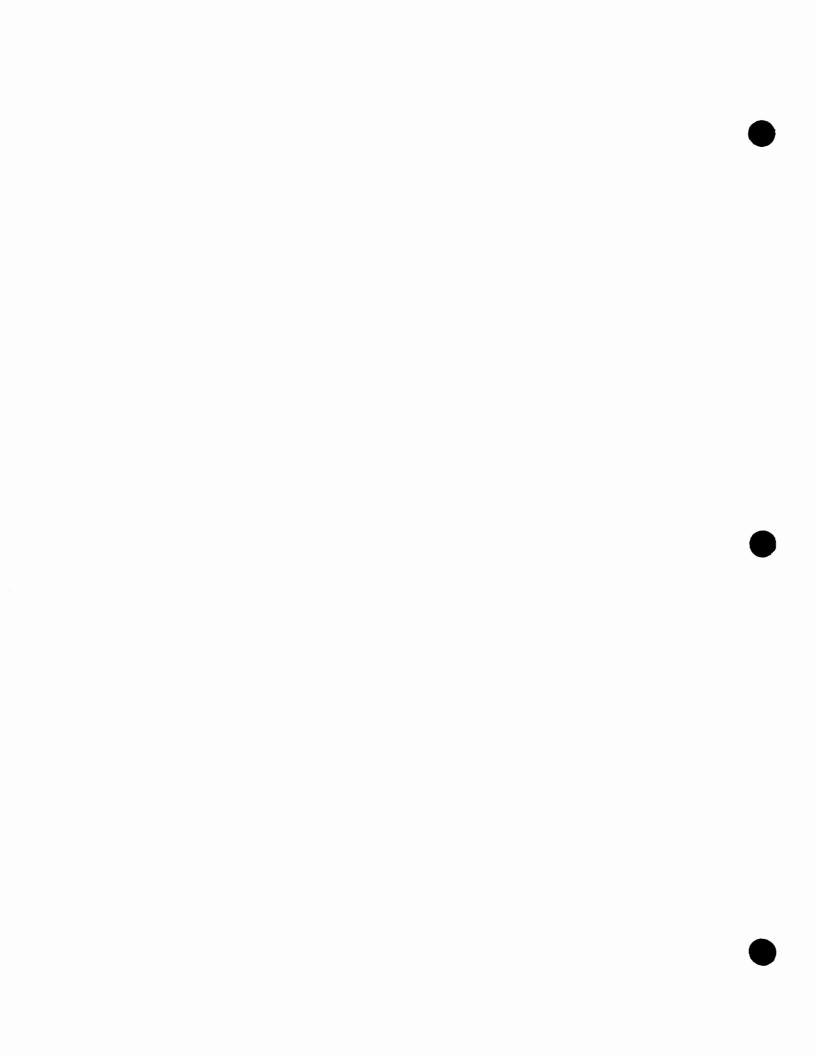
Date

NAME	FIRM OR AGENCY AND ADDRESS
· Chy Bron	Nims
Robin Huffman	NC Psychistrio Assoc
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Gry Griggs Andrew Dep	medical student - ECU
Sarah Medrilla	LOANC
Ryan Mewald	win
Haby Kingsburg	KP
Douis /Sa/backon	NC Board of Norsing
Amy Sitchugh	NC Board of Nuising
NATHAN COPELANT	NCVA 8

House Comm. on Health

03/15/17

NAME	FIRM OR AGENCY AND ADDRESS
Phoebe Landon	MWC
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Mart Halel.	» NC SUA
Parlkiele	NCSA
Doda Rinfa	CCR
Scot McCheoca	NCSA
Jon Blank	NCSA
tatricia Surgio	Joral MD
Charlene Edwards Green Mi) ACSA
Dave Horne	SA
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House Comm. on Health

03/15/17

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Elizabeth Langdon	NCBON
Louanne Mobiley	NLOTA
Joya Datus	CCL
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Dana Simpson	5A

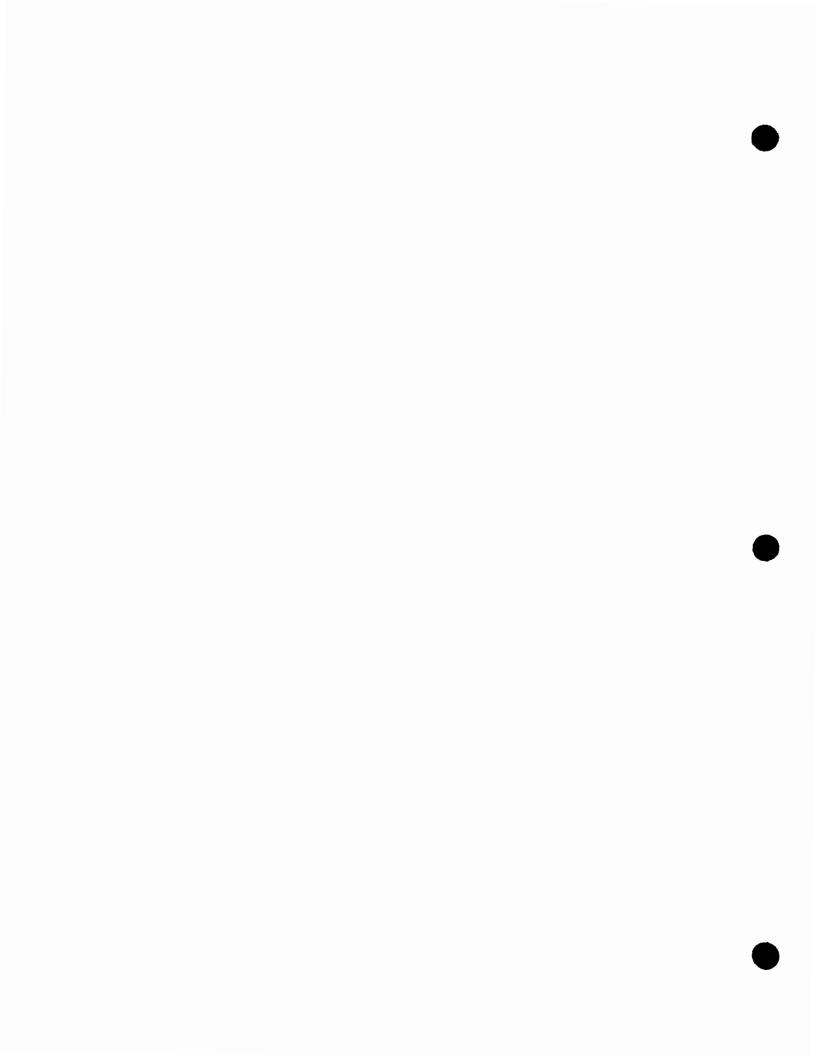
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House Comm. on Health

03/15/17

Date

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Steve Mitchell	·Actellas
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Harry Su ton-marce	CRNA
TJ Burnee	NP

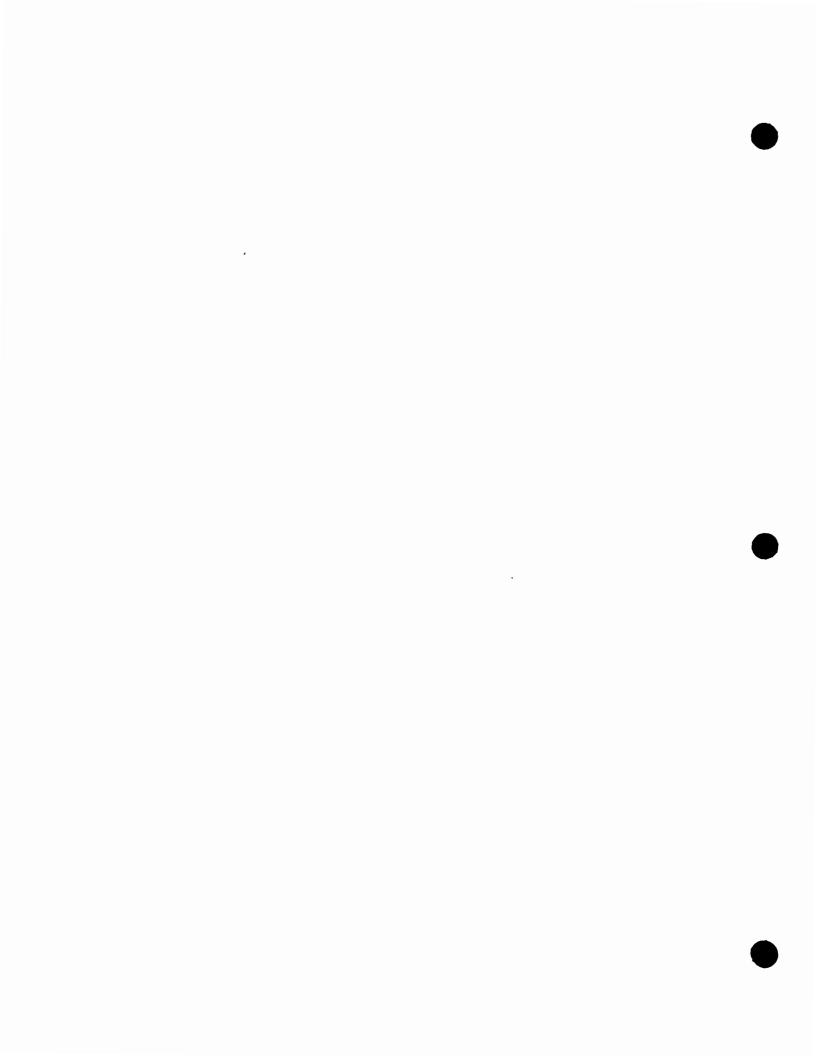


House Comm. on Health

03/15/17

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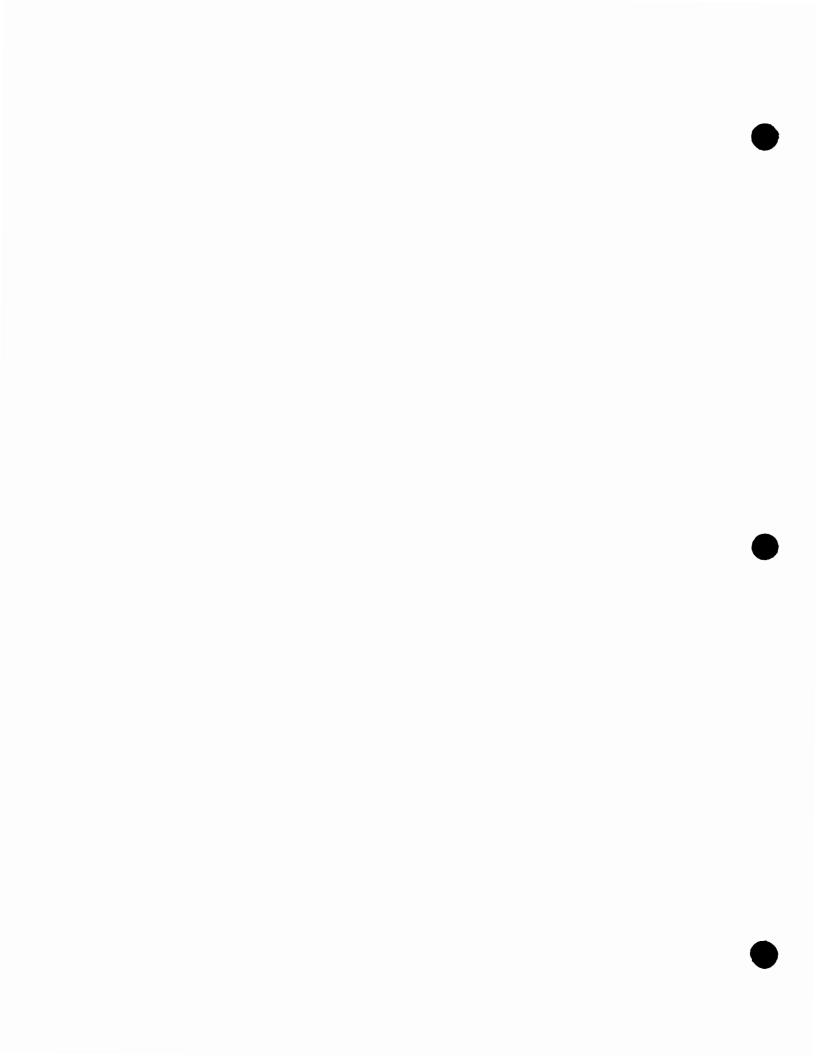
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Andy Munn	MVA



House Comm. on Health

03/15/17

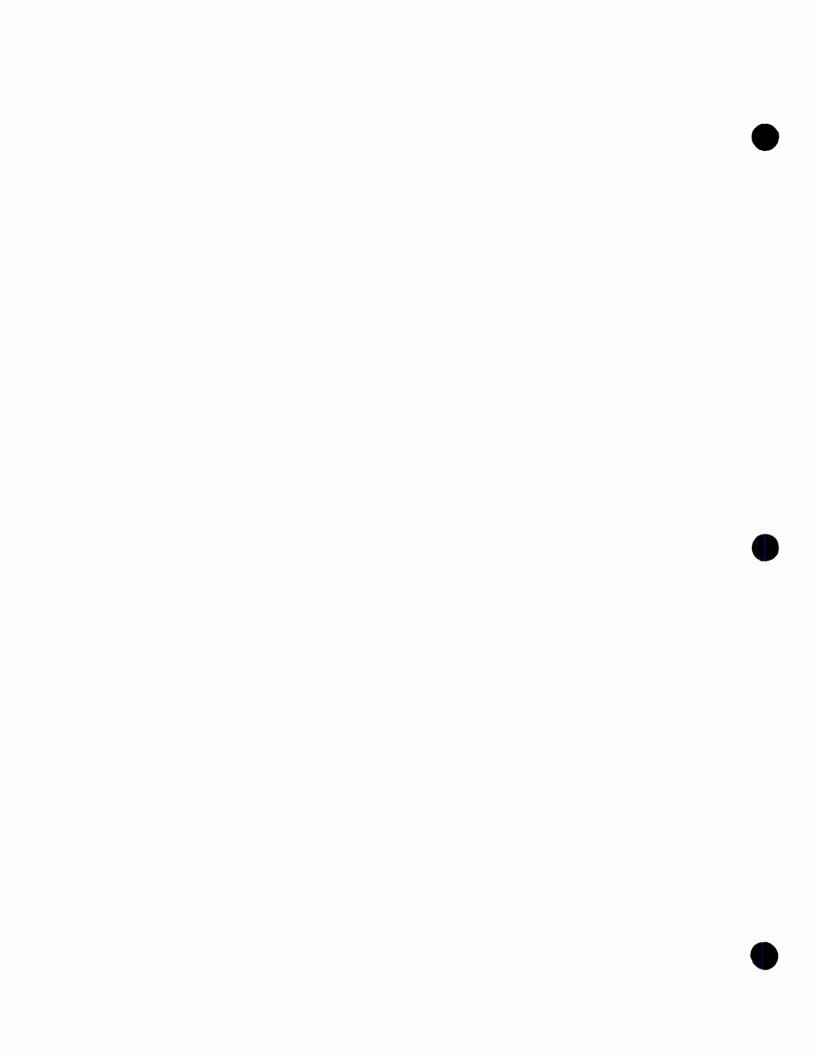
NAME	FIRM OR AGENCY AND ADDRESS
Julia Alonge 155500st	NC Board of Nursing
Alex Miller	· AMGA
Sarah Welfe	mut
LTMCCrimmon	DHH5
Radel Jealir	Pola
MiduleFrazier	SML
Chis McCline	BP
Viggiz Pottsn	ACDS.
C/14	WCFPC
Der Payell	NCFPL.
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House Comm. on Health

03/15/17

NAME	FIRM OR AGENCY AND ADDRESS
Bubara Hors	NCRTZ
Casse Gui	Ciena chels
Julia Adams Scheunch	Oak City GR.
Dennifer Walour	15dC
Andy Chase	KMA
TRACY COLUMPA	AHAZ
C'histing Crang	Wakeherd
Apring Elek	Constlan
Wetter Baland	PPAB.
PAUL PACKARS	CAVA - NCANA
Kimberly Gordin	CMNA, NEANA.

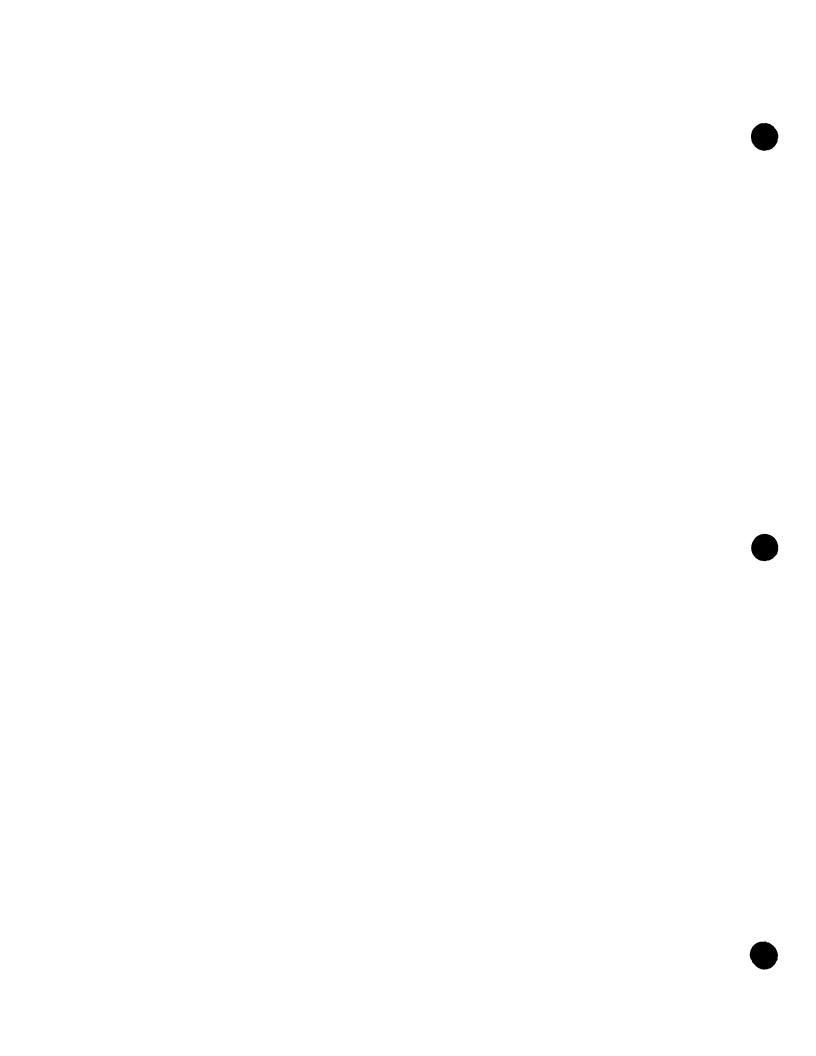


House Comm. on Health

03/15/17

Date

NAME	FIRM OR AGENCY AND ADDRESS
Tracy Kimbrell	Parker Poe
Jours 12 Classe	
Francy Loudry	NCBON
Alec Parker	No Deutal Society
Sisa Word	NC Dertal Soxiety
STEONEN MECHAUX-SMEN	NORTH CAROLINA ASSUCRATION OF NURSE ANESTWETTESTS
Ryan Holton	NCANA
JIM THOMPSON	NCANA
Cathy Brigg	NIANK
Story Yavrey	MCANA
Tina Gordon	NC Nurses



House Comm. on Health

03/15/17

Date

NAME	FIRM OR AGENCY AND ADDRESS
Mary Graff	NCNA
Schauthia Placock	NCNA
Sara Aubhell	ncna
Donna Mclean	NCNA
JASON F. SIMPSON, MO	NC ASSUL. OF ANESTHESIOLOGISTS / AANC
Laurie Onorio	Walk West
Kelsey Byerly	Walk West
Lindsez Goper	Campbell LAN
Frank Manole	MinuteClinic
Jessica Sparrow	J.G. Sparrow Behavioral Health Services
BRUCE VAUDE BUNG	NC SOCIET OF Ordie MANNEGATIAL SURLUAS

House Comm. on Health

03/15/17

NAME	FIRM OR AGENCY AND ADDRESS
Jennie Sasa RN, BSN	NCNA
Raheleh Tschoepe, ot	NCOTA
Monica Huang	NCOTA
Quinn Hoffman	NCOTA
Valenc Fox	NCO1A
Rachal Lee Stuart	NCOTA
3m Harrell	B+ 4
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House Committee on Health Wednesday, March 22, 2017 at 11:00 AM Room 643 of the Legislative Office Building

MINUTES

The House Committee on Health met at 11:00 AM on March 22, 2017 in Room 643 of the Legislative Office Building. Representatives Adcock, Ball, Blackwell, Boswell, Brisson, Burr, Carney, Cunningham, Dobson, Dollar, Dulin, Earle, Ford, Howard, Hunter, Insko, Jackson, Bert Jones, Lambeth, Lucas, Malone, Murphy, Potts, Rogers, Setzer, Shepard, Szoka, White, Wray, Yarborough, and Zachary attended.

Representative Josh Dobson, Chair, presided.

The following bills were considered:

HB 307 Board Cert. Behavior Analyst/Autism Coverage. (Representatives McGrady, Shepard, Jackson, Murphy)

Representative McGrady presented the bill. Representative Lucas motioned for a favorable report with a serial referral to Insurance.

HB 116 Student Safety in Athletics. (Representatives Warren, Lambeth, Murphy, Rogers) Representative Warren presented the bill. Representative Carney motioned for a favorable report, unfavorable to the original, favorable to the PCS and a serial referral to Education K-12.

Check-Off Donation: Cancer Screening. (Representatives Dollar, Howard, Stevens, S. Martin)

Representative Dollar presented the bill. Representative Howard motioned for a favorable report.

HB 277 Expand Rx Drug Abuse Advisory Committee. (Representatives Faircloth, R. Turner, Murphy, Ross)

Representative Faircloth presented the bill. Representative Adcock motioned for a favorable report.

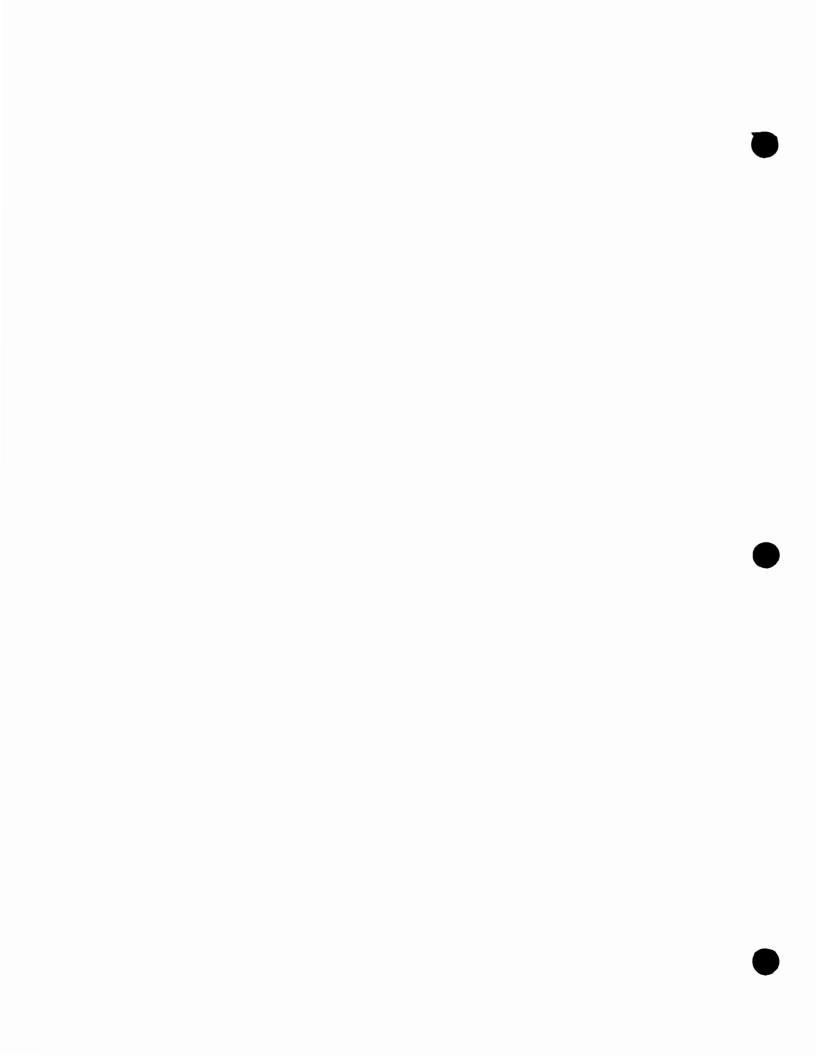
HB 285 Suicide Prevention/Awareness School Personnel. (Representatives Murphy, Hardister, Dollar, Dobson)

Representatives Murphy and Hardister presented the bill. Four Amendments were brought forth and voted on. Representative Dollar motioned for a favorable report, unfavorable to the original, rolled into a new PCS with a serial referral to Education K-12.

The meeting adjourned at 12:02pm.

Representative Josh Dobson, Chair

Presiding



NORTH CAROLINA HOUSE OF REPRESENTATIVES COMMITTEE MEETING NOTICE AND BILL SPONSOR NOTIFICATION 2017-2018 SESSION

You are hereby notified that the House Committee on Health will meet as follows:

DAY & DATE: Wednesday, March 22, 2017

TIME: 11:00 AM LOCATION: 643 LOB

COMMENTS: Because of the number of bills, Health may need to meet again 15 minutes after

Session.

The following bills will be considered:

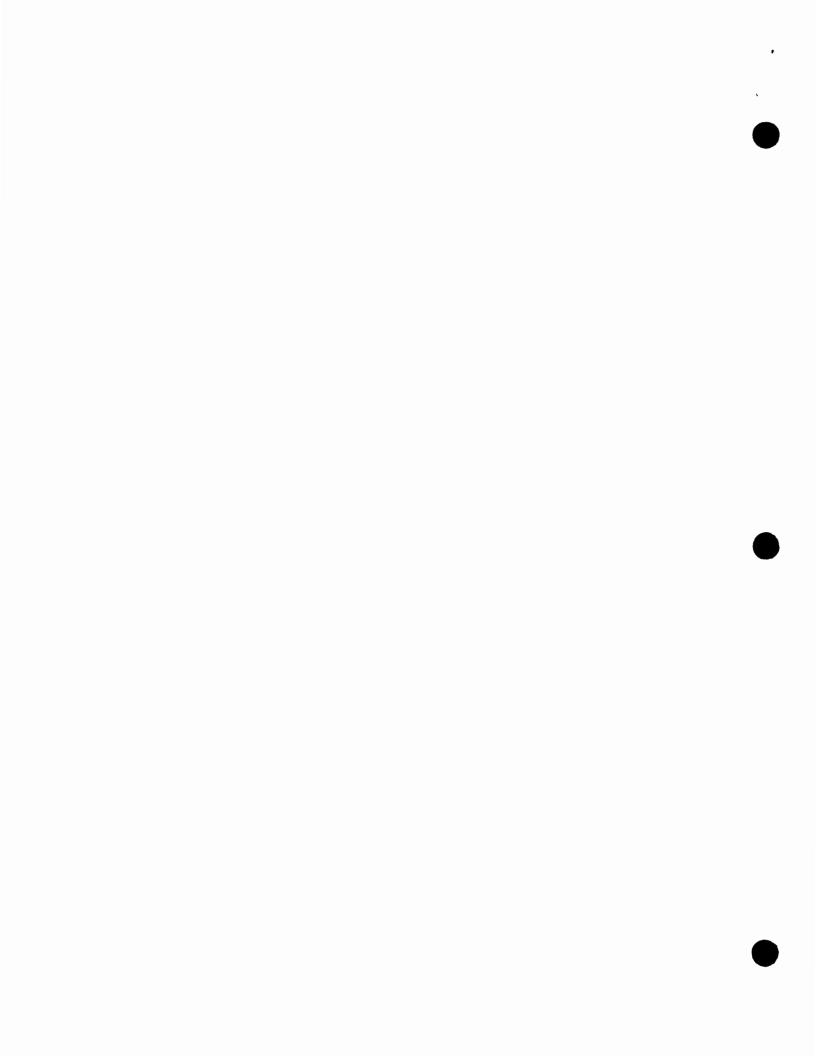
BILL NO.	SHORT TITLE	SPONSOR
HB 307	Board Cert. Behavior Analyst/Autism	Representative McGrady
	Coverage.	Representative Shepard
		Representative Jackson
		Representative Murphy
HB 116	Student Safety in Athletics.	Representative Warren
		Representative Lambeth
		Representative Murphy
		Representative Rogers
HB 164	Check-Off Donation: Cancer	Representative Dollar
	Screening.	Representative Howard
		Representative Stevens
		Representative S. Martin
HB 192	Establish Music Therapy Practice Act.	Representative Warren
		Representative Blackwell
		Representative Corbin
		Representative Williams
HB 277	Expand Rx Drug Abuse Advisory	Representative Faircloth
	Committee.	Representative R. Turner
		Representative Murphy
		Representative Ross
HB 285	Suicide Prevention/Awareness School	Representative Murphy
	Personnel.	Representative Hardister
		Representative Dollar
		Representative Dobson

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Respectfully,

Representative Justin P. Burr, Co-Chair Representative Josh Dobson, Co-Chair Representative Bert Jones, Co-Chair Representative Donny Lambeth, Co-Chair Representative Gregory F. Murphy, MD, Co-Chair

I hereby certify this notice was filed by the committee assistant at the following offices at 1:12 PM on
Monday, March 20, 2017.
Principal Clerk Reading Clerk – House Chamber
Brenda Olls (Committee Assistant)



Corrected #1: Remove HB 192.

NORTH CAROLINA HOUSE OF REPRESENTATIVES COMMITTEE MEETING NOTICE AND BILL SPONSOR NOTIFICATION 2017-2018 SESSION

You are hereby notified that the House Committee on Health will meet as follows:

DAY & DATE: Wednesday, March 22, 2017

TIME: 11:00 AM LOCATION: 643 LOB

COMMENTS: Because of the number of bills, Health may need to meet again 15 minutes after

Session.

The following bills will be considered:

BILL NO.	SHORT TITLE	SPONSOR
HB 307	Board Cert. Behavior Analyst/Autism	Representative McGrady
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		Representative Jackson
		Representative Murphy
HB 116	Student Safety in Athletics.	Representative Warren
		Representative Lambeth
		Representative Murphy
		Representative Rogers
HB 164	Check-Off Donation: Cancer	Representative Dollar
	Screening.	Representative Howard
		Representative Stevens
		Representative S. Martin
HB 192	Establish Music Therapy Practice Act.	Representative Warren
		Representative Blackwell
		Representative Ccrb in
		Representative Williams
HB 277	Expand Rx Drug Abuse Advisory	Representative Faircloth
	Committee.	Representative R. Turner
		Representative Murphy
		Representative Ross
HB 285	Suicide Prevention/Awareness School	Representative Murphy
	Personnel.	Representative Hardister
		Representative Dollar
		Representative Dobson

Respectfully,

Representative Justin P. Burr, Co-Chair Representative Josh Dobson, Co-Chair Representative Bert Jones, Co-Chair Representative Donny Lambeth, Co-Chair Representative Gregory F. Murphy, MD, Co-Chair

I hereby certify this notice was filed by the committee assistant at the following offices at 3:37 PM on Tuesday, March 21, 2017.
Principal Clerk Reading Clerk – House Chamber
Brenda Olls (Committee Assistant)

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House Committee on Health Wednesday, March 22, 2017, 11:00 AM 643 Legislative Office Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

BILL NO.	SHORT TITLE	SPONSOR
HB 307	Board Cert. Behavior Analyst/Autism	Representative McGrady
	Coverage.	Representative Shepard
	·	Representative Jackson
		Representative Murphy
HB 116	Student Safety in Athletics.	Representative Warren
	•	Representative Lambeth
		Representative Murphy
		Representative Rogers
HB 164	Check-Off Donation: Cancer	Representative Dollar
	Screening.	Representative Howard
		Representative Stevens
		Representative S. Martin
_HB 192	Establish Music Therapy Practice Act.	Representative Warren
		Representative Blackwell
		Representative Corbin
		Representative Williams
HB 277	Expand Rx Drug Abuse Advisory	Representative Faircloth
	Committee.	Representative R. Turner
		Representative Murphy
		Representative Ross
HB 285	Suicide Prevention/Awareness School	Representative Murphy
	Personnel.	Representative Hardister
		Representative Dollar
		Representative Dobson

Other Business

Adjournment



HOUSE BILL 307: Board Cert. Behavior Analyst/Autism Coverage.

2017-2018 General Assembly

Committee: House Health. If favorable, re-refer to Date: March 16, 2017

Insurance

Introduced by: Reps. McGrady, Shepard, Jackson, Murphy Prepared by: Jason Moran-Bates

Analysis of: First Edition Committee Co-Counsel

OVERVIEW: House Bill 307 would amend G.S. 58-3-192 to require insurers to provide coverage for adaptive behavior treatment provided by a board-certified behavior analyst.

CURRENT LAW: Under current law, insurers must provide coverage for adaptive behavior treatment, in the amount of at least \$40,000 per year, for individuals 18 years of age or younger. In order to qualify for coverage, the treatment must be provided by a licensed psychologist or psychological associate, a licensed psychiatrist or developmental pediatrician, a licensed speech and language pathologist, a licensed occupational therapist, a licensed clinical social worker, a licensed professional counselor, or a licensed marriage and family therapist. Under G.S. 90-270.2(8), the practice of psychology includes behavior analysis and therapy. North Carolina currently does not have an occupational licensing or certification board for behavior analysts.

BILL ANALYSIS: House Bill 307 would add "board-certified behavior analyst" to the list of professionals who can provide adaptive behavior treatment and have it be covered by insurance.

EFFECTIVE DATE: This act becomes effective July 1, 2017, and applies to insurance contracts issued, renewed, or amended on or after that date.

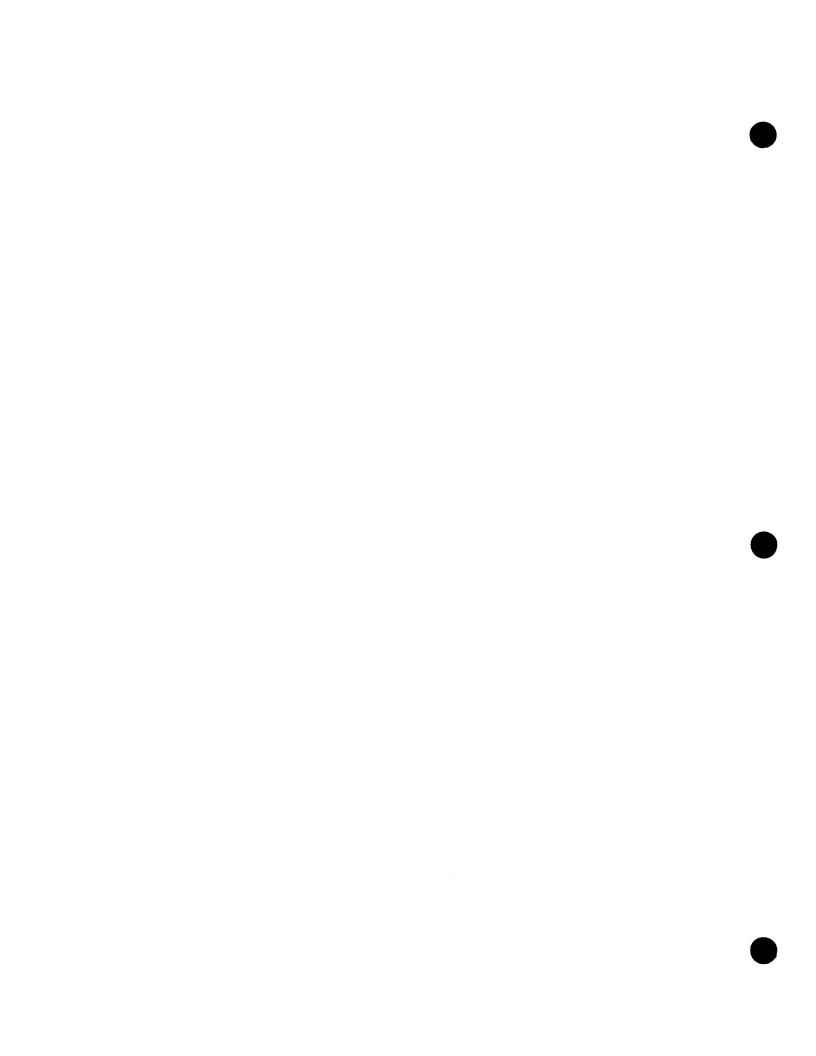
BACKGROUND: Adaptive behavior treatment is the use of certain techniques (e.g., rewarding desired behaviors) to bring about meaningful and positive changes in the behavior of individuals diagnosed with Autism Spectrum Disorder. It is frequently performed by behavior analysts. In general, behavior analysts are certified by the Behavior Analyst Certification Board (BACB). BACB certification requires, at a minimum, a graduate degree in behavior analysis, education, or psychology, which must include completion of qualified coursework; 750-1500 hours of supervised practical experience; and successful completion of a comprehensive exam. All certificate holders must adhere to the Professional and Ethical Compliance Code for Behavior Analysts and take thirty-six hours of continuing education every three years to maintain their credentials.

As of 2015, forty-four states require some form of insurance coverage for adaptive behavior treatment. Twenty-three of those states require behavior analysts who provide adaptive behavior treatment to be fully licensed, with certification by the BACB as a prerequisite for licensure. The remaining states require behavior analysts to be certified by the BACB.





Legislative Analysis Division 919-733-2578

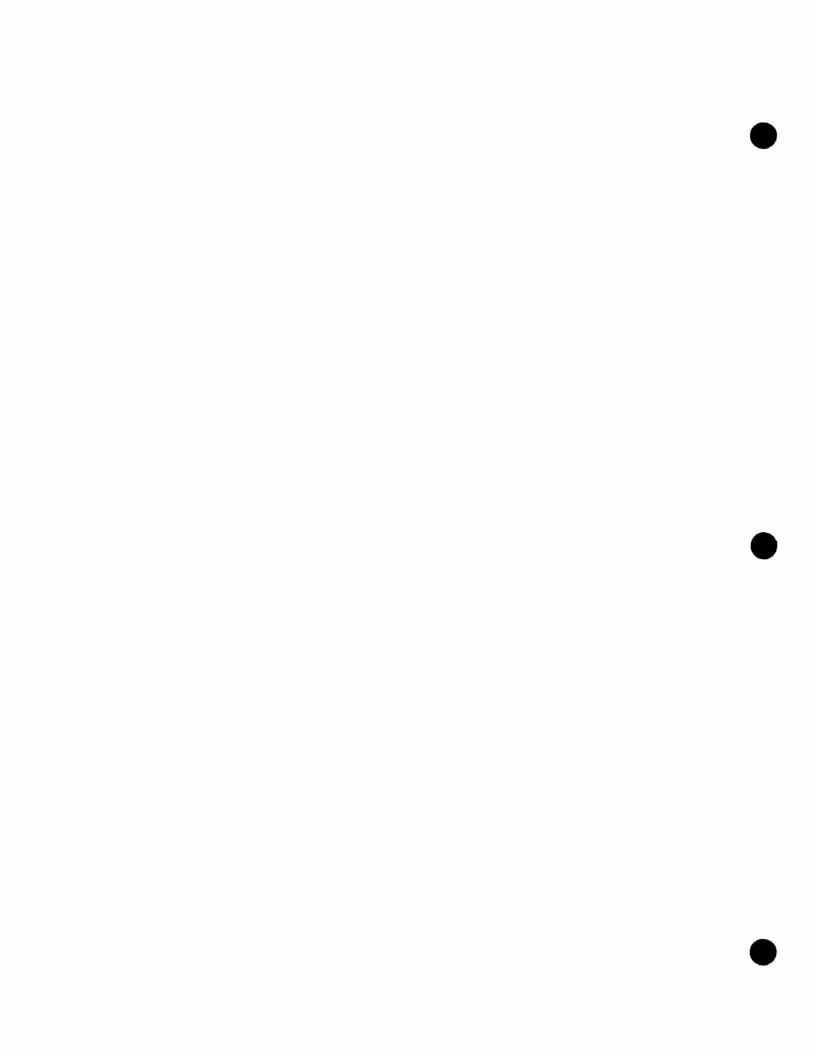


GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2017

H HOUSE BILL 307

Short Title:	Board Cert. Behavior Analyst/Autism Coverage.	(Public)
Sponsors:	Representatives McGrady. Shepard, Jackson, and Murphy (Primary For a complete list of sponsors, refer to the North Carolina General Assemble.)	-
Referred to:	Health, if favorable, Insurance	
	March 13, 2017	
BENEFIT BEHAVI The General	A BILL TO BE ENTITLED A ALLOW ADAPTIVE BEHAVIOR TREATMENT COVERED IN PLAN TO BE PROVIDED OR SUPERVISED BY A BOAF OR ANALYST. Assembly of North Carolina enacts: ECTION 1. G.S. 58-3-192(a)(1) reads as rewritten: Coverage for autism spectrum disorder.	
	s used in this section, the following definitions apply:	
(1	Adaptive behavior treatment. – Behavioral and development that systematically manage instructional and environmental consequences of behavior that have been shown to be clithrough research published in peer reviewed scientific journals randomized. quasi-experimental, or single subject designs following requirements must be met: a. The intervention must be necessary to (i) increase adaptive behaviors. (ii) decrease maladaptive behaviors maintain, or restore, to the maximum extent practicable of an individual.	I factors or the nically effective and based upon s. Both of the appropriate or or (iii) develop, the functioning
	 b. The treatment must be ordered by a licensed physic psychologist and the treatment must be provided or super the following licensed professionals, so long as supervision provided is commensurate with the licens training, experience, and scope of practice: A licensed psychologist or psychological associated. A licensed psychiatrist or developmental pediatred. A licensed speech and language pathologist. A licensed occupational therapist. A licensed clinical social worker. A licensed professional counselor. A licensed marriage and family therapist. A board certified behavior analyst." 	ervised by one of the services or ed-professional's ate. ician.
	ECTION 2. This act becomes effective July 1, 2017, and appl	ies to insurance
contracts issu	ed, renewed, or amended on or after that date.	





GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2017

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HOUSE BILL 116 PROPOSED COMMITTEE SUBSTITUTE H116-CSTA-5 [v.4] 03/21/2017 03:35:44 PM

Short Title:

Student Safety in Athletics.

(Public)

Sponsors:
Referred to:

February 16, 2017

A BILL TO BE ENTITLED
AN ACT TO REQUIRE THE STATE BOARD OF EDUCATION AND LOCAL BOARDS
OF EDUCATION TO EDUCATE THOSE INVOLVED IN SCHOOL ATHLETIC
ACTIVITIES ON SUDDEN CARDIAC ARREST AND HEAT-RELATED ILLNESSES
TO DIRECT THE STATE BOARD TO ESTABLISH A DATABASE ON THE
OCCURRENCE OF INJURY AND ILLNESS OF STUDENT ATHLETES
PARTICIPATING IN ATHLETIC ACTIVITIES, AND TO RECODIFY THE
STATUTORY PROVISIONS ON CONCUSSION SAFETY AND VENUE SPECIFIC
EMERGENCY ACTION PLANS.

The General Assembly of North Carolina enacts:

SECTION 1. Chapter 115C of the General Statutes is amended by adding a new Article to read:

"Article 29E.

"Student Safety in Athletics.

"§ 115C-407.40. Definitions.

The following definitions apply in this Article:

- (1) Athletic activity. An activity offered to students enrolled in a high school or middle school covering grades six or higher under any of the following circumstances:
 - a. Interscholastic athletics.
 - b. An athletic contest or competition, other than interscholastic athletics, that is sponsored by a school, including cheerleading, or any other sports activities provided by a club or school-affiliated organization that is school-sponsored.
 - <u>c.</u> <u>Practices, interschool practices, and scrimmages for all of the activities listed under this subdivision.</u>
- (2) Catastrophic illness or injury. An illness or injury occurring during athletic activity that results in a fatality, permanent disability, or serious injury, including a fractured neck, severe traumatic brain injury such as a subdural hematoma, temporary or transient paralysis, heat stroke related to exercise, sickle-cell trait associated collapse, sudden cardiac arrest, or commotio cordis.
- (3) Concussion. A traumatic brain injury caused by a direct or indirect impact to the head that results in disruption of normal brain function, which may or may not result in loss of consciousness.



- (4) Heat exhaustion. A heat-related illness resulting in the depletion of body fluids and causing weakness, dizziness, nausea, and possible collapse.
- (5) Heat stroke. A heat-related illness in which the person's core body temperature is greater than 105 degrees Fahrenheit, with complications involving the central nervous system that occur after exposure to high temperatures.
- (6) Sudden cardiac arrest. The sudden, unexpected loss of heart function, breathing, and consciousness.

"§ 115C-407.41. Sudden cardiac arrest education.

- (a) The State Board of Education shall develop guidelines and educational materials, which may be provided through a directory of relevant Web sites, to be used by local boards of education to inform students who participate in athletic activities and those students' parents and coaches on the awareness, recognition, and management of sudden cardiac arrest. In developing these guidelines and materials, the State Board may utilize existing materials developed by heart health awareness organizations, including the American Heart Association, Parent Heart Watch, and the Sudden Arrhythmia Death Syndromes Foundation. The State Board shall also publish a list of approved providers of CPR instruction training courses to be offered to coaches of athletic activities.
- (b) All students who participate in athletic activities and the parents of those students shall receive, on an annual basis, a sudden cardiac arrest information sheet that includes information developed pursuant to subsection (a) of this section. Parents must sign the sheet and return it to the coach before their children can participate in any such athletic activities. Each school shall maintain complete and accurate records of its compliance with the requirements of this subsection pertaining to the provision of educational materials on sudden cardiac arrest.
- (c) Each local school administrative unit shall require the head coach or the athletic director for each athletic activity to complete and maintain CPR certification offered by a provider approved by the State Board of Education under subsection (a) of this section. The CPR-certified head coach or athletic director shall be present during each athletic activity.
- (d) Other sponsors of youth athletic activities are encouraged to adopt guidelines to address sudden cardiac arrest for students participating in athletics that are consistent with this section.

"§ 115C-407.42. Heat exhaustion and heat stroke education; removal from athletic participation.

- (a) The State Board of Education shall adopt guidelines and educational materials, which may be provided through a directory of relevant Web sites, to be used by local boards of education to inform students who participate in athletic activities and those students' parents and coaches on (i) heat-related illnesses, including heat stroke and heat exhaustion, and (ii) the health risks associated with continuing athletic play or practice after experiencing signs and symptoms of a heat-related illness. In developing these guidelines and materials, the State Board may utilize existing materials on the signs, symptoms, and prevention of heat-related illnesses, including guidelines on heat and humidity adopted by the North Carolina High School Athletic Association.
- (b) All students who participate in athletic activities and the parents of those students shall receive, on an annual basis, a heat exhaustion and heat stroke information sheet that includes information developed pursuant to subsection (a) of this section. Parents must sign the sheet and return it to the coach before their children can participate in any such athletic activities. Each school shall maintain complete and accurate records of its compliance with the requirements of this subsection pertaining to the provision of educational materials on heat exhaustion and heat stroke information.

exhibits symptoms of heat exhaustion or heat stroke, as determined by a game official, coach from the student's team, licensed athletic trainer, licensed healthcare professional, or other official designated by the school under the venue-specific emergency action plan under G.S. 115C-407.45, at any time prior to, during, or following an athletic activity, shall be removed from participation in an athletic activity. The venue-specific emergency action plan shall provide for circumstances in which specific cooling methods must be made available during an athletic activity, including weather conditions requiring access to an immersion pool. A student removed or prevented from participating in an athletic activity in accordance with this subsection shall not return to participation until the student is evaluated and cleared for return to participation in writing a licensed healthcare professional or other official designated by the school under the venue-specific emergency action plan.

(d) Other sponsors of youth athletic activities are encouraged to adopt guidelines to address heat-related illness for students participating in athletics that are consistent with this section.

protocol for students participating in athletic activities consistent with the guidelines and

educational materials adopted in accordance with subsection (a) of this section. A student who

Each local board of education shall adopt a mandatory heat stroke prevention

"§ 115C-407.43. Concussion safety.

The State Board of Education shall adopt rules governing athletic activities with regard to concussion safety for students who participate in athletic activity that provide for the following:

- All coaches, school nurses, athletic directors, first responders, volunteers, students who participate in interscholastic athletic activities, and the parents of those students shall receive, on an annual basis, a concussion and head injury information sheet. School employees, first responders, volunteers, and students must sign the sheet and return it to the coach before they can participate in athletic activities, including tryouts, practices, or competition. Parents must sign the sheet and return it to the coach before their children can participate in any such athletic activities. The signed sheets shall be maintained in accordance with subdivision (3) of this section.
- If a student participating in an athletic activity exhibits signs or symptoms consistent with concussion, the student shall be removed from the activity at that time and shall not be allowed to return to play or practice that day. The student shall not return to play or practice on a subsequent day until the student is evaluated by and receives written clearance for such participation from one of the following (i) a physician licensed under Article 1 of Chapter 90 of the General Statutes with training in concussion management, (ii) a neuropsychologist licensed under Article 18A of Chapter 90 of the General Statutes with training in concussion management and working in consultation with a physician licensed under Article 1 of Chapter 90 of the General Statutes, (iii) an athletic trainer licensed under Article 34 of Chapter 90 of the General Statutes, (iv) a physician assistant, consistent with the limitations of G.S. 90-18.1, or (v) a nurse practitioner, consistent with the limitations of G.S. 90-18.2.
- (3) Each school shall maintain complete and accurate records of its compliance with the requirements of this section pertaining to head injuries.

"§ 115C-407.44. Requirements for student participation in athletic activities; informational sessions.

(a) Each school year, prior to participation by a student in an athletic activity, the student's parent or guardian shall sign and return to the student's school an acknowledgment of receipt and review of (i) a sudden cardiac arrest awareness information sheet developed in accordance with G.S. 115C-407.41, (ii) a heat-related illness awareness information sheet

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developed in accordance with G.S. 115C-407.42, and (iii) a concussion awareness information sheet developed in accordance with G.S. 115C-407.43.

- (b) Each school year, prior to participation by a student in an athletic activity, the student shall complete a pre-participation athletic activity form that includes questions related to cardiac health history developed in accordance with materials provided by the State Board of Education under G.S. 115C-407.41.
- (c) A school may hold an informational meeting prior to the start of each athletic season for all ages of competitors regarding student safety in athletics, including sudden cardiac arrest awareness, heat-related illness awareness, and concussion awareness. A school is encouraged to invite physicians, pediatric cardiologists, and athletic trainers to attend the meeting to provide information to students, parents, coaches, and other school employees.

"§ 115C-407.45. Venue-specific emergency action plans.

A local board of education shall require each middle school and high school to develop a venue-specific emergency action plan to deal with catastrophic illnesses or injuries and acute medical conditions in which the condition of an individual may deteriorate rapidly. The plan shall include a delineation of roles, methods of communication, available emergency equipment, including, but not limited to automatic external defibrillators (AEDs), and access to and a plan for emergency transport. The venue-specific emergency action plan shall be (i) in writing, (ii) reviewed by an athletic trainer licensed in North Carolina, (iii) approved by the principal of the school, (iv) distributed to all appropriate personnel, (v) posted conspicuously at all venues, and (vi) reviewed and rehearsed annually by all licensed athletic trainers, first responders, coaches, school nurses, athletic directors, and volunteers for interscholastic athletic activities.

"§ 115C-407.46. Reporting of catastrophic illnesses and injuries and concussions.

- (a) The State Board of Education shall create a database maintained by the Department of Public Instruction for high school and middle school personnel to report catastrophic illnesses and injuries and concussions that occur during athletic activities involving student athletes. The State Board shall assign a school code for each high school and middle school for the purposes of reporting information to be included in the database. At a minimum, the State Board shall require that the following information is included in a report by high school and middle school personnel:
 - (1) The school code for the high school or middle school.
 - (2) Age group of the student athlete.
 - (3) Gender.
 - (4) Sport that the student athlete was playing when the student became ill or injured.
 - (5) Type of athletic event.
 - (6) The date of illness or injury.
 - (7) The date of return to play, if applicable.
 - (8) The category of illness or injury.
 - (9) Whether the illness or injury resulted in a fatality.
- (b) During each month in which student athletes participate in an athletic activity at a high school or middle school, the athletic director or designee, or the principal or designee if there is no assigned athletic director, of that high school or middle school shall report to the Department of Public Instruction on whether a catastrophic illness or injury or a concussion has occurred involving a student athlete as set forth in subsection (a) of this section.
- (c) The Department of Public Instruction shall only provide access to the information contained in the database created and maintained pursuant to this section to local boards of education, the North Carolina High School Athletic Association, the National Center for Catastrophic Sport Injury Research, and the Matthew A. Gfeller Sport-Related Traumatic Brain Injury Research Center housed at the University of North Carolina at Chapel Hill. The

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information contained in the database shall not contain personally identifiable student data as defined in G.S. 115C-402.5 and shall not be considered a public record under G.S. 132-1.

"§ 115C-407.47. Civil liability. A local board of education, its members, employees, designees, agents, or volunteers, the

members of the State Board of Education, and the Department of Public Instruction or its employees shall not be liable in civil damages to any party for any act authorized by this Article or for any omission relating to that act unless that act or omission amounts to gross negligence, wanton conduct, or intentional wrongdoing."

SECTION 2. G.S. 115C-12(23) reads as rewritten:

"(23) Power to Adopt Eligibility Rules for Interscholastic Athletic Competition. — The State Board of Education shall adopt rules governing interscholastic athletic activities conducted by local boards of education, including (i) eligibility for student participation. With regard to middle schools and high schools, the rules shall provide for the following:participation and (ii) student safety in accordance with Article 29E of this Chapter.

> All coaches, school nurses, athletic directors, first responders, volunteers, students who participate in interscholastic athletic activities, and the parents of those students shall receive, on an annual basis, a concussion and head injury information sheet. School employees, first responders, volunteers, and students must sign the sheet and return it to the coach before they can participate in interscholastic athletic activities, including tryouts, practices, or competition. Parents must sign the sheet and return it to the coach before their children can participate in any such interscholastic athletic activities. The signed sheets shall be maintained in accordance with sub-subdivision d. of this subdivision.

For the purpose of this subdivision, a concussion is a traumatic brain injury caused by a direct or indirect impact to the head that results in disruption of normal brain function, which may or may not result in loss of consciousness.

b. If a student participating in an interscholastic athletic activity exhibits signs or symptoms consistent with concussion, the student shall be removed from the activity at that time and shall not be allowed to return to play or practice that day. The student shall not return to play or practice on a subsequent day until the student is evaluated by and receives written clearance for such participation from (i) a physician licensed under Article 1 of Chapter 90 of the General Statutes with training in concussion management, (ii) a neuropsychologist licensed under Article 18A of Chapter 90 of the General Statutes with training in concussion management and working in consultation with a physician licensed under Article 1 of Chapter 90 of the General Statutes, (iii) an athletic trainer licensed under Article 34 of Chapter 90 of the General Statutes, (iv) a physician assistant, consistent with the limitations of G.S. 90-18.1, or (v) a nurse practitioner, consistent with the limitations of G.S. 90-18.2.

Each school shall develop a venue specific emergency action plan to e. deal with serious injuries and acute medical conditions in which the condition of the patient may deteriorate rapidly. The plan shall include a delineation of roles, methods of communication, available emergency equipment, and access to and plan for emergency

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	General Assembly Of I	North Carolina	Session 2017
1		transport. This plan must be (i) in writing, (ii)	reviewed by an athletic
2		trainer licensed in North Carolina, (iii) appro	oved by the principal of
3		the school, (iv) distributed to all appropriat	e personnel, (v) posted
4		conspicuously at all venues, and (vi) re	eviewed and rehearsed
5		annually by all licensed athletic trainers, fin	
6		school nurses, athletic directors, and volun	teers for interscholastic
7		athletic activities.	
8	d.	Each school shall maintain complete and	
9		compliance with the requirements of this si	ubdivision pertaining to
10		head injuries.	
11		he State Board of Education may authorize a de	
12	apply	and enforce the Board's rules governing partic	ipation in interscholastic
13		cic activities at the high school level."	
14	SECTION 3	3. This act is effective when it becomes law and	d applies beginning with
15	•	ear. The reporting requirements of G.S. 115C-40	
16	act, apply to injuries and	l illnesses that occur on or after January 1, 2018	•

Page 6 House Bill 116 H116-CSTA-5 [v.4]



HOUSE BILL 116: Student Safety in Athletics.

2017-2018 General Assembly

Committee: House Health. If favorable, re-refer to Date:

Education - K-12. If favorable, re-refer to

Judiciary IV

Introduced by: Reps. Warren, Lambeth, Murphy, Rogers

Analysis of: PCS to First Edition

CS to First Edition

Prepared by: Jennifer Mundt Committee Staff

March 22, 2017

H116-CSTA-5

OVERVIEW: House Bill 116 would (i) direct the State Board of Education and local boards of education to educate those involved in school athletic activities on sudden cardiac arrest and heat-related illnesses, (ii) direct the State Board to establish a database on the occurrence of injury and illness of students participating in athletic activities, and (iii) recodify the statutes governing concussion safety and venue-specific emergency action plans.

CURRENT LAW: G.S. 115C-12(23), enacted in 2011, directed the State Board of Education (State Board) to adopt rules governing interscholastic athletic activities involving middle and high school students' eligibility to participate in those activities provided certain information, procedures, and plans were implemented pertaining to concussion and head injuries.

BILL ANALYSIS: House Bill 116 would create a new article on student safety in athletics in the statutes governing elementary and secondary education (Chapter 115C of the General Statutes) that sets out the following:

- <u>Definitions.</u> Defines the terms "athletic activity," "catastrophic illness or injury," "concussion," "heat exhaustion," "heat stroke," and "sudden cardiac arrest."
- Education requirements. Directs the State Board of Education to develop guidelines and educational materials for local boards of education to provide to both students who participate in athletic activities and their parents on sudden cardiac arrest and heat-related illnesses on an annual basis. This bill also recodifies G.S. 115C-12(23) that governs middle and high school student interscholastic athletic activity involvement and eligibility for participation vis-à-vis concussion and head injuries as G.S. 115C-407.43.
- <u>CPR certification.</u> With regard to <u>sudden cardiac arrest</u>, the statute would direct each local education agency to require that the head coach or athletic director for each athletic activity complete and maintain CPR certification, and be present during each athletic activity.
- Mandatory protocols.
 - With regard to <u>heat related illnesses</u>, the statute would direct each local board of education to adopt a mandatory heat stroke prevention protocol and provides that if a student exhibits signs of heat exhaustion or heat stroke as determined by an official designated in the venue-specific emergency action plan (EAP), then that student must be removed or prevented from participating in the activity until such time the student is cleared to return, in writing, by





Legislative Analysis Division 919-733-2578

House PCS 116

Page 2

either a licensed health care professional or an official designated in the venue-specific EAP.

The PCS removes from the 1st Edition of the bill a provision that would have allowed a student's parent or guardian to authorize the student's return to the athletic activity after experiencing heat-related illness or symptoms consistent with concussion.

O With regard to <u>sudden cardiac arrest</u>, the statute would require a student to annually complete a form that includes questions related to cardiac health history in order to participate in an athletic activity.

• Documentation and Reporting.

 Requires a parents' signature of receipt and review of the information awareness sheets developed on concussion before their student may participate in athletic activities and requires each school to maintain complete and accurate records of its compliance with the provisions of the Article.

The PCS makes conforming changes to the 1st Edition of the bill to also require a parents' signature of receipt and review of the information awareness sheets developed for <u>sudden</u> cardiac arrest and heat-related illnesses before their student may participate in athletic activities and requires each school to maintain complete and accurate records of its compliance with the provisions of the Article.

- Directs the State Board to create a database, maintained by the Department of Public Instruction (DPI), for high school and middle school personnel to report catastrophic illnesses and injuries and concussions that occur during athletic activities. Detailed information must be reported each month on any illnesses, injuries, and concussions. The database may only be accessed by the North Carolina High School Athletic Association, the National Center for Catastrophic Sport Injury Research, and the Gfeller Sport-Related Traumatic Brain Injury Research Center housed at the University of North Carolina at Chapel Hill. Any information contained in the database must not contain personally identifiable student data and is not considered a public record.
- <u>Civil Liability.</u> The statute would provide that a local board of education, its members, employees, designees, agents, or volunteers, the members of the State Board, and DPI or its employees are not liable in civil damages to any party for any act authorized in this article or for any omission relating to the act unless that act or omission amounts to gross negligence, wanton conduct, or intentional wrongdoing.

EFFECTIVE DATE: This act would become effective when it becomes law and applies beginning with the 2017-2018 school year. The reporting requirements apply to injuries and illnesses that occur on or after January 1, 2018.

GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2017

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Short Title:

HOUSE BILL 116

Student Safety in Athletics.

(Public)

Sponsors:	Sponsors: Representatives Warren, Lambeth, Murphy, and Rogers (Primary Sponsors). For a complete list of sponsors, refer to the North Carolina General Assembly web site.		
Dafama 14a			
Referred to:	Health, if favorable, Education - K-12, if favorable, Judiciary IV		
	February 16, 2017		
	A BILL TO BE ENTITLED		
AN ACT TO	REQUIRE THE STATE BOARD OF EDUCATION AND LOCAL BOARDS OF		
EDUCAT	ION TO EDUCATE THOSE INVOLVED IN SCHOOL ATHLETIC ACTIVITIES		
	DEN CARDIAC ARREST AND HEAT-RELATED ILLNESSES, TO DIRECT		
THE STA	ATE BOARD TO ESTABLISH A DATABASE ON THE OCCURRENCE OF		
INJURY	AND ILLNESS OF STUDENT ATHLETES PARTICIPATING IN ATHLETIC		
ACTIVIT	IES, AND TO RECODIFY THE STATUTORY PROVISIONS ON CONCUSSION		
SAFETY	AND EMERGENCY ACTION PLANS.		
	Assembly of North Carolina enacts:		
	ECTION 1. Chapter 115C of the General Statutes is amended by adding a new		
Article to read			
	"Article 29E.		
	"Student Safety in Athletics.		
	40. Definitions.		
	ving definitions apply in this Article:		
<u>(1</u>			
	middle school covering grades six or higher under any of the following		
	<u>circumstances:</u>		
	a. <u>Interscholastic athletics.</u>		
	b. An athletic contest or competition, other than interscholastic athletics		
	that is sponsored by a school, including cheerleading, or any other		
	sports activities provided by a club or school-affiliated organization that is school-sponsored.		
	c. Practices, interschool practices, and scrimmages for all of the activities listed under this subdivision.		
(2			
12	activity that results in a fatality, permanent disability, or serious injury		
	including a fractured neck, severe traumatic brain injury such as a subdura		
hematoma, temporary or transient paralysis, heat stroke related			
	sickle-cell trait associated collapse, sudden cardiac arrest, or commotio cordis.		
<u>(3</u>			
<u>13</u>	the head that results in disruption of normal brain function, which may or may		
	not result in loss of consciousness.		
(4			
1.	fluids and causing weakness, dizziness, nausea, and possible collapse.		



- (5) Heat stroke. A heat-related illness in which the person's core body temperature is greater than 105 degrees Fahrenheit, with complications involving the central nervous system that occur after exposure to high temperatures.
- (6) Sudden cardiac arrest. The sudden, unexpected loss of heart function, breathing, and consciousness.

"§ 115C-407.41. Sudden cardiac arrest education.

- (a) The State Board of Education shall develop guidelines and educational materials, which may be provided through a directory of relevant Web sites, to be used by local boards of education to inform students who participate in athletic activities and those students' parents and coaches on the awareness, recognition, and management of sudden cardiac arrest. In developing these guidelines and materials, the State Board may utilize existing materials developed by heart health awareness organizations, including the American Heart Association, Parent Heart Watch, and the Sudden Arrhythmia Death Syndromes Foundation. The State Board shall also publish a list of approved providers of CPR instruction training courses to be offered to coaches of athletic activities.
- (b) Each local school administrative unit shall require the head coach or the athletic director for each athletic activity to complete and maintain CPR certification offered by a provider approved by the State Board of Education under subsection (a) of this section. A coach shall not be eligible to coach an athletic activity until such time the coach completes the training course.
- (c) Other sponsors of youth athletic activities are encouraged to adopt guidelines to address sudden cardiac arrest for students participating in athletics that are consistent with this section.

"§ 115C-407.42. Heat exhaustion and heat stroke education; removal from athletic participation.

- (a) The State Board of Education shall adopt guidelines and educational materials, which may be provided through a directory of relevant Web sites, to be used by local boards of education to inform students who participate in athletic activities and those students' parents and coaches on (i) heat-related illnesses, including heat stroke and heat exhaustion, and (ii) the health risks associated with continuing athletic play or practice after experiencing signs and symptoms of a heat-related illness. In developing these guidelines and materials, the State Board may utilize existing materials on the signs, symptoms, and prevention of heat-related illnesses, including guidelines on heat and humidity adopted by the North Carolina High School Athletic Association.
- (b) Each local board of education shall adopt a mandatory heat stroke prevention protocol for students participating in athletic activities consistent with the guidelines and educational materials adopted in accordance with subsection (a) of this section. A student who exhibits symptoms of heat exhaustion or heat stroke, as determined by a game official, coach from the student's team, verified athletic trainer, licensed healthcare professional, or other official designated by the school under the venue-specific emergency action plan under G.S. 115C-407.45, at any time prior to, during, or following an athletic activity shall be removed by the coach from participation in an athletic activity. The venue-specific emergency action plan shall provide for circumstances in which specific cooling methods must be made available during an athletic activity, including weather conditions requiring access to an immersion pool. A student removed or prevented from participating in an athletic activity in accordance with this subsection shall not return to participation until the student is evaluated and cleared for return to participation in writing by (i) the student's parent or legal guardian or (ii) a licensed healthcare professional or other official designated by the school under the venue-specific emergency action plan.
- (c) Other sponsors of youth athletic activities are encouraged to adopt guidelines to address heat-related illness for students participating in athletics that are consistent with this section.
- "§ 115C-407.43. Concussion safety.

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The State Board of Education shall adopt rules governing interscholastic athletic activities with regard to concussion safety for student athletes in middle schools and high schools that provide for the following:

- All coaches, school nurses, athletic directors, first responders, volunteers, (1) students who participate in interscholastic athletic activities, and the parents of those students shall receive, on an annual basis, a concussion and head injury information sheet. School employees, first responders, volunteers, and students must sign the sheet and return it to the coach before they can participate in interscholastic athletic activities, including tryouts, practices, or competition. Parents must sign the sheet and return it to the coach before their children can participate in any such interscholastic athletic activities. The signed sheets shall be maintained in accordance with subdivision (3) of this section.
- If a student participating in an interscholastic athletic activity exhibits signs or (2) symptoms consistent with concussion, the student shall be removed from the activity at that time and shall not be allowed to return to play or practice that day. The student shall not return to play or practice on a subsequent day until the student is evaluated by and receives written clearance for such participation from (i) the student's parent or legal guardian, (ii) a physician licensed under Article 1 of Chapter 90 of the General Statutes with training in concussion management, (iii) a neuropsychologist licensed under Article 18A of Chapter 90 of the General Statutes with training in concussion management and working in consultation with a physician licensed under Article 1 of Chapter 90 of the General Statutes, (iv) an athletic trainer licensed under Article 34 of Chapter 90 of the General Statutes, (v) a physician assistant, consistent with the limitations of G.S. 90-18.1, or (vi) a nurse practitioner, consistent with the limitations of G.S. 90-18.2.
- Each school shall maintain complete and accurate records of its compliance <u>(3)</u> with the requirements of this section pertaining to head injuries.

"§ 115C-407.44. Requirements for student participation in athletic activities; informational sessions.

- Each school year, prior to participation by a student in an athletic activity, the student's parent or guardian shall sign and return to the student's school an acknowledgment of receipt and review of (i) a sudden cardiac arrest awareness information sheet developed in accordance with G.S. 115C-407.41, (ii) a heat-related illness awareness information sheet developed in accordance with G.S. 115C-407.42, and (iii) a concussion awareness information sheet developed in accordance with G.S. 115C-407.43.
- Each school year, prior to participation by a student in an athletic activity, the student shall complete a pre-participation athletic activity form that includes questions related to cardiac health history developed in accordance with materials provided by the State Board of Education under G.S. 115C-407.41.
- A school may hold an informational meeting prior to the start of each athletic season (c) for all ages of competitors regarding student safety in athletics, including sudden cardiac arrest awareness, heat-related illness awareness, and concussion awareness. A school is encouraged to have physicians, pediatric cardiologists, and athletic trainers attend the meeting to provide information to students, parents, coaches, and other school employees.

"§ 115C-407.45. Venue-specific emergency action plans.

A local board of education shall require each middle school and high school to develop a venue-specific emergency action plan to deal with serious injuries and acute medical conditions in which the condition of an individual may deteriorate rapidly. The plan shall include a delineation of roles, methods of communication, available emergency equipment, and access to and plan for emergency transport. This plan must be (i) in writing, (ii) reviewed by an athletic trainer licensed

Page 4

in North Carolina, (iii) approved by the principal of the school, (iv) distributed to all appropriate personnel, (v) posted conspicuously at all venues, and (vi) reviewed and rehearsed annually by all licensed athletic trainers, first responders, coaches, school nurses, athletic directors, and volunteers for interscholastic athletic activities.

"§ 115C-407.46. Reporting of catastrophic illnesses and injuries and concussions.

- (a) The State Board of Education shall create a database maintained by the Department of Public Instruction for high school and middle school personnel to report catastrophic illnesses and injuries and concussions occurring during athletic activities involving student athletes. The State Board shall assign a school code for each high school and middle school for the purposes of reporting information to be included in the database. The State Board shall require at least the following information be included in a report by high school and middle school personnel:
 - (1) The school code for the high school or middle school.
 - (2) Age group of the student athlete.
 - (3) Gender.
 - (4) Sport that the student athlete was playing when becoming ill or injured.
 - (5) Type of athletic event.
 - (6) The date of illness or injury.
 - (7) The date of return to play, if applicable.
- (8) The category of illness or injury.
 - (9) Whether the illness or injury resulted in a fatality.
- (b) Each month in which student athletes are participating in an athletic activity at a high school or middle school, the athletic director or designee, or the principal or designee if there is no assigned athletic director, of that high school or middle school shall report to the Department of Public Instruction on whether a catastrophic illness or injury or a concussion has occurred involving a student athlete as set forth in subsection (a) of this section.
- (c) The Department of Public Instruction shall only provide access to the information contained in the database created and maintained under this section to local boards of education, the North Carolina High School Athletic Association, and the National Center for Catastrophic Sport Injury Research and the Matthew A. Gfeller Sport-Related Traumatic Brain Injury Research Center housed at the University of North Carolina at Chapel Hill. The information contained in the database shall not contain personally identifiable student data as defined in G.S. 115C-402.5 and shall not be considered a public record under G.S. 132-1.

"§ 115C-407.47. Civil liability.

A local board of education, its members, employees, designees, agents, or volunteers, the members of the State Board of Education, and the Department of Public Instruction or its employees shall not be liable in civil damages to any party for any act authorized by this Article or for any omission relating to that act unless that act or omission amounts to gross negligence, wanton conduct, or intentional wrongdoing."

SECTION 2. G.S. 115C-12(23) reads as rewritten:

- "(23) Power to Adopt Eligibility Rules for Interscholastic Athletic Competition. The State Board of Education shall adopt rules governing interscholastic athletic activities conducted by local boards of education, including (i) eligibility for student participation. With regard to middle schools and high schools, the rules shall provide for the following:participation and (ii) student safety in accordance with Article 29E of this Chapter.
 - a. All coaches, school nurses, athletic directors, first responders, volunteers, students who participate in interscholastic athletic activities, and the parents of those students shall receive, on an annual basis, a concussion and head injury information sheet. School employees, first responders, volunteers, and students must sign the sheet and return it to the coach before they can participate in interscholastic athletic activities,

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including tryouts, practices, or competition. Parents must sign the sheet and return it to the coach before their children can participate in any such interscholastic athletic activities. The signed sheets shall be maintained in accordance with sub-subdivision d. of this subdivision.

For the purpose of this subdivision, a concussion is a traumatic brain injury caused by a direct or indirect impact to the head that results in disruption of normal brain function, which may or may not result in loss of consciousness.

- If a student participating in an interscholastic athletic activity exhibits signs or symptoms consistent with concussion, the student shall be removed from the activity at that time and shall not be allowed to return to play or practice that day. The student shall not return to play or practice on a subsequent day until the student is evaluated by and receives written clearance for such participation from (i) a physician licensed under Article 1 of Chapter 90 of the General Statutes with training in concussion management, (ii) a neuropsychologist licensed under Article 18A of Chapter 90 of the General Statutes with training in concussion management and working in consultation with a physician licensed under Article 1 of Chapter 90 of the General Statutes, (iii) an athletic trainer licensed under Article 34 of Chapter 90 of the General Statutes, (iv) a physician assistant, consistent with the limitations of G.S. 90-18.1, or (v) a nurse practitioner, consistent with the limitations of G.S. 90-18.2.
- e. Each school shall develop a venue specific emergency action plan to deal with serious injuries and acute medical conditions in which the condition of the patient may deteriorate rapidly. The plan shall include a delineation of roles, methods of communication, available emergency equipment, and access to and plan for emergency transport. This plan must be (i) in writing, (ii) reviewed by an athletic trainer licensed in North Carolina, (iii) approved by the principal of the school, (iv) distributed to all appropriate personnel, (v) posted conspicuously at all venues, and (vi) reviewed and rehearsed annually by all licensed athletic trainers, first responders, coaches, school nurses, athletic directors, and volunteers for interscholastic athletic activities.
- d. Each school shall maintain complete and accurate records of its compliance with the requirements of this subdivision pertaining to head injuries.

The State Board of Education may authorize a designated organization to apply and enforce the Board's rules governing participation in interscholastic athletic activities at the high school level."

SECTION 3. This act is effective when it becomes law and applies beginning with the 2017-2018 school year. The reporting requirements of G.S. 115C-407.46, as enacted by this act, apply to injuries and illnesses that occur on or after January 1, 2018.

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HOUSE BILL 164: Check-Off Donation: Cancer Screening.

2017-2018 General Assembly

Committee: House Health

Analysis of:

Introduced by: Reps. Dollar, Howard, Stevens, S. Martin

First Edition

Date:

March 21, 2017

Prepared by: Theresa Matula

Committee Staff

OVERVIEW: House Bill 164 would allow an individual taxpayer to contribute all or part of an income tax refund to the Cancer Prevention and Control Branch, Division of Public Health (DPH), Department of Health and Human Services (DHHS, to be used for the early detection of breast and cervical cancer. The bill would become effective for the 2017 tax year and sunset for the 2021 tax year.

CURRENT LAW:

G.S. 105-269.5 currently allows individual and corporate taxpayers to contribute income tax refunds to the Wildlife Conservation Account to be used for the management, protection, and preservation of wildlife.

G.S. 105-269.7 currently allows individual and corporate taxpayers to contribute income tax refunds and donations to the NC Education Endowment Fund to be appropriated by the General Assembly for teacher compensation that is related directly to improving student academic outcomes in public schools.

BILL ANALYSIS:

Section 1 of House Bill 164 would add a new subsection to the Revenue Laws allowing an individual taxpayer to make an irrevocable election to direct all or part of a tax refund to the Cancer Prevention and Control Branch, Division of Public Health (DPH), Department of Health and Human Services (DHHS). Check-off donations would be used for early detection of breast and cervical cancer in accordance with the NC Breast and Cervical Cancer Control Program.

The bill requires the Department of Revenue (DOR) to provide appropriate language and space on the individual income tax form to make the election and to include in the income tax instructions an explanation that any donations will be used for early detection of breast and cervical cancer. Additionally, the DOR is required to transmit the check-off donations to the State Treasurer, and the State Treasurer must distribute the donations to the Cancer Prevention and Control Branch of the Division of Public Health of the Department of Health and Human Services.

Section 2 provides that the General Assembly finds that the funds generated by the check-off donation are intended to be additional funding for early detection of breast and cervical cancer and are not intended to replace current appropriations.

EFFECTIVE DATE: House Bill 164 would become effective for the 2017 tax year and sunset for the 2021 tax year.

BACKGROUND: According to their <u>website</u>, the purpose of the Cancer Prevention and Control Branch is to reduce the overall cancer burden in North Carolina through the following actions:

• Planning, directing, and supporting cancer prevention and control efforts through collaborative work with partners in local, state, and national organizations, and universities;





Legislative Analysis Division 919-733-2578

House Bill 164

Page 2

- Reducing the number of people who get and die from breast and cervical cancers and cardiovascular disease by providing testing and follow-up services for uninsured and underinsured women in North Carolina;
- Identifying opportunities to promote healthy behaviors related to eating, exercising, not using tobacco products, and safe environments; and
- Recommending health education activities for everyone.

The Cancer Prevention and Control Branch provides a fact sheet on Breast Cancer and Cervical Cancer.

According to information provided by the staff to the House Finance Committee, for the 2015 tax year, 7,476 taxpayers contributed a total of \$136,271 to the Wildlife Conservation Account, and 3,358 taxpayers contributed \$65,649 to the NC Education Endowment Fund.

^{*} Greg Roney, Staff to House Finance, substantially contributed to this summary.

GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2017

HOUSE BILL 164

(Dulalia)

Short Title: Check-Off Donation: Cancer Screening.

(Public)

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Sponsors:

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Representatives Dollar, Howard, Stevens, and S. Martin (Primary Sponsors).

For a complete list of sponsors, refer to the North Carolina General Assembly web site.

Referred to:

Finance, if favorable, Health

February 23, 2017

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A BILL TO BE ENTITLED

AN ACT TO PROVIDE SPACE ON THE INCOME TAX RETURN FOR INDIVIDUALS TO

MAKE DONATIONS FOR EARLY DETECTION OF BREAST AND CERVICAL CANCER, AS PROVIDED BY THE BREAST AND CERVICAL CANCER CONTROL PROGRAM.

The General Assembly of North Carolina enacts:

SECTION 1. Article 9 of Chapter 105 of the General Statutes is amended by adding a new section to read:

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"§ 105-269.8. Contribution by individual for early detection of breast and cervical cancer.

An individual entitled to a refund of income taxes under Part 2 of Article 4 of this Chapter may elect to contribute all or part of the refund to be used for early detection of breast and cervical cancer at the Cancer Prevention and Control Branch of the Division of Public Health of the Department of Health and Human Services. The Secretary shall provide appropriate language and space on the individual income tax form in which to make the election. The Secretary shall include in the income tax instructions an explanation that the contributions will be used for early detection of breast and cervical cancer only. The election becomes irrevocable upon filing the individual's income tax return for the taxable year.

The Secretary shall transmit the contributions made pursuant to this section to the State Treasurer to be distributed for early detection of breast and cervical cancer. The State Treasurer shall distribute the contributions to the Cancer Prevention and Control Branch of the Division of Public Health of the Department of Health and Human Services. Funds distributed pursuant to this section shall be used only for early detection of breast and cervical cancer and shall be used in accordance with North Carolina's Breast and Cervical Cancer Control Program's policies and procedures."

SECTION 2. The General Assembly finds that the funds generated by this act are intended to be additional funding for early detection of breast and cervical cancer and are not intended to replace current appropriations for early detection of breast and cervical cancer.

SECTION 3. This act is effective for taxable years beginning on or after January 1, 2017, and expires for taxable years beginning on or after January 1, 2021.





HOUSE BILL 277: Expand Rx Drug Abuse Advisory Committee.

2017-2018 General Assembly

Committee: House Health Date: March 22, 2017
Introduced by: Reps. Faircloth, R. Turner, Murphy, Ross First Edition Prepared by: Committee Counsel

OVERVIEW: House Bill 277 would codify language from the 2015 budget creating a Prescription Drug Abuse Advisory Committee, making a number of technical changes to that language and adding to the list of representatives required to be on the Committee a representative from the Division of Adult Correction and Juvenile Justice within the Department of Public Safety.

CURRENT LAW: The Prescription Drug Abuse Advisory Committee is housed and staffed by the Department of Health and Human Services (DHHS) and charged by statute with developing and implementing a statewide strategic plan to combat the problem of prescription drug abuse. In addition to any other person the Secretary designates, the Committee must include representatives from the following:

- DHHS Division of Medical Assistance
- DHHS Division of Mental Health, Developmental Disabilities, and Substance Abuse Services
- DHHS Division of Public Health
- Rural Health Section of DHHS Division of Public Health
- State Bureau of Investigation
- Attorney General's Office
- North Carolina Board of Dental Examiners
- North Carolina Board of Nursing
- North Carolina Board of Podiatry Examiners
- North Carolina Medical Board
- North Carolina Board of Pharmacy
- UNC Injury Prevention Research Center
- The substance abuse treatment community
- Governor's Institute on Substance Abuse, Inc.
- Department of Insurance drug take-back program

BILL ANALYSIS: House Bill 277 adds to the above list of required representatives a representative from the Division of Adult Correction and Juvenile Justice from the Department of Public Safety, codifies the language as G.S. 90-113.75A, and makes a number of technical changes to the language of the existing session law.

EFFECTIVE DATE: This act is effective when it becomes law.





Legislative Analysis Division 919-733-2578

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GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2017

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HOUSE BILL 277

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Short Title: Expand Rx Drug Abuse Advisory Committee. (Public) Representatives Faircloth, R. Turner, Murphy, and Ross (Primary Sponsors). Sponsors: For a complete list of sponsors, refer to the North Carolina General Assembly web site. Referred to: Health March 8, 2017 A BILL TO BE ENTITLED AN ACT ADDING ONE REPRESENTATIVE OF THE DIVISION OF ADULT CORRECTION AND JUVENILE JUSTICE OF THE DEPARTMENT OF PUBLIC SAFETY TO THE PRESCRIPTION DRUG ABUSE ADVISORY COMMITTEE. The General Assembly of North Carolina enacts: SECTION 1. Subsections (m) through (q) of Section 12F.16 of S.L. 2015-241 are codified as G.S. 90-113.75A and read as rewritten: "§ 90-113.75A. Prescription Drug Abuse Advisory Committee; statewide strategic plan. There is hereby created the Prescription Drug Abuse Advisory Committee, to be housed in and staffed by the Department of Health and Human Services (DHHS). Department. The Committee shall develop and, through its members, implement a statewide strategic plan to combat the problem of prescription drug abuse. The Committee shall include representatives from the following, as well as any other persons designated by the Secretary of Health and Human Services: (1) The Department's Division of Medical Assistance, DHHS. Assistance. The Department's Division of Mental Health, Developmental Disabilities, and (2)Substance Abuse Services, DHHS. Services. The Department's Division of Public Health, DHHS. Health. (3) (4) The Rural Health Section of the Department's Division of Public Health, DHHS. Health. The Division of Adult Correction and Juvenile Justice of the Department of (4a)Public Safety. The State Bureau of Investigation. (5) (6) The Attorney General's Office. The following health care regulatory boards with oversight of prescribers and (7) dispensers of prescription drugs: North Carolina Board of Dental Examiners. North Carolina Board of Nursing. b. c. North Carolina Board of Podiatry Examiners. North Carolina Medical Board. North Carolina Board of Pharmacy. The UNC Injury Prevention Research Center. (8) (9)The substance abuse treatment community. (10)Governor's Institute on Substance Abuse, Inc.



The Department of Insurance's drug take-back program.

After developing the strategic plan, the Committee shall be the State's steering committee to monitor achievement of strategic objectives and receive regular reports on progress made toward reducing prescription drug abuse in North Carolina.

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- In developing the statewide strategic plan to combat the problem of prescription drug abuse, the Prescription Drug Abuse Advisory Committee shall, at a minimum, complete the following steps:
- 6 7
- Identify a mission and vision for North Carolina's system to reduce and prevent (1)prescription drug abuse.

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Scan the internal and external environment for the system's strengths, (2) weaknesses, opportunities, and challenges (a SWOC analysis).

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Compare threats and opportunities to the system's ability to meet challenges and (3) seize opportunities (a GAP analysis).

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Identify strategic issues based on SWOC and GAP analyses. (4)

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Formulate strategies and resources for addressing these issues. (5)

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The strategic plan for reducing prescription drug abuse shall include three to five (c) strategic goals that are outcome-oriented and measureable. Each goal must be connected with objectives supported by the following five mechanisms of the system:

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Oversight and regulation of prescribers and dispensers by State health care (1)regulatory boards.

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(2) Operation of the Controlled Substances Reporting System.

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Operation of the Medicaid lock-in program to review behavior of patients with (3) high use of prescribed controlled substances.

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Enforcement of State laws for the misuse and diversion of controlled (4) substances.

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Any other appropriate mechanism identified by the Committee. (5)

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DHHS, The Department, in consultation with the Prescription Drug Abuse Advisory (d) Committee, shall develop and implement a formalized performance management system that connects the goals and objectives identified in the statewide strategic plan to operations of the Controlled Substances Reporting System and Medicaid lock-in program, law enforcement activities, and oversight of prescribers and dispensers. The performance management system must be designed to monitor progress toward achieving goals and objectives and must recommend actions to be taken when performance falls short.

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Beginning on December 1, 2016, and annually thereafter, DHHS shall submit an (e) annual report on the performance of North Carolina's system for monitoring prescription drug abuse to the Joint Legislative Oversight Committee on Health and Human Services and the Joint Legislative Oversight Committee on Justice and Public Safety."

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SECTION 2. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2017

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HOUSE BILL 285 PROPOSED COMMITTEE SUBSTITUTE H285-CSTA-6 [v.3]

03/21/2017 02:20:44 PM

Short Title: Suicide Prevention/Awareness School Personnel. (Public)

Sponsors:

Referred to:

March 9, 2017

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A BILL TO BE ENTITLED

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AN ACT TO PROVIDE FOR A TRAINING PROGRAM ON YOUTH SUICIDE AWARENESS AND PREVENTION AND A RISK REFERRAL PROTOCOL FOR SCHOOL PERSONNEL.

5 The General Assembly of North Carolina enacts:

6 7 **SECTION 1.** Article 25A of Chapter 115C of the General Statutes is amended by adding a new section to read:

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"§ 115C-375.10. Youth suicide awareness and prevention training and risk referral protocol for school personnel.

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(a) State Board Training Program and Protocol. – The State Board of Education, in consultation with the Department of Health and Human Services, Division of Public Health, shall develop a youth suicide awareness and prevention training program and a model risk referral protocol for local school administrative units and charter schools to provide to school personnel who work directly with students in grades kindergarten through 12. The training program shall consist of at least two hours of evidence-based instruction to increase awareness of suicide, identification of risk factors and signs, and information for student referral for suicide prevention resources and support. The model risk referral protocol shall provide guidelines to local school administrative units on identification of at-risk students, suicide prevention procedures, and referral sources. The training program and model risk referral protocol shall be periodically reviewed and updated as necessary.

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(b) Training and Protocol Requirements. — Each local school administrative unit shall provide the training program and model risk referral protocol developed by the State Board of Education pursuant to subsection (a) of this section, or a locally-developed plan that meets the requirements of subsection (c) of this section, to school personnel who work directly with students in grades 7 through 12 at no cost to the school employee. School personnel who work directly with students in grades 7 through 12 shall receive youth suicide awareness and prevention training within 12 months of employment with a local board of education and every 5 years thereafter while employed with that local board of education. The training may be offered in various formats, including electronically, either via videoconference, or through an individual program of study that consists of at least two hours of instruction.

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(c) Locally-Developed Plan: Training and Risk Referral Protocols. – A local board of education may comply with the training and risk referral protocol requirements of this section by developing a local plan in accordance with subdivisions (1) and (2) of this subsection.

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(1) A locally-developed youth suicide awareness and prevention training program shall include, at a minimum:



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- Information on State and national data on suicide deaths and 1 2 attempts, suicide methods, and at-risk population. 3 Myths and attitudes about suicide. <u>b.</u> 4 Warning signs and symptoms for suicide <u>c.</u> 5 d. How to identify at-risk students and steps for referring at-risk students to support services. 6 7 Methods and factors to prevent suicide. <u>e.</u> 8 Safe messaging protocols for students. f. 9 (2) A locally-developed risk referral protocol on identification of at-risk students, suicide prevention procedures, and referral sources shall include, at 10 11 a minimum: A plan to provide specialized training for student support personnel, 12 <u>a.</u> including administrators, school nurses, counselors, social workers, 13 14 and psychologists. 15 <u>b.</u> A safety plan for the school in the event of (i) the identification of a student as being at-risk of suicide, including a student help plan and 16 17 immediate assistance, and (ii) a suicide death or suicide attempt by a 18 student enrolled in the school, including a care plan for peers and 19 school personnel. 20 The designation of a school employee as the school suicide c. 21 prevention responder. 22 <u>d</u>. A protocol for communication with a parent or legal guardian of a student who is identified as at-risk, including safe transfer of the 23 24 student to the parent or legal guardian. 25 A plan for post-intervention for a student who has been identified as <u>e.</u> at-risk or has attempted suicide, including reentry into the classroom. 26 Reporting. - As part of the Healthy Active Children Policy survey report required 27 (d) 28 by State Board of Education policy, SHLT-000, each local school administrative unit shall 29 report to the Department of Public Instruction on its compliance during the previous school 30 year with the mandatory training and risk referral protocols required by this section on or 31 before September 15 of each year. 32 No local board of education, nor its members, employees, designees, agents, or (e) 33 volunteers, shall be liable in civil damages to any party for any act or omission of an act relating to the provision of, participation in, or implementation of the components of the 34 35 training program or protocol required by this section unless that act or omission amounts to 36 gross negligence, wanton conduct, or intentional wrongdoing. 37 For purposes of this section, the term "school personnel" includes teachers, teacher 38 assistants, bus drivers, cafeteria workers, janitorial staff, media coordinators, athletic coaches, 39 administrators, administrative assistants, school safety resource officers, school nurses, social 40 workers, psychologists, counselors, and any other school employee who has direct contact with 41 students in grades kindergarten through 12." 42 **SECTION 2.** G.S. 115C-218.75 is amended by adding a new subsection to read: 43 Youth Suicide Awareness and Prevention Training and Risk Referral Protocol. -44 Each charter school shall provide a youth suicide awareness and prevention training program 45 and risk referral protocol to school personnel who work directly with students in grades seven 46
 - Each charter school shall provide a youth suicide awareness and prevention training program and risk referral protocol to school personnel who work directly with students in grades seven through 12 once every 5 years in accordance with G.S. 115C-375.10. Each charter school shall report to the Department of Public Instruction on its compliance during the previous school year with the mandatory training and risk referral protocols required by G.S. 115C-375.10. on or before September 15 of each year. No charter school board of directors, nor its members, employees, designees, agents, or volunteers, shall be liable in civil damages to any party for any act or omission of an act relating to the provision of, participation

General Assembly Of North Carolina

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Session 2017

in, or implementation of the components of the training program or protocol required by this section unless that act or omission amounts to gross negligence, wanton conduct, or intentional wrongdoing."

SECTION 3. This act is effective when it becomes law and applies beginning with the 2018-2019 school year.

H285-CSTA-6 [v.3] House Bill 285 Page 3

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HOUSE BILL 285: Suicide Prevention/Awareness School Personnel.

2017-2018 General Assembly

Committee:

House Health. If favorable, re-refer to Date:

March 22, 2017

Education - K-12

Introduced by: Reps. Murphy, Hardister, Dollar, Dobson

Prepared by: Jennifer Mundt

Analysis of:

PCS to First Edition

Committee Staff

H285-CSTA-6

OVERVIEW: House Bill 285 would provide for a training program on youth suicide awareness and prevention and a risk referral protocol for school personnel.

[As introduced, this bill was identical to S316, as introduced by Sens. Krawiec, D. Davis, Pate, which is currently in Senate Health Care.]

BILL ANALYSIS: House Bill 285 would create new statutes regarding youth suicide awareness and prevention training and risk referral protocols in the statutes that pertain to special medical needs of students in elementary and secondary education and the statutes that pertain to charter schools' general operating requirements (in Article 25A of Chapter 115C and Article 14A of the General Statutes, respectively) that do the following:

- Directs the State Board of Education (State Board), in consultation with the Division of Public Health in the Department of Health and Human Services, to develop, review, and update periodically, a youth suicide awareness and training program (training program) and a model risk referral protocol (model protocol) for local school administrative units (LEA) and charter schools.
- The proposed committee substitute amends the 1st Edition of the bill to require that both the training program and model protocol are provided to school personnel who work directly with students in grades 7 through 12, rather than kindergarten through 12.
 - The training program must be provided at no cost to the school employee within 12 months of employment and every 5 years thereafter, which includes least 2 hours of evidence-based instruction to increase awareness of suicide, risk factors and signs, and information for referral to resources and support.
 - The model protocol must provide guidelines to LEAs on the identification of at-risk students, suicide prevention measures, and referral sources.

¹G.S. 115C-375.10(f) would define "school personnel" for purposes of this program to mean: teachers, teacher assistants, bus drivers, cafeteria workers, janitorial staff, media coordinators, athletic coaches, administrators, administrative assistants, school safety resource officers, school nurses, social workers, psychologists, counselors, and any other school employee who has direct contact with students in grades kindergarten through 12.





House PCS 285

Page 2

- Authorizes LEAs to comply with the training program and model protocol requirements by developing a local plan that includes, at a minimum, the criteria identified in G.S. 115C-375.10(c)(1) and (c)(2), respectively.
- Directs each LEA and charter school to report to the Department of Public Instruction on its compliance with the training program and model protocols during the previous school year by September 15 of each year.
- Provides that no local board of education or charter school, nor their members, employees, designees, agents, or volunteers, are liable in civil damages to any party for any act or omission of an act relating to the provision of, participation in, or implementation of the components of the training program or protocol required by this section unless that act or omission amounts to gross negligence, wanton conduct, or intentional wrongdoing.

EFFECTIVE DATE: This act is effective when it becomes law and applies beginning with the 2018-2019 school year.

GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2017

H

HOUSE BILL 285

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Short Title: Suicide Prevention/Awareness School Personnel. (Public) Representatives Murphy, Hardister, Dollar, and Dobson (Primary Sponsors). Sponsors: For a complete list of sponsors, refer to the North Carolina General Assembly web site. Referred to: Health, if favorable, Education - K-12

March 9, 2017

A BILL TO BE ENTITLED

AN ACT TO PROVIDE FOR A TRAINING PROGRAM ON YOUTH SUICIDE AWARENESS AND PREVENTION AND RISK REFERRAL PROTOCOL FOR SCHOOL PERSONNEL. The General Assembly of North Carolina enacts:

SECTION 1. Article 25A of Chapter 115C of the General Statutes is amended by adding a new section to read:

"§ 115C-375.10. Youth suicide awareness and prevention training and risk referral protocol for school personnel.

- State Board Training Program and Protocol. The State Board of Education, in consultation with the Department of Health and Human Services, Division of Public Health, shall develop a youth suicide awareness and prevention training program and a model risk referral protocol for local school administrative units and charter schools to provide to school personnel who work directly with students in grades K through 12, including teachers, teacher assistants, bus drivers, cafeteria workers, janitorial staff, media coordinators, athletic coaches, administrators, administrative assistants, school safety resource officers, school nurses, social workers, psychologists, and counselors. The training program shall consist of at least two hours of evidence-informed instruction to increase awareness of suicide, identification of risk factors and signs, and information for student referral for suicide prevention resources and support. The model risk referral protocol shall provide guidelines to local school administrative units on identification of at-risk students, suicide prevention procedures, and referral sources. The training program and model risk referral protocol shall be periodically reviewed and updated as necessary.
- (b) Training and Protocol Requirements. – Each local school administrative unit shall provide the training program and model risk referral protocol developed by the State Board of Education under subsection (a) of this section, or a locally developed plan that meets the requirements of subsection (c) of this section, to school personnel who work directly with students in grades K through 12 at no cost to the employee. A school employee who works directly with students in grades K through 12 shall receive training within 12 months of employment with a local board of education and annually thereafter while employed with that local board of education. The training may be offered in various formats, including electronically, through videoconferencing, or through an individual program of study of designated materials consisting of at least two hours of instruction.
- Locally Developed Training and Risk Referral Protocols. A local board of education may comply with the training and protocol requirements of this section by developing a local plan that includes, at a minimum, (i) conveying information on State and national data on suicide deaths and attempts, suicide methods, and at-risk populations, (ii) myths and attitudes about



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suicide, (iii) warning signs and symptoms for suicide, (iv) identification of at-risk students and steps for referring students to support services, (v) protective factors for prevention of suicide, and (vi) safe messaging to children. In addition, a local plan shall include protocols for implementation and mandatory training that include at least the following:

- (1) A plan to include specialized training for student support personnel, including administrators, school nurses, counselors, social workers, and psychologists.
- A safety plan for the school in the event of (i) identification of a student as being at-risk of suicide, including a student help plan and immediate assistance, and (ii) a suicide death or suicide attempt by a student enrolled in the school, including a care plan for peers and school personnel.
- (3) Designation of a school employee as the school suicide prevention responder.
- (4) A plan for communication with a parent or legal guardian of a student identified as at-risk, including safe transfer of the student to the parent or legal guardian.
- (5) A plan for post-intervention for a student who has been identified as at-risk or has attempted suicide, including reentry into the classroom.
- (d) Reporting. By September 15 of each year, as part of the Healthy Active Children Policy survey report required by State Board of Education policy, SHLT-000, each local school administrative unit shall report to the Department of Public Instruction on prior school year compliance with the mandatory training requirements and prevention activities required by this section.
- (e) No local board of education, nor its members, employees, designees, agents, or volunteers, shall be liable in civil damages to any party for any act or omission of an act relating to the provision of, participation in, or implementation of the components of the training program or protocol required by this section unless that act or omission amounts to gross negligence, wanton conduct, or intentional wrongdoing."

SECTION 2. G.S. 115C-218.75 is amended by adding a new subsection to read:

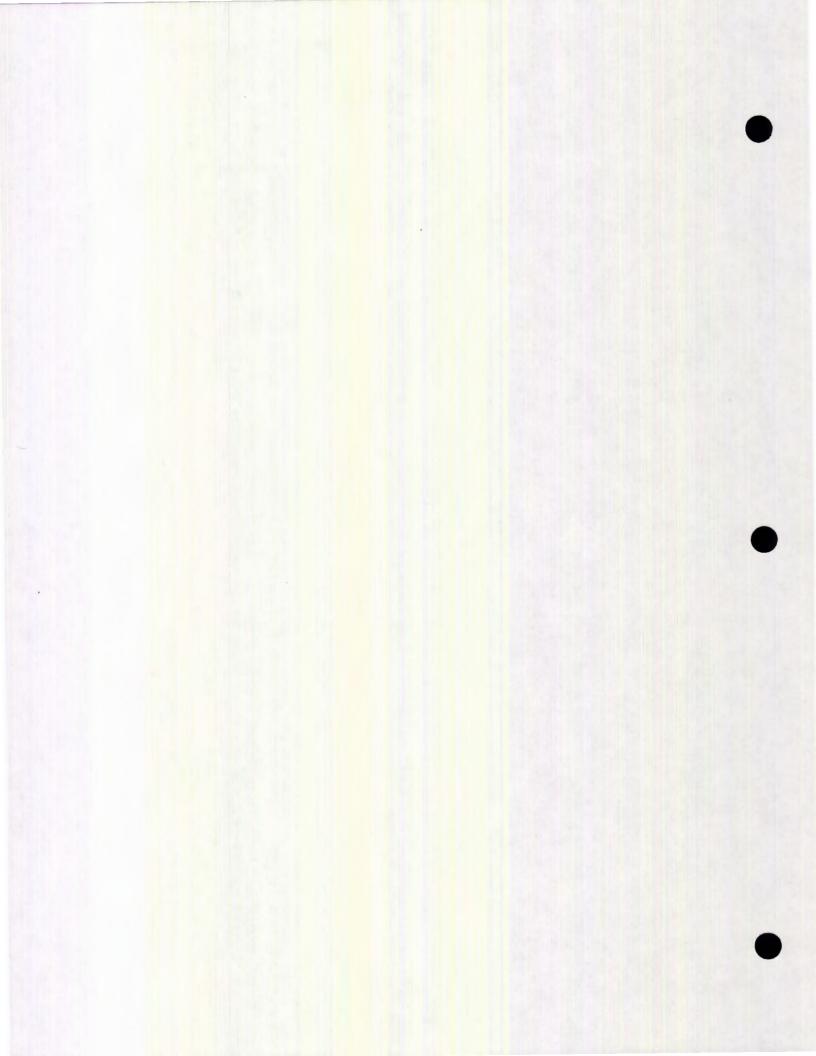
- "(g) Youth Suicide Awareness and Prevention Training and Risk Referral Protocol. Each charter school shall provide a youth suicide awareness and prevention training program and risk referral protocol to school personnel who work directly with students in grades K through 12 on an annual basis in accordance with G.S. 115C-375.10. By September 15 of each year, the charter school shall report to the Department of Public Instruction on prior school year compliance with required training requirements and prevention activities. No charter school board of directors, nor its members, employees, designees, agents, or volunteers, shall be liable in civil damages to any party for any act or omission of an act relating to the provision of, participation in, or implementation of the components of the training program or protocol required by this section unless that act or omission amounts to gross negligence, wanton conduct, or intentional wrongdoing."
- **SECTION 3.** This act is effective when it becomes law and applies beginning with the 2018-2019 school year.



NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT House Bill 285

	H285-ATA-5 [v.1]		(to be filled in by Principal Clerk)	Page 1 of 1
	Amends Title [NO] H285-CSTA-6 [v.3]	Date	3/22	,2017
	Representative Greg Murphy			
}	moves to amend the bill on page 1, line 14 by replacing the word "kindergarten" with the number	" <u>7</u> ".		
	SIGNED Signed Amendment Sponsor			
	SIGNED Committee Chair if Senate Committee A	mendr	nent	
	Committee Chair it Senate Committee A	menar	Hent	
	ADOPTED FAILED		TABLED	





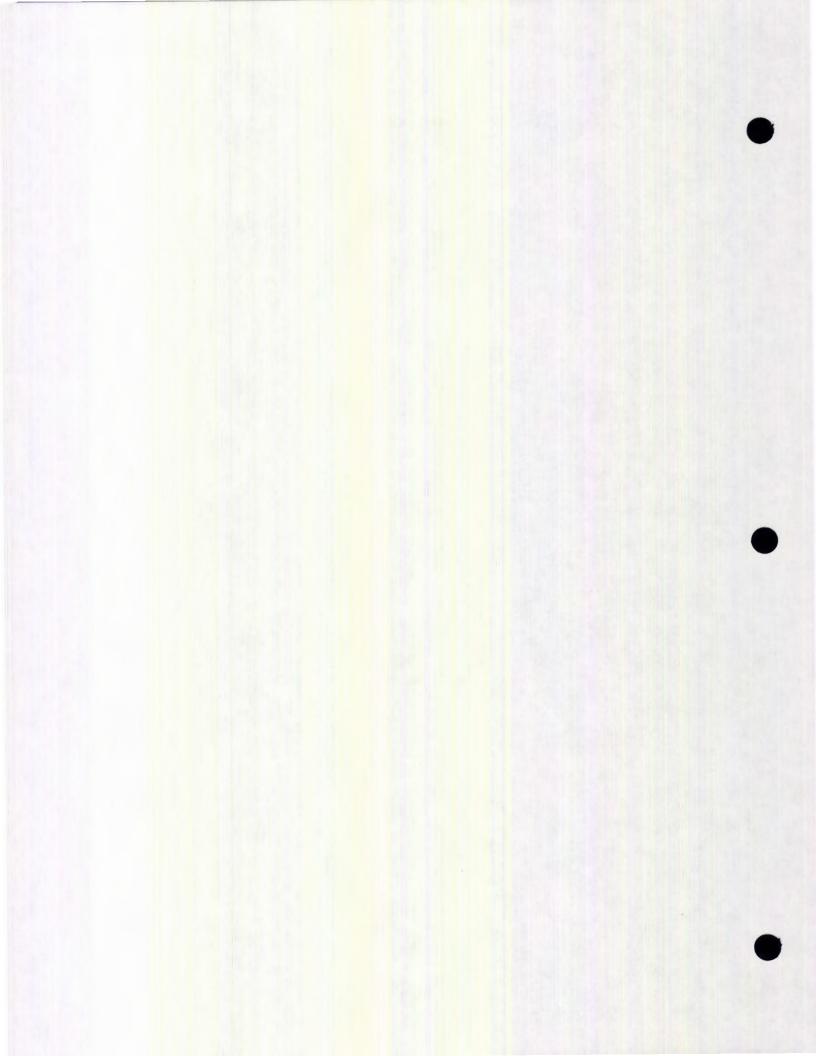


NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT House Bill 285

		AMENDMENT NO.	
H285-ATA-7 [v.1]		(to be filled in by Principal Clerk)	
11263-A1A-7 [V.1]		Timerpar Cicik)	Page 1 of 1
Amends Title [NO] H285-CSTA-6[v.3]	Date _	2/82	,2017
Representative Cunningham			
moves to amend the bill on page 2, line 31, by rewriting that line to read: "before September 15 of each year. The Department of the page 2, line 31, by rewriting that line to read:			
received pursuant to this section and submit an oprevious school year with the mandatory training	and ris	sk referral protocols	to the Joint
Legislative Oversight Committee on Health and I			
Education Oversight Committee on or before Decem	ber 1 of	each year.".	
SIGNED Carla Cunningham Amendment Sponsor			
SIGNED			
Committee Chair if Senate Committee	Amendn	nent	
ADOPTED FAILED		TABLED	

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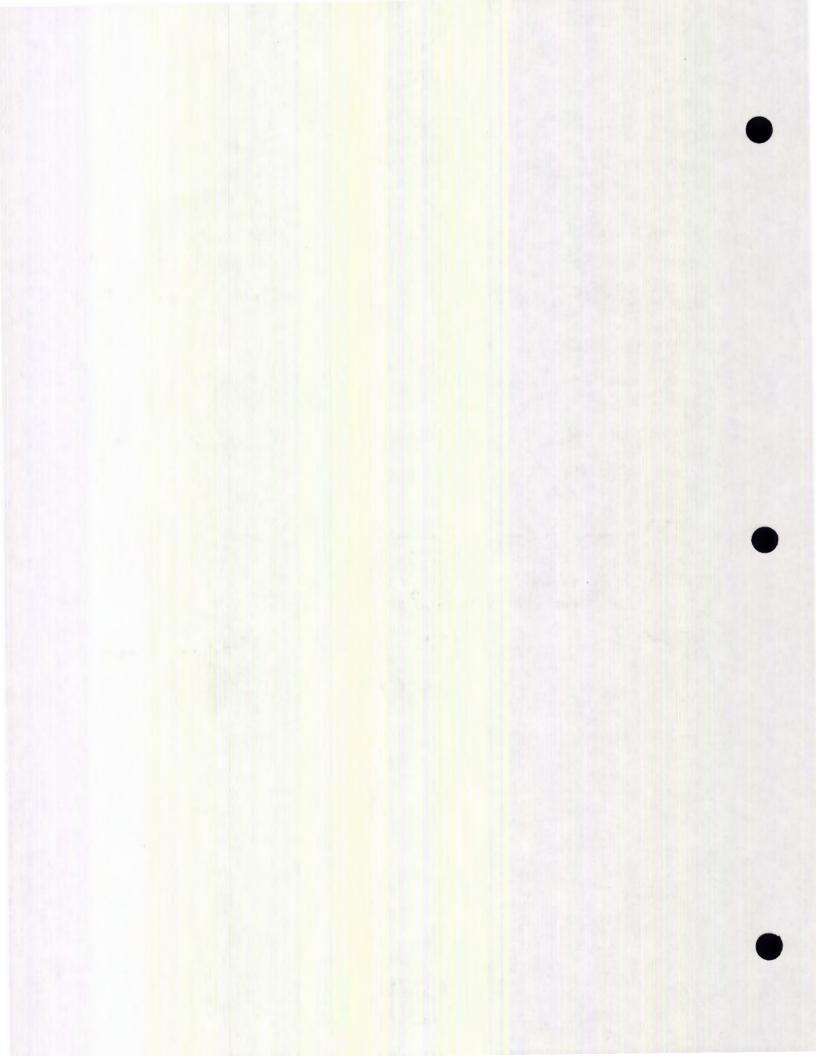




NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT House Bill 285

				to be filled in by	
	H285-ATA-6 [v.1]			Principal Clerk)	
					Page 1 of 1
	Amends Title [NO] H285-CSTA-6 [v.3]		Date	2/20	.2017
	Representative Cunningham				
1 2 3	moves to amend the bill on p by deleting the number "5" a		vith the number "2"	, and	
4 5 6 7 8	on page 2, line 46, by deleting the number "5" a	and replacing it w	vith the number "2"		
	SIGNED Carla	Amendment Spo	onsor	_	
	SIGNED				
	Committee Cha	air if Senate Con	nmittee Amendmer	nt	
	ADOPTED	FAILED_	1	TABLED	





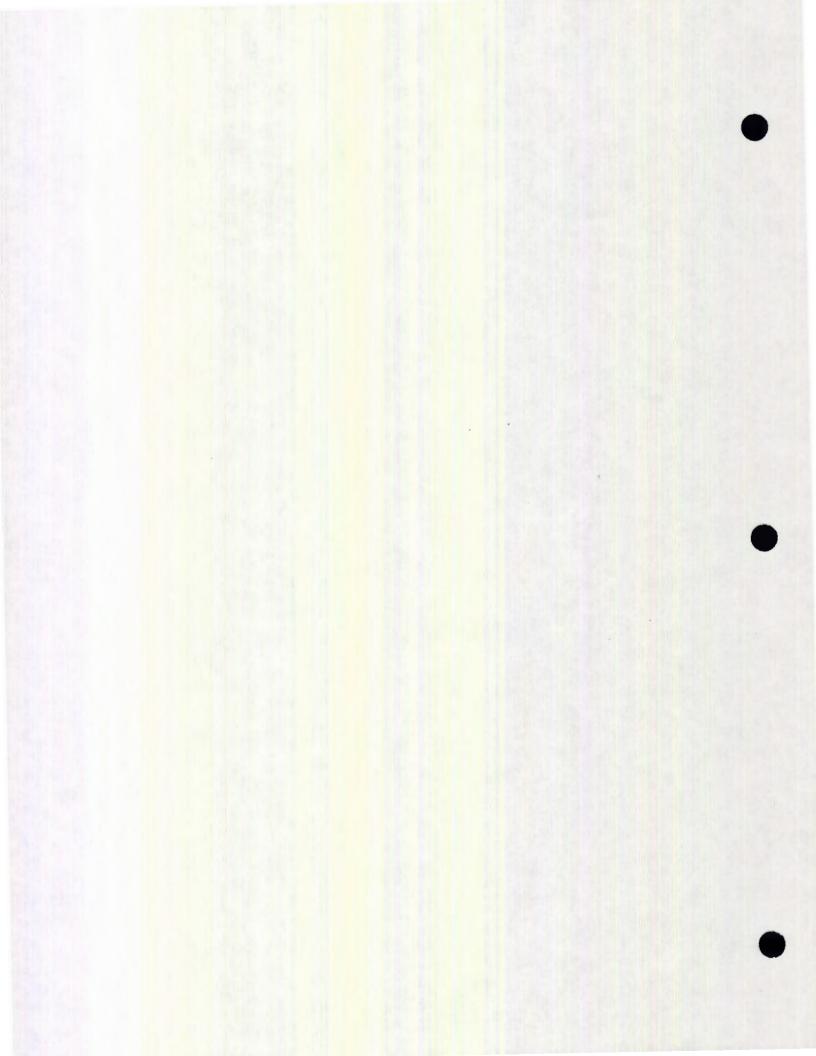


NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT House Bill 285

AMENDMENT NO.

	H285-ATY-3 [v.2]	(to be filled in by Principal Clerk)	
		_	Page 1 of 1
	Amends Title [NO] First Edition	Date 7/22	,2017
	Representative Carney		
1 2 3	moves to amend the bill on page 1, line 14, line 2 with the number "6".	25, and line 26, by replacing the	he number "7"
4 5	And to further amend the bill on page 2, line 45 l"six".	by replacing the word "seven"	with the word
	SIGNED Amendment Sponsor		
	SIGNED		
	Committee Chair if Senate Committee	e Amendment	
	ADOPTED FAILED	TABLED	





NORTH CAROLINA GENERAL ASSEMBLY HOUSE OF REPRESENTATIVES

HEALTH COMMITTEE REPORT

Representative Justin P. Burr, Co-Chair Representative Josh Dobson, Co-Chair Representative Bert Jones, Co-Chair Representative Donny Lambeth, Co-Chair Representative Gregory F. Murphy, MD, Co-Chair

FAVORABLE

HB 164 Check-Off Donation: Cancer Screening.

Draft Number: None
Serial Referral: None
Recommended Referral: None
Long Title Amended: No
Floor Manager: Dollar

HB 277 Expand Rx Drug Abuse Advisory Committee.

Draft Number: None
Serial Referral: None
Recommended Referral: None
Long Title Amended: No
Floor Manager: Faircloth

FAVORABLE AND RE-REFERRED

HB 307 Board Cert. Behavior Analyst/Autism Coverage.

Draft Number: None

Serial Referral: INSURANCE

Recommended Referral: None
Long Title Amended: No
Floor Manager: McGrady

TOTAL REPORTED: 3





NORTH CAROLINA GENERAL ASSEMBLY HOUSE OF REPRESENTATIVES

HEALTH COMMITTEE REPORT

Representative Justin P. Burr, Co-Chair Representative Josh Dobson, Co-Chair Representative Bert Jones, Co-Chair Representative Donny Lambeth, Co-Chair Representative Gregory F. Murphy, MD, Co-Chair

FAVORABLE COM SUB, UNFAVORABLE ORIGINAL BILL AND RE-REFERRED

HB 116 Student Safety in Athletics.

Draft Number: H116-PCS40268-TA-5
Serial Referral: EDUCATION - K-12

Recommended Referral: None Long Title Amended: Yes Floor Manager: Warren

HB 285 Suicide Prevention/Awareness School Personnel.

Draft Number: H285-PCS40265-TA-6
Serial Referral: EDUCATION - K-12

Recommended Referral: None Long Title Amended: Yes Floor Manager: Murphy

TOTAL REPORTED: 2





Committee Sergeants at Arms

NAME OF	COMMITTEE H	<u>ouse Co</u>	<u>mm.</u>	on H	<u>ealth</u>	
DATE:(03/22/17	Room;	444	643	\$11 \$11.100 MARKET MARK	
		House Sgt-A	it Arms:			
1. Name: Y	oung Bae	11 Arr 100-100	***************************************			
2. Name: <u>J</u>	im Moran		and the second s			
	Rex Foster					
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5. Name:					•	
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Hou Pages Assignments Wednesday, March 22, 2017 Session: 2:00 PM

Committee	Room	Time	Staff	Comments	Member
State and Local Government	544	10:00 AM	Autumn Brisson		Rep. William Brisson
			Akirah Graves		Rep. Rodney Moore
Aging	Other	11:00 AM	Blake Bellanger		Rep. Larry Bell
			Connor Scanlon		Rep. Joe John
Health	643	11:00 AM	Lily Ahlin		Rep. George Cleveland
			Colin Konieczka		Rep. Linda Hunt-Williams
Pensions and Retirement	415	12:00 PM	Autumn Brisson		Rep. William Brisson
			Kailey Gause		Rep. William Brisson
Judiciary I	415	1:00 PM	Joshua Babson		Rep. William Brisson
			Garrett Penley		Rep. Julia Howard
Judiciary III	421	1:00 PM	Kailey Gause		Rep. William Brisson
			Kayla Yarborough		Rep. Dean Arp
Regulatory Reform	643	1:00 PM	Blake Bellanger		Rep. Larry Bell
V ,			Colin Konieczka		Rep. Linda Hunt-Williams

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House Comm. on Health

03/22/17

Name of Committee

Date

NAME	FIRM OR AGENCY AND ADDRESS
amanda Donovan	ICTS
Carcar Huie	MVA
Leanne Winner	NCSBA
Doda Binfer	CCR
Loya Peters	CSS
Kristen Kucera	UNC-CH Sport Injury Research
ALAN DECCAPENNA	DPH -DHHS
Sonyabono	DM4DDSas/DHHs
Brittoni Blockmon	Hational US Society
Kelsey Byerly	Walk West
Mother than	Donc

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House Comm. on Health

03/22/17

Name of Committee

Date

NAME	FIRM OR AGENCY AND ADDRESS
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Jon Carr	Jordan Poin Can fin
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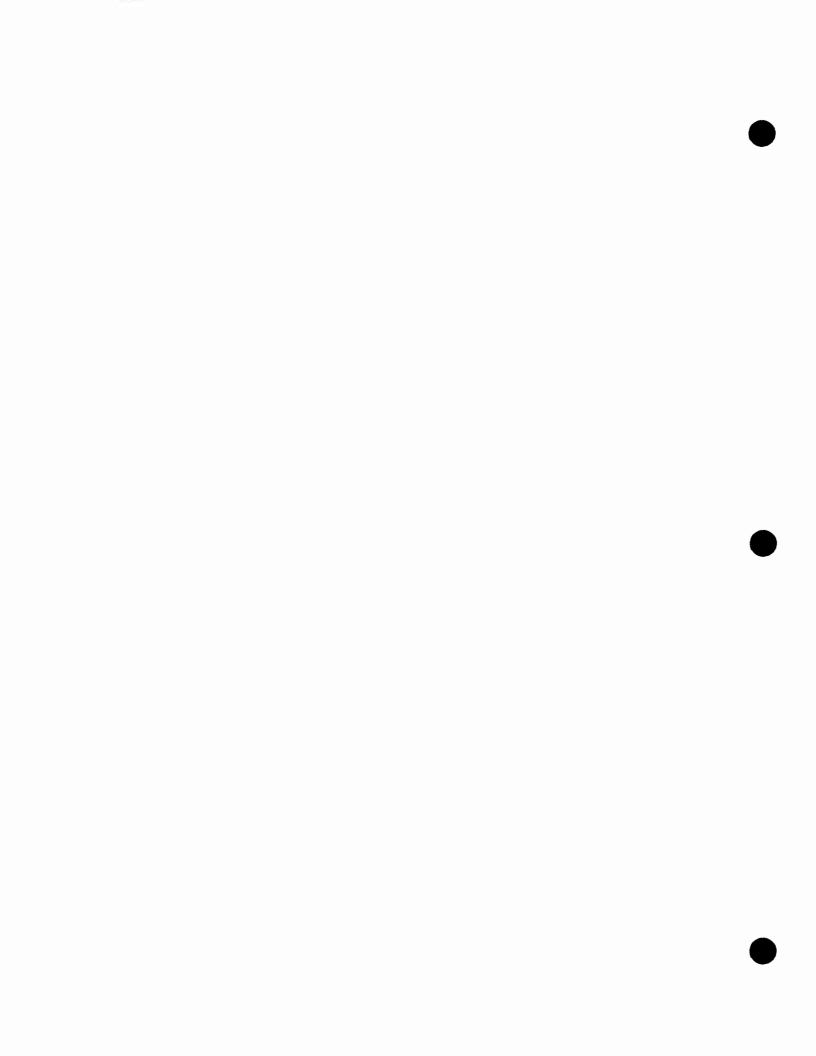
House Comm. on Health

03/22/17

Name of Committee

Date

NAME	FIRM OR AGENCY AND ADDRESS
David Barer	Brody School of Medicine 4B Bousley Dr. Ant may greenville ME 23.
CS/80//s	C54
Robini Huffman	NC Psychiatric Assoc.
BRUCE THOMPSON	PARKOR POS
Ista Perkinin	Perkusm San
Fredel Benli	Phla
Grey Grages	NCAFP
300	, TSC
Kelly Vosel	Kr Stategics
Patrick Brown	Muhal Drus Company
MARTY BOCOCK	PRIME THERADEOTIES



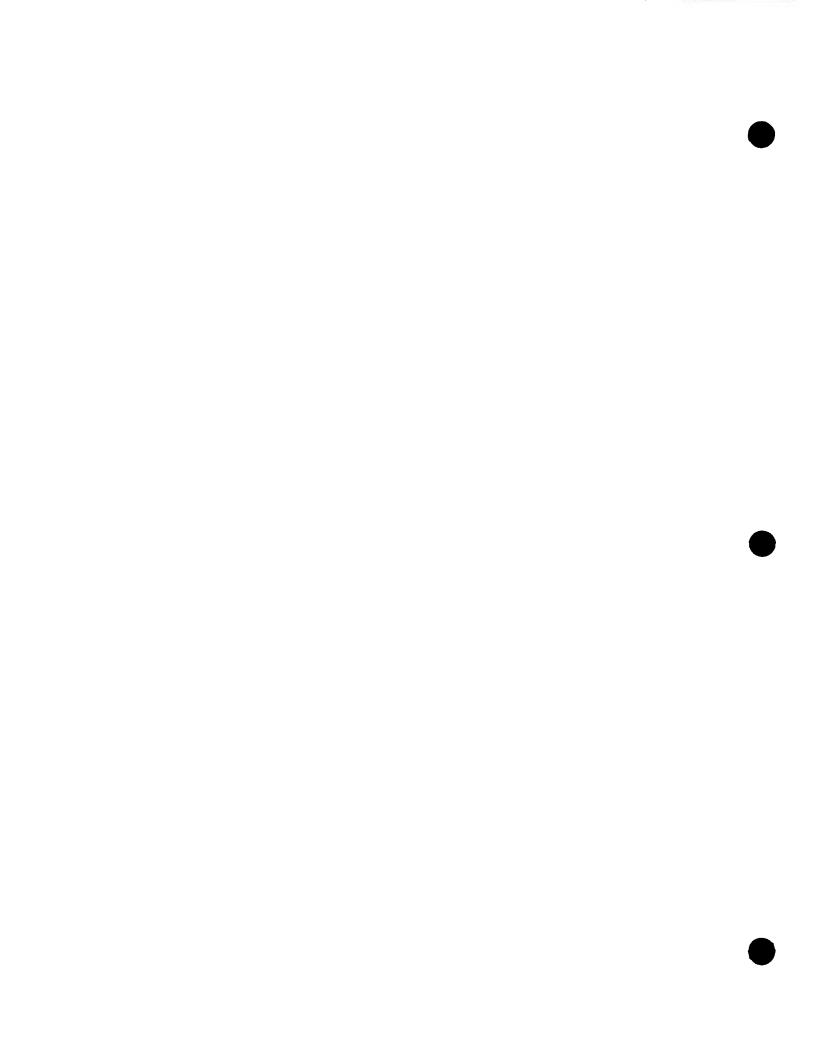
House Comm. on Health

03/22/17

Name of Committee

Date

NAME	FIRM OR AGENCY AND ADDRESS
PeyTON MAINAMO	2
Sol Hayrand	OPM & ASSOC.
Jusan Harrison	TYCDTSEA
Julia Adams Scheurick	Oak City UR
Ryan Blackledge	. Cone Itenth
Ters Lummy	THA
Christine Wason	ACS CAN
Brian Perkins	Alliance OHC
Joney Mun	MVA.
TJBrasee	NP
Ladan Penguan	CSS



House Comm. on Health

03/22/17

Name of Committee

Date

NAME	FIRM OR AGENCY AND ADDRESS
John Del Grown	BrubakertAssac
Sarah Bales	11 11 11
Debi Nelson	nc DPH
Sue Am Forrest	Nems
SUSAN KANSAGRA	NC DPH
Josh Jackson	NCMS
Katy Kilgstun	3P
Doug Hear	Durz
DANIEL VANLIERE	VIDANT HEALTH
Nathadall Cerall	Carolina Health Care
don'a holy	Novant Health

House Comm. on Health

03/22/17

Name of Committee

Date

NAME	FIRM OR AGENCY AND ADDRESS
KelloHertcher	NC CFTF
Ellen Esset	MCDPI
Honter Walton	HCW
JOB CAMIBR	T5S
Samanha Read Shin MD	. WCMS
MILHAEL D Parmer D.O.	wems
Robb Jansen	NCSBE
Burt Jenkins	NCDPI
Colleen Kochenek	NCCEP.
Brua Medant	NCSBA
Kay Castillo	NASW-NC

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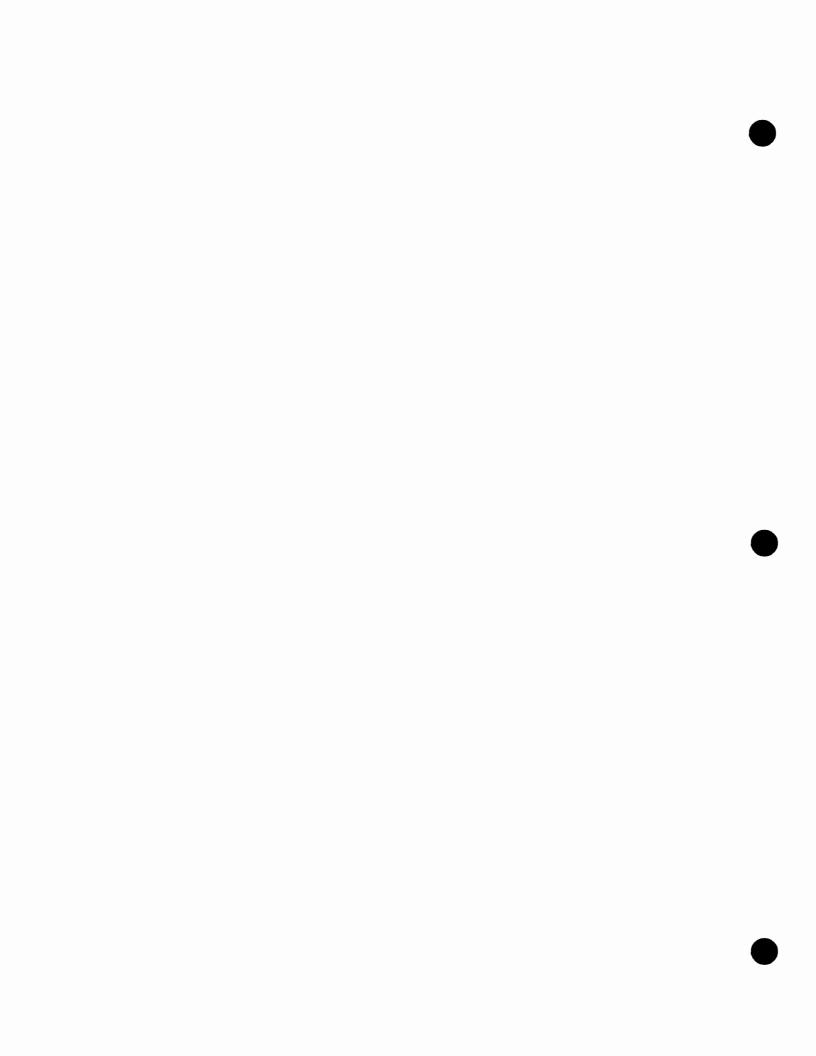
House Comm. on Health

03/22/17

Name of Committee

Date

NAME	FIRM OR AGENCY AND ADDRESS
Jennifer Mahan	ASNC
Bhir Borguk	RA-Rep. Buer
Richard Bostie	NC 56A
Lindsey Dawing	FSP
Jake Spe	NCEPC
Jacob Andberry	Rep-Cewis
Caron Christian	NC4A
and Brandon	NC SPS
Ard Carlon	In Old of PUR
Readie Holen	The Largenine Group
Christian Campbell	Rep-Malone



House Comm. on Health

03/22/17

Name of Committee

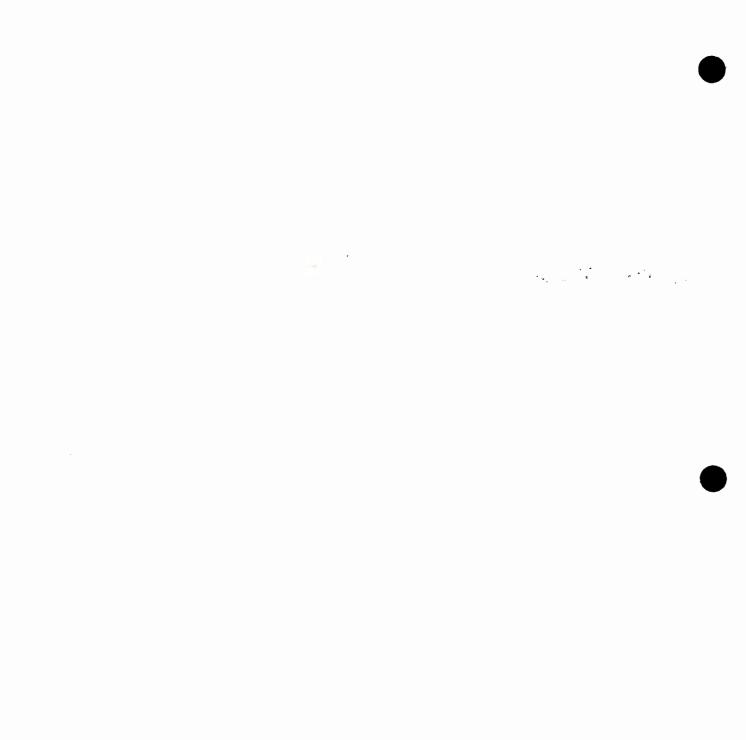
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

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FIRM OR AGENCY AND ADDRESS

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Ben Papkin	. DHHS
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Windy mies	Parent



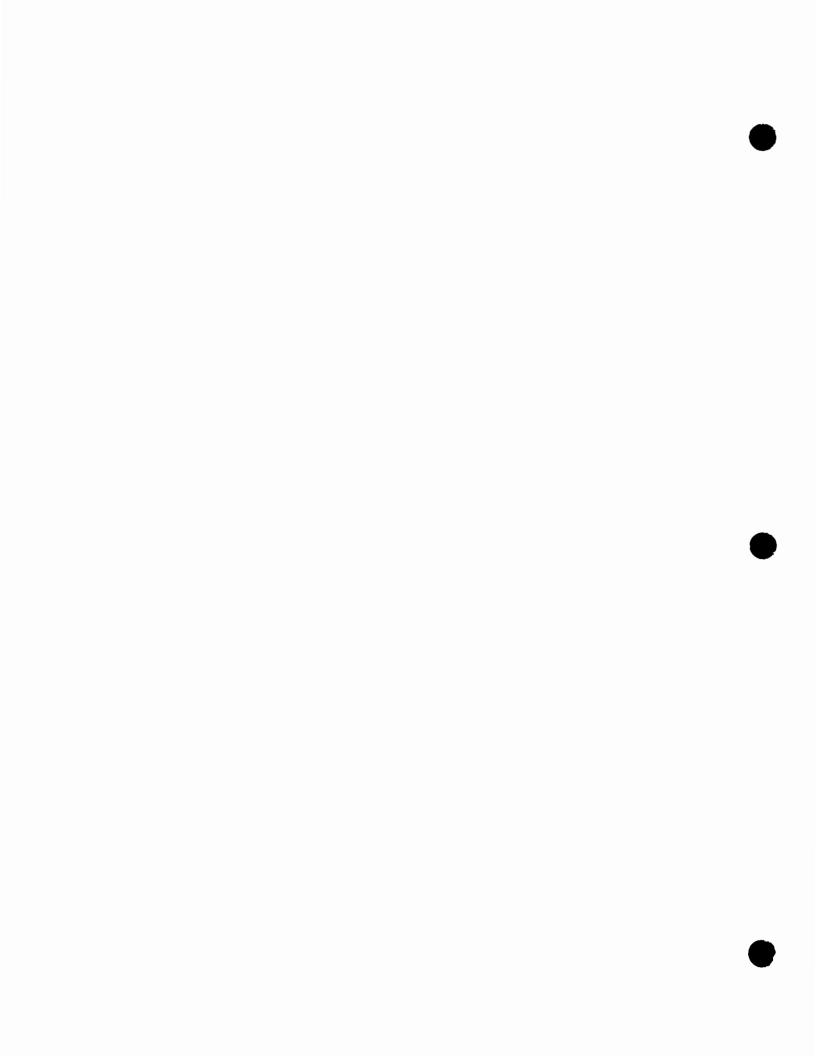
House Comm. on Health

03/22/17

Name of Committee

Date

NAME	FIRM OR AGENCY AND ADDRESS
R's Castillo	Parent
Monique Baker, BIBA	Effective Intervention Suite #1
Lorri Unumb	Autism Speaks
Therens	cs5
Sara Carbane	Effective Interventions Southern Pines NX
Brond's Meuse	Learn with the Best
Janua Salland	Parent
Kin Sjorves	NCKIA
Caroline Miller	AMGA
Matt (rus)	Ne Chilo
Saral Vidnie	PC Child



House Committee on Health Wednesday, March 29, 2017 at 11:00 AM Room 643 of the Legislative Office Building

MINUTES

The House Committee on Health met at 11:00 AM on March 29, 2017 in Room 643 of the Legislative Office Building. Representatives Adcock, Ball, Blackwell, Boswell, Brisson, Carney, Cunningham, Dobson, Dollar, Dulin, Earle, Howard, Hunter, Insko, Bert Jones, Lambeth, Lucas, Malone, Murphy, Potts, Rogers, Setzer, Shepard, Szoka, White, Wray, Yarborough, and Zachary attended.

Representative Bert Jones, Chair, presided.

The following bills were considered:

HB 243 Strengthen Opioid Misuse Prevention (STOP)Act. (Representatives Murphy, Davis, Malone, Horn)

Rep. Murphy explained the bill and offered 2 amendments to the bill to be rolled into a PCS. These amendments passed. After discussion by committee members, Rep. Murphy motioned for Unfavorable to the original bill, favorable to the PCS. All being in favor, the bill passed.

HB 425 Improve Utilization of MH Professionals. (Representatives Dobson, Dollar, Murphy, Earle)

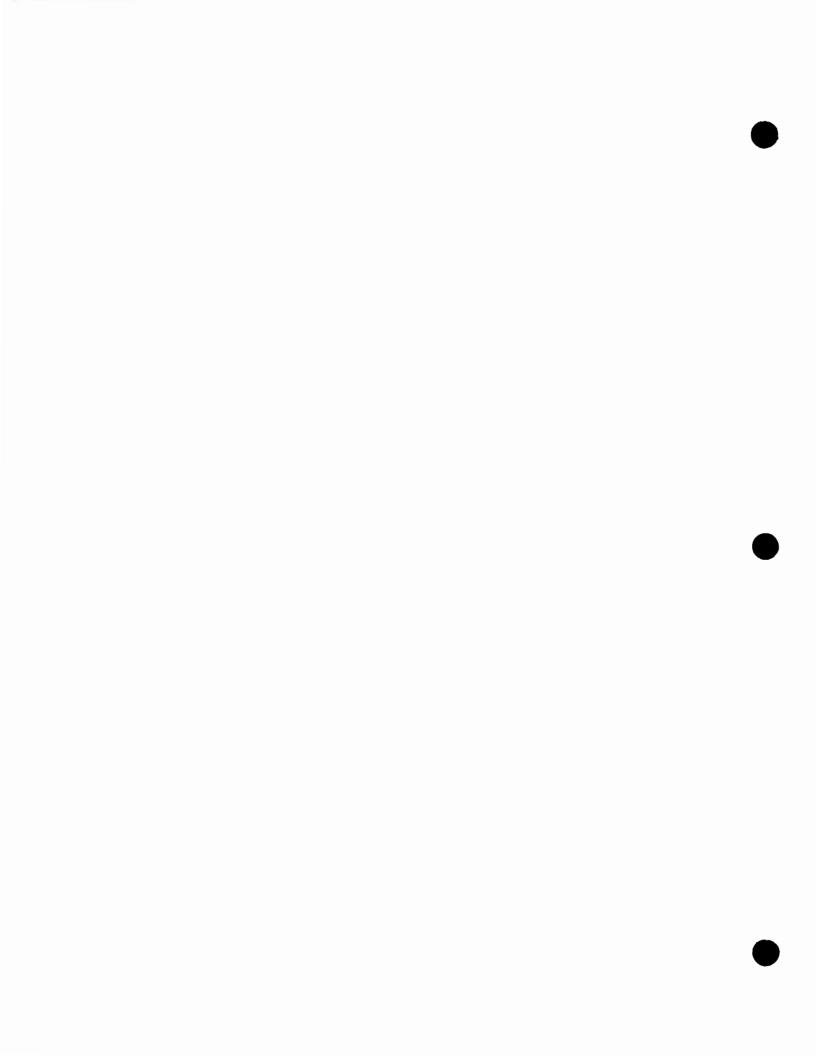
Rep. Dobson explained the PCS for HB 425. Rep. Insko offered an amendment, which was discussed. Both support for and opposition to the amendment were heard. Members voted on the amendment and it failed 13-11. Rep. Dobson motioned for Unfavorable to the original bill, favorable to the PCS. Members voted and the bill passed.

The meeting adjourned at 11:55.

Representative Bert Jones, Chair

Presiding

Brenda Olls, Committee Clerk



NORTH CAROLINA HOUSE OF REPRESENTATIVES COMMITTEE MEETING NOTICE AND BILL SPONSOR NOTIFICATION 2017-2018 SESSION

You are hereby notified that the **House Committee on Health** will meet as follows:

DAY & DATE: Wednesday, March 29, 2017

TIME: 11:00 AM LOCATION: 643 LOB

COMMENTS: Rep. Jones will be presiding.

The following bills will be considered:

SPONSOR
Representative Murphy
Representative Davis
Representative Malone
Representative Horn
Representative Dobson
Representative Dollar
Representative Murphy
Representative Earle

Respectfully,

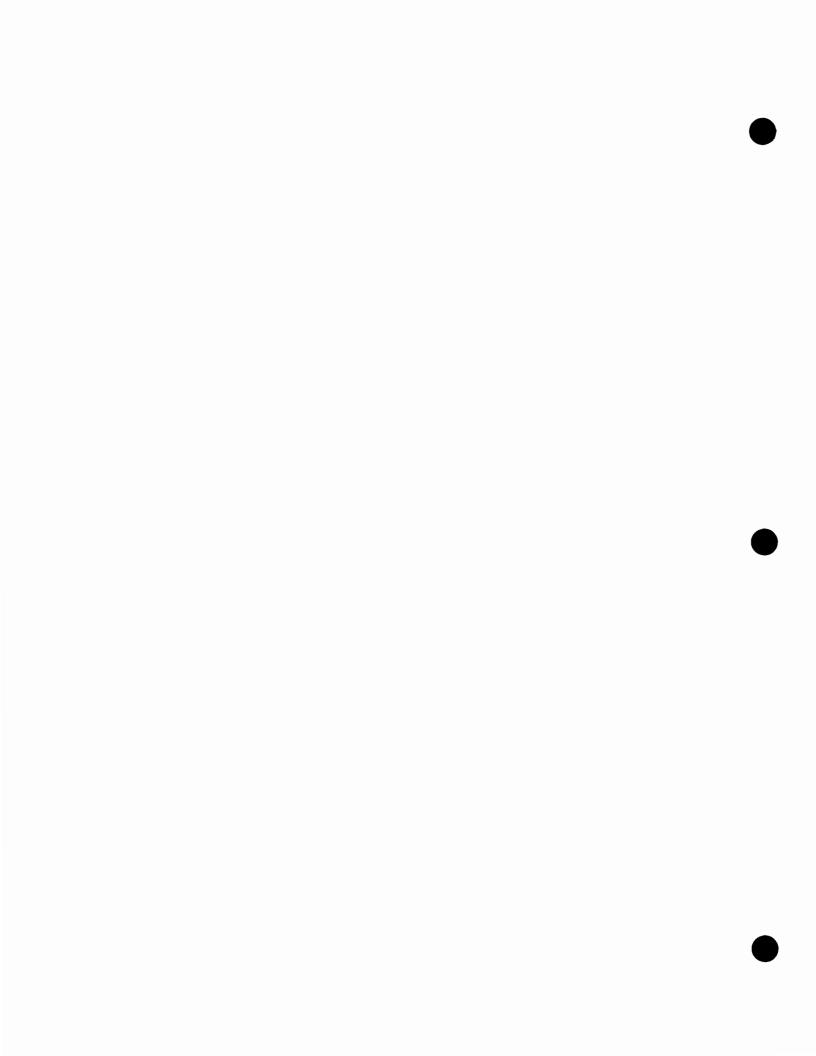
Representative Justin P. Burr, Co-Chair Representative Josh Dobson, Co-Chair Representative Bert Jones, Co-Chair Representative Donny Lambeth, Co-Chair Representative Gregory F. Murphy, MD, Co-Chair

I hereby certify this notice was filed by the committee assistant at the following offices at 5:26 PM on Monday, March 27, 2017.

Principal Clerk

Brenda Olls (Committee Assistant)

___ Reading Clerk – House Chamber



House Committee on Health Wednesday, March 29, 2017, 11:00 AM 643 Legislative Office Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

BILL NO.	SHORT TITLE	SPONSOR
HB 243	Strengthen Opioid Misuse Prevention	Representative Murphy
	(STOP)Act.	Representative Davis
		Representative Malone
		Representative Horn
HB 425	Improve Utilization of MH	Representative Dobson
	Professionals.	Representative Dollar
		Representative Murphy
		Representative Earle

Presentations

Other Business

Adjournment



GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2017

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HOUSE BILL 243 PROPOSED COMMITTEE SUBSTITUTE H243-CSTY-1 [v.14]

03/28/2017 03:13:08 PM

Short Title:

Strengthen Opioid Misuse Prevention (STOP)Act.

(Public)

Sponsors:

Representatives Murphy, Davis, Malone, and Horn (Primary Sponsors).

Referred to:

March 6, 2017

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A BILL TO BE ENTITLED

AN ACT STRENGTHENING OPIOID MISUSE PREVENTION BY EXTENDING STANDING ORDERS FOR OPIOID ANTAGONIST TO COMMUNITY HEALTH GROUPS; REQUIRING SUPERVISING PHYSICIANS TO PERSONALLY CONSULT WITH PHYSICIAN ASSISTANTS AND NURSE PRACTITIONERS WHO PRESCRIBE CERTAIN SCHEDULE II OR III CONTROLLED SUBSTANCES FOR LONG-TERM USE; REQUIRING ELECTRONIC PRESCRIBING OF CERTAIN SCHEDULE II AND III CONTROLLED SUBSTANCES; ESTABLISHING MAXIMUM LIMITS FOR INITIAL PRESCRIPTIONS OF CERTAIN SCHEDULE II AND III CONTROLLED SUBSTANCES: REQUIRING HOSPICE AND PALLIATIVE CARE PROVIDERS PROVIDE EDUCATION REGARDING PROPER DISPOSAL OF CERTAIN UNUSED CONTROLLED SUBSTANCES; CLARIFYING ALLOWABLE FUNDS FOR SYRINGE EXCHANGE PROGRAMS; REQUIRING VETERINARIAN PARTICIPATION IN THE CONTROLLED SUBSTANCES REPORTING SYSTEM; ESTABLISHING CIVIL PENALTIES FOR PHARMACIES THAT EMPLOY DISPENSERS WHO IMPROPERLY REPORT INFORMATION TO THE CONTROLLED SUBSTANCES REPORTING SYSTEM (CSRS); EXPANDING THE ROLE OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (DHHS) IN USING CSRS DATA TO DETECT AND PREVENT FRAUD AND MISUSE; MANDATING DISPENSER REGISTRATION FOR ACCESS TO THE CSRS; MANDATING DISPENSER AND PRACTITIONER USE OF THE CSRS; REQUIRING DHHS TO REPORT PRACTITIONERS WHO FAIL TO PROPERLY USE THE CSRS; CREATING A SPECIAL REVENUE FUND TO SUPPORT THE CSRS; AND REQUIRING AN ANNUAL REPORT FROM DHHS ON THE CSRS.

252627

The General Assembly of North Carolina enacts:

PART I. TITLE OF ACT

SECTION 1. This act shall be known and may be cited as the "Strengthen Opioid Misuse Prevention Act of 2017" or the "STOP Act."

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PART II. EXTEND STANDING ORDERS FOR OPIOID ANTAGONIST TO COMMUNITY HEALTH GROUPS

SECTION 2. G.S. 90-12.7 reads as rewritten:

"§ 90-12.7. Treatment of overdose with opioid antagonist; immunity.

(a) As used in this section, "opioid antagonist" means naloxone hydrochloride that is approved by the federal Food and Drug Administration for the treatment of a drug overdose.



- (b) The following individuals may prescribe an opioid antagonist in the manner prescribed by this subsection:
 - A practitioner acting in good faith and exercising reasonable care may directly or by standing order prescribe an opioid antagonist to (i) a person at risk of experiencing an opiate-related overdose or (ii) a family member, friend, or other person in a position to assist a person at risk of experiencing an opiate-related overdose. As an indicator of good faith, the practitioner, prior to prescribing an opioid under this subsection, may require receipt of a written communication that provides a factual basis for a reasonable conclusion as to either of the following:
 - a. The person seeking the opioid antagonist is at risk of experiencing an opiate-related overdose.
 - b. The person other than the person who is at risk of experiencing an opiate-related overdose, and who is seeking the opioid antagonist, is in relation to the person at risk of experiencing an opiate-related overdose:
 - 1. A family member, friend, or other person.
 - 2. In the position to assist a person at risk of experiencing an opiate-related overdose.
 - (2) The State Health Director <u>or a designee</u> may prescribe an opioid antagonist pursuant to subdivision (1) of this subsection by means of a statewide standing order.
 - A practitioner acting in good faith and exercising reasonable care may directly or by standing order prescribe an opioid antagonist to any governmental or nongovernmental organization, including a local health department, a law enforcement agency, or an organization that promotes scientifically proven ways of mitigating health risks associated with substance use disorders and other high-risk behaviors, for the purpose of distributing, through its agents, the opioid antagonist to (i) a person at risk of experiencing an opiate-related overdose or (ii) a family member, friend, or other person in a position to assist a person at risk of experiencing an opiate-related overdose.
- (c) A pharmacist may dispense an opioid antagonist to a person described in subdivision (b)(1) of this section or organization pursuant to a prescription issued pursuant to in accordance with subsection (b) of this section. For purposes of this section, the term "pharmacist" is as defined in G.S. 90-85.3.
- (c1) A governmental or nongovernmental organization, including a local health department, a law enforcement agency, or an organization that promotes scientifically proven ways of mitigating health risks associated with substance use disorders and other high-risk behaviors may, through its agents, distribute an opioid antagonist obtained pursuant to a prescription issued in accordance with subdivision (3) of subsection (b) of this section to (i) a person at risk of experiencing an opiate-related overdose or (ii) a family member, friend, or other person in a position to assist a person at risk of experiencing an opiate-related overdose. An organization, through its agents, shall include with any distribution of an opioid antagonist pursuant to this subsection basic instruction and information on how to administer the opioid antagonist.
- (d) A person who receives an opioid antagonist that was prescribed pursuant to subsection (b) of this section or distributed pursuant to subsection (c1) of this section may administer an opioid antagonist to another person if (i) the person has a good faith belief that the other person is experiencing a drug-related overdose and (ii) the person exercises reasonable care in administering the drug to the other person. Evidence of the use of reasonable

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care in administering the drug shall include the receipt of basic instruction and information on how to administer the opioid antagonist.

- All of the following individuals are immune from any civil or criminal liability for actions authorized by this section:
 - Any practitioner who prescribes an opioid antagonist pursuant to subsection (1) (b) of this section.
 - (2) Any pharmacist who dispenses an opioid antagonist pursuant to subsection (c) of this section.
 - (3) Any person who administers an opioid antagonist pursuant to subsection (d) of this section.
 - (4) The State Health Director acting pursuant to subsection (b) of this section.
 - (5) Any organization, or agent of the organization, that distributes an opioid antagonist pursuant to subsection (c1) of this section."

PART III. IMPROVE OPIOID PRESCRIBING PRACTICES

SECTION 3. G.S. 90-87 reads as rewritten:

"§ 90-87. Definitions.

As used in this Article:

"Targeted controlled substance" means any controlled substance included in (26a)G.S. 90-90 (1), (2), or (3), or G.S. 90-91(d).

SECTION 4. G.S. 90-18.1(b) is amended by adding a new subdivision to read:

If the prescription is for a targeted controlled substance as defined in Article 5 of Chapter 90 of the General Statutes and therapeutic use of the targeted controlled substance will or is expected to exceed a period of 30 days, the physician assistant shall personally consult with the supervising physician prior to prescribing the targeted controlled substance to verify that the prescription is medically appropriate for the patient. For as long as a targeted controlled substance is continuously prescribed to the same patient, the physician assistant shall consult with the supervising physician at least once every 90 days to verify that the prescription remains medically appropriate for the patient."

SECTION 5. G.S. 90-18.2(b) is amended by adding a new subdivision to read:

If the prescription is for a targeted controlled substance as defined in Article 5 of Chapter 90 of the General Statutes and therapeutic use of the targeted controlled substance will or is expected to exceed a period of 30 days, the nurse practitioner shall personally consult with the supervising physician prior to prescribing the targeted controlled substance to verify that the prescription is medically appropriate for the patient. For as long as a targeted controlled substance is continuously prescribed to the same patient, the nurse practitioner shall consult with the supervising physician at least once every 90 days to verify that the prescription remains medically appropriate for the patient."

SECTION 6. G.S. 90-106 reads as rewritten:

"§ 90-106. Prescriptions and labeling.

Except when dispensed directly by a practitioner, other than a pharmacist, to an (a) ultimate user, no controlled substance included in Schedule II of this Article may be dispensed without the written prescription of a practitioner. No Schedule II substance shall be dispensed pursuant to a written or electronic prescription more than six months after the date it was prescribed.

- (a1) Electronic prescription required; exceptions. Unless otherwise exempted by this subsection, a practitioner shall electronically prescribe all targeted controlled substances. This subsection does not apply to prescriptions for targeted controlled substances issued by any of the following:
 - (1) A practitioner, other than a pharmacist, who dispenses directly to an ultimate user.
 - (2) A practitioner who orders a controlled substance to be administered in a hospital, nursing home, hospice facility, or residential care facility as defined in G.S. 14-32.2.
 - A practitioner who experiences temporary technological or electrical failure, or other extenuating circumstance that prevents the prescription from being transmitted electronically; provided, however, that the practitioner documents the reason for this exception in the patient's medical record.
 - A practitioner who writes a prescription to be dispensed by a pharmacy located on federal property; provided, however, that the practitioner documents the reason for this exception in the patient's medical record.
- (a2) <u>Verification by dispenser not required.</u> A dispenser is not required to verify that a practitioner properly falls under one of the exceptions specified in subsection (a1) of this section prior to dispensing a targeted controlled substance. A dispenser may continue to dispense targeted controlled substances from valid written, oral, or facsimile prescriptions that are otherwise consistent with applicable laws.
- (a3) Limitation on prescriptions upon initial consultation for acute pain. A practitioner may not prescribe more than a five-day supply of any targeted controlled substance upon the initial consultation and treatment of a patient for acute pain, unless the prescription is for post-operative acute pain relief for use immediately following a surgical procedure. A practitioner shall not prescribe more than a seven-day supply of any targeted controlled substance upon the initial consultation and treatment of a patient for acute pain. Upon any subsequent consultation for the same pain, the practitioner may issue any appropriate renewal, refill, or new prescription for a targeted controlled substance. This subsection does not apply to prescriptions for controlled substances issued by a practitioner who orders a controlled substance to be wholly administered in a hospital, nursing home licensed under Chapter 131E, hospice facility, or residential care facility as defined in G.S. 14-32.2(c1).
- (a4) **Definitions.** As used in this subsection, the following terms have the following meanings:
 - (1) Acute pain. Pain, whether resulting from disease, accident, intentional trauma, or other cause, that the practitioner reasonably expects to last for three months or less. The term does not include chronic pain or pain being treated as part of cancer care, hospice care, palliative care, or medication-assisted treatment for substance use disorder.
 - (2) <u>Chronic pain. Pain that typically lasts for longer than three months or that lasts beyond the time of normal tissue healing.</u>
 - Surgical procedure. A procedure that is performed for the purpose of structurally altering the human body by incision or destruction of tissues as part of the practice of medicine. This term includes the diagnostic or therapeutic treatment of conditions or disease processes by use of instruments such as lasers, ultrasound, ionizing, radiation, scalpels, probes, or needles that cause localized alteration or transportation of live human tissue by cutting, burning, vaporizing, freezing, suturing, probing, or manipulating by closed reduction for major dislocations and factures, or otherwise altering by any mechanical, thermal, light-based, electromagnetic, or chemical means.

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- Dispenser Immunity. A dispenser shall be immune from any civil or criminal liability or disciplinary action from the Board of Pharmacy for dispensing a prescription written by a prescriber in violation of this section.
- In emergency situations, as defined by rule of the Commission, Schedule II drugs may be dispensed upon oral prescription of a practitioner, reduced promptly to writing and filed by the dispensing agent. Prescriptions shall be retained in conformity with the requirements of G.S. 90-104. No prescription for a Schedule II substance may be refilled.
- Except when dispensed directly by a practitioner, other than a pharmacist, to an ultimate user, no controlled substance included in Schedules III or IV, except paregoric, U.S.P., as provided in G.S. 90-91(e)1, may be dispensed without a prescription, and oral prescriptions shall be promptly reduced to writing and filed with the dispensing agent. Such prescription may not be filled or refilled more than six months after the date thereof or be refilled more than five times after the date of the prescription.
- No controlled substance included in Schedule V of this Article or paregoric, U.S.P., may be distributed or dispensed other than for a medical purpose.
- No controlled substance included in Schedule VI of this Article may be distributed or dispensed other than for scientific or research purposes by persons registered under, or permitted by, this Article to engage in scientific or research projects.
- No controlled substance shall be dispensed or distributed in this State unless such (f) substance shall be in a container clearly labeled in accord with regulations lawfully adopted and published by the federal government or the Commission.
- (g) When a copy of a prescription for a controlled substance under this Article is given as required by G.S. 90-70, such copy shall be plainly marked: "Copy – for information only." Copies of prescriptions for controlled substances shall not be filled or refilled.
- A pharmacist dispensing a controlled substance under this Article shall enter the date of dispensing on the prescription order pursuant to which such controlled substance was dispensed.
- A manufacturer's sales representative may distribute a controlled substance as a (i) complimentary sample only upon the written request of a practitioner. Such request must be made on each distribution and must contain the names and addresses of the supplier and the requester and the name and quantity of the specific controlled substance requested. The manufacturer shall maintain a record of each such request for a period of two years."
- **SECTION 7.** Article 5 of Chapter 90 of the General Statutes is amended by adding a new section to read:

"§ 90-106.3. Disposal of residual pain prescriptions following death of hospice or palliative care patient.

Any hospice or palliative care provider who prescribes a targeted controlled substance to be administered to a patient in his or her home for the treatment of pain as part of in-home hospice or palliative care shall, at the commencement of treatment, provide oral and written information to the patient and his or her family regarding the proper disposal of such targeted controlled substances. This information shall include the availability of permanent drop-boxes or periodic "drug take-back" events that allow for the safe disposal of controlled substances such as those permanent drop boxes and events that may be identified through North Carolina Operation Medicine Drop."

PART IV. CLARIFY ALLOWABLE FUNDS FOR SYRINGE EXCHANGE **PROGRAMS**

SECTION 8. G.S. 90-113.27(b)(2) reads as rewritten:

Needles, hypodermic syringes, and other injection supplies at no cost and in "(2)quantities sufficient to ensure that needles, hypodermic syringes, and other

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injection supplies are not shared or reused. No public-State funds may be 1 2 used to purchase needles, hypodermic syringes, or other injection supplies." 3 4 PART V. STRENGTHEN CONTROLLED SUBSTANCES REPORTING SYSTEM 5 **SECTION 9.** G.S. 90-113.72 reads as rewritten: 6 "§ 90-113.72. Definitions. 7 The following definitions apply in this Article: 8 "Commission" means the Commission. - The Commission for Mental (1)9 Health, Developmental Disabilities, and Substance Abuse Services established under Part 4 of Article 3 of Chapter 143B of the General 10 11 Statutes. "Controlled substance" means a Controlled Substance. - A controlled 12 (2) 13 substance as defined in G.S. 90-87(5). "Department" means the Department. - The Department of Health and 14 (3) 15 Human Services. "Dispenser" means a Dispenser. - A person who delivers a Schedule II (4) 16 17 through V controlled substance to an ultimate user in North Carolina, but does not include any of the following: 18 A licensed hospital or long-term care pharmacy that dispenses such 19 20 substances for the purpose of inpatient administration. Repealed by Session Laws 2013-152, s. 1, effective January 1, 2014, 21 b. and applicable to prescriptions delivered on or after that date. 22 23 A wholesale distributor of a Schedule II through V controlled C. 24 substance. 25 A person licensed to practice veterinary medicine pursuant to Article d. 11 of Chapter 90 of the General Statutes. 26 27 Pharmacy. – A person or entity holding a valid pharmacy permit pursuant to (4a) G.S. 90-85.21 or G.S. 90-85.21A. 28 29 "Ultimate user" means a Ultimate user. - A person who has lawfully (5) obtained, and who possesses, a Schedule II through V controlled substance 30 31 for the person's own use, for the use of a member of the person's household, or for the use of an animal owned or controlled by the person or by a 32 33 member of the person's household." 34 **SECTION 10.** G.S. 90-113.73 reads as rewritten: 35 "§ 90-113.73. Requirements for controlled substances reporting system; civil 36 penalties for failure to properly report. The Department shall establish and maintain a reporting system of prescriptions for 37 all Schedule II through V controlled substances. Each dispenser shall submit the information in 38 accordance with transmission methods and frequency established by rule by the Commission. 39 The Department may issue a waiver to a dispenser who is unable to submit prescription 40 information by electronic means. The waiver may permit the dispenser to submit prescription 41 information by paper form or other means, provided all information required of electronically 42 submitted data is submitted. The dispenser shall report the information required under this 43 section no later than the close of business three business days after the day when the 44 45 prescription was delivered, beginning the next day after the delivery date; however, dispensers are encouraged to report the information no later than 24 hoursthe close of the next business 46 day after the prescription the prescription is delivered; however dispensers are encouraged to 47

report the information no later than 24 hours after the prescription was delivered. The

information shall be submitted in a format as determined annually by the Department based on

the format used in the majority of the states operating a controlled substances reporting system. In the event the dispenser is unable to report the information within the timeframe required by

this section because the system is not operational or there is some other temporary electrical or technological failure, this inability shall be documented in the dispenser's records. Once the electrical or technological failure has been resolved, the dispenser shall promptly report the information.

- (b) The Commission shall adopt rules requiring dispensers to report the following information. The Commission may modify these requirements as necessary to carry out the purposes of this Article. The dispenser shall report:
 - (1) The dispenser's DEA number.
 - (2) The name of the patient for whom the controlled substance is being dispensed, and the patient's or if the controlled substance is dispensed for an animal, the name of the owner of the animal, and the following information of the patient or owner:
 - a. Full address, including city, state, and zip code,
 - b. Telephone number, and
 - c. Date of birth.
 - (3) The date the prescription was written.
 - (4) The date the prescription was filled.
 - (5) The prescription number.
 - (6) Whether the prescription is new or a refill.
 - (7) Metric quantity of the dispensed drug.
 - (8) Estimated days of supply of dispensed drug, if provided to the dispenser.
 - (9) National Drug Code of dispensed drug.
 - (10) Prescriber's DEA number.
 - (11) Method of payment for the prescription.
 - (12) If the prescriber is a physician assistant or a nurse practitioner, the name of that individual's supervising physician.
- (c) A dispenser shall not be required to report instances in which a controlled substance is provided directly to the ultimate user and the quantity provided does not exceed a 48-hour supply.
- (d) A dispenser shall not be required to report instances in which a Schedule V non-narcotic, non-anorectic Schedule V controlled substance is provided directly to the ultimate user for the purpose of assessing a therapeutic response when prescribed according to indications approved by the United States Food and Drug Administration.
- (e) The Department shall assess, against any pharmacy that employs dispensers found to have failed to report information in the manner required by this section within a reasonable period of time after being informed by the Department that the required information is missing or incomplete, a civil penalty of not more than one hundred dollars (\$100.00) for a first violation, two hundred fifty dollars (\$250) for a second violation, and five hundred dollars (\$500.00) for each subsequent violation if the pharmacy fails to report as required under this section, up to a maximum of five thousand dollars (\$5,000) per pharmacy per calendar year. Each day of a continuing violation shall constitute a separate violation. The clear proceeds of penalties assessed under this section shall be deposited to the Civil Penalty and Forfeiture Fund in accordance with Article 31A of Chapter 115C of the General Statutes. The Commission shall adopt rules to implement this subsection that include factors to be considered in determining the amount of the penalty to be assessed."

SECTION 11. G.S. 90-113.74(b1) reads as rewritten:

- "(b1) The Department may review the prescription information data in the controlled substances reporting system and upon review may:
 - (1a) Notify practitioners and their respective licensing boards of prescribing behavior that (i) increases risk of diversion of controlled substances, (ii)

increases risk of harm to the patient, or (iii) is an outlier among other practitioner behavior.

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SECTION 12. Article 5E of Chapter 90 of the General Statutes is amended by adding new sections to read:

"§ 90-113.74B. Mandatory dispenser registration for access to controlled substances reporting system; exception.

- (a) Within 30 days after obtaining an initial or renewal license to practice pharmacy, the licensee shall demonstrate to the satisfaction of the North Carolina Board of Pharmacy that he or she is registered for access to the controlled substances reporting system. A violation of this section may constitute cause for the Board of Pharmacy to suspend or revoke the license.
- (b) This section does not apply to a licensee employed in a pharmacy practice setting where a Schedule II, III, or IV controlled substance will not be dispensed.

"§ 90-113.74C. Practitioner use of controlled substances reporting system; mandatory reporting of violations.

- Prior to initially prescribing a targeted controlled substance to a patient, a (a) practitioner shall review the information in the controlled substances reporting system pertaining to the patient for the 12-month period preceding the initial prescription. For every subsequent three-month period that the targeted controlled substance remains a part of the patient's medical care, the practitioner shall review the information in the controlled substances reporting system pertaining to the patient for the 12-month period preceding the determination that the targeted controlled substance should remain a part of the patient's medical care. Each instance in which the practitioner reviews the information in the controlled substances reporting system pertaining to the patient shall be documented in the patient's medical record. In the event the practitioner is unable to review the information in the controlled substances reporting system pertaining to the patient because the system is not operational or there is some other temporary electrical or technological failure, this inability shall be documented in the patient's medical record. Once the electrical or technological failure has been resolved, the practitioner shall review the information in the controlled substances reporting system pertaining to the patient and the review shall be documented in the patient's medical record.
- (b) A practitioner may, but is not required to, review the information in the controlled substances reporting system pertaining to a patient prior to prescribing a targeted controlled substance to the patient in any of the following circumstances:
 - (1) The controlled substance is to be administered to a patient in a health care setting, hospital, nursing home, or residential care facility as defined in G.S. 14-32.2.
 - (2) The controlled substance is prescribed for the treatment of cancer or another condition associated with cancer.
 - (3) The controlled substance is prescribed to a patient in hospice care or palliative care.
- (c) The Department shall conduct periodic audits of the review of the controlled substances reporting system by prescribers. The Department shall determine a system for selecting a subset of prescriptions to examine during each auditing period. The Department shall report to the appropriate licensing board any prescriber found to be in violation of this section. A violation of this section may constitute cause for the licensing board to suspend or revoke a prescriber's license.

"§ 90-113.74D. Dispenser use of controlled substances reporting system.

(a) Prior to dispensing a targeted controlled substance, a dispenser shall review the information in the controlled substances reporting system pertaining to the patient for the preceding 12-month period and document this review under any of the following circumstances:

Annually on November 1, beginning November 1, 2019, the Department shall report to the Joint Legislative Oversight Committee on Health and Human Services, the North Carolina Medical Board, the North Carolina Board of Podiatry Examiners, the North Carolina Board of Nursing, the North Carolina Dental Board, the North Carolina Veterinary Medical Board, and the North Carolina Board of Pharmacy on data reported to the controlled substances reporting system. The report shall include at least all of the following information about targeted controlled substances reported to the system during the preceding calendar year:

- (1) The total number of prescriptions dispensed, broken down by Schedule.
- (2) <u>Demographics about the ultimate users to whom prescriptions were dispensed.</u>
- (3) Statistics regarding the number of pills dispensed per prescription.
- (4) The number of ultimate users who were prescribed a controlled substance by two or more practitioners.

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- (5) The number of ultimate users to whom a prescription was dispensed in more than one county.
- The categories of practitioners prescribing controlled substances and the number of prescriptions authorized by each category of practitioner. For the purpose of this subdivision, medical doctors, surgeons, palliative care practitioners, oncologists and other practitioners specializing in oncology, pain management practitioners, practitioners who specialize in hematology, including the treatment of Sickle Cell Disease, and practitioners who specialize in treating substance use disorder shall be treated as distinct categories of practitioners.
- (7) Any other data deemed appropriate and requested by the Joint Legislative Oversight Committee on Health and Human Services, the North Carolina Medical Board, the North Carolina Board of Nursing, the North Carolina Dental Board, the North Carolina Veterinary Medical Board, or the North Carolina Board of Pharmacy."

SECTION 13.(a) Section 12F.16(h) of Session Law 2015-241 reads as rewritten:

"SECTION 12F.16.(h) The Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DHHS), shall continue to work toward establishing interstate connectivity for the Controlled Substances Reporting System (CSRS) established under G.S. 90-113.73. DHHS shall apply for grant funding from the National Association of Boards of Pharmacy to establish the connection to PMP InterConnect.interstate connectivity for the CSRS. The Department shall request forty thousand thirty-five dollars (\$40,035) to establish the initial interface for PMP InterConnectinterstate connectivity for the CSRS and thirty thousand dollars (\$30,000) for two years of ongoing interstate connectivity service, maintenance, and support for PMP InterConnect in order to create interstate connectivity for the drug monitoring program as required by subdivision (2) of subsection (f) of this section.support."

SECTION 13.(b) Section 12F.16(i)(3) of Session Law 2015-241 reads as rewritten:

"(3) For the 2015-2016 fiscal year, the sum of forty thousand thirty-five dollars (\$40,035) shall be used to establish the initial interface for PMP InterConnect, interstate connectivity for the CSRS, as required by subdivision (2) of subsection (f) of this section. This amount shall be adjusted or eliminated if DHHS is successful in obtaining grant awards or identifying other allowable receipts for this purpose. If receipts are used for this purpose, this nonrecurring appropriation shall revert to the General Fund. Upon receipt of any grant funding used for this purpose or upon identification of other allowable receipts for this purpose, DHHS shall reimburse the General Fund for the costs associated with establishing interstate connectivity for the CSRS. The reimbursement amount shall be limited to the amount of any grant funding received by DHHS for this purpose plus the amount of any allowable receipts used by DHHS for this purpose, but shall not exceed the amount of the nonrecurring funds appropriated in this section."

PART VI. EFFECTIVE DATE

SECTION 14.(a) Sections 1, 2, 3, 4, 5, 7, 8, 11, and 13 of this act become effective July 1, 2017.

SECTION 14.(b) Subsections (a), (a1), and (a2) of G.S. 90-106, as amended by Section 6 of this act become effective January 1, 2020.

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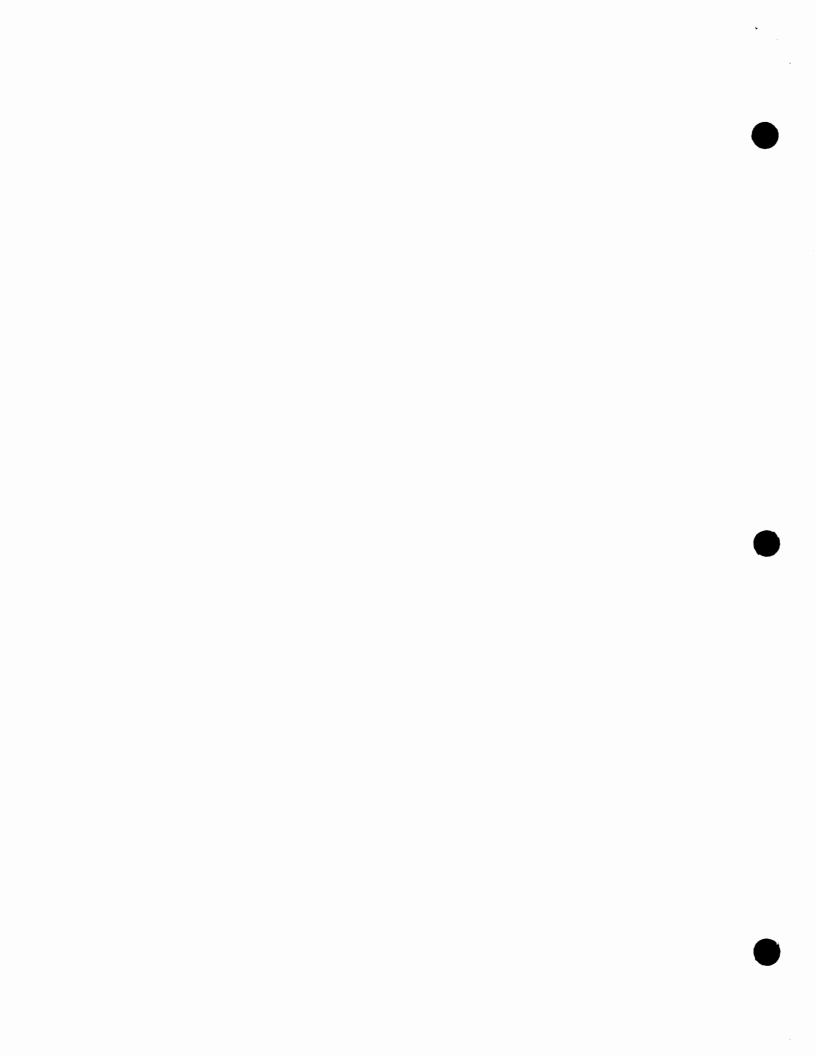
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SECTION 14.(c) Subsections (a3) and (a4) of G.S. 90-106, as amended by Section 6 of this act become effective January 1, 2018.

SECTION 14.(d) G.S. 90-113.75A and G.S. 90-113.75B, as enacted by Section 12 of this act, become effective September 1, 2017.

SECTION 14.(e) Subsection (b) of G.S. 90-113.73(b) as enacted by Section 10 of this act is effective when it becomes law. The remainder of Section 10 of this act becomes effective 30 days after the date the Chief Information Officer notifies the Revisor of Statutes that the Controlled Substance Reporting System (CSRS) database has the capability to record the information described in Section 10 of this act. The Chief Information Officer shall notify the Revisor of Statutes once the CSRS database has the capability to record the information described in Section 10 of this act.

SECTION 14.(f) The remainder of this act is effective when it becomes law and applies to acts committed 30 days after the date the State Chief Information Officer notifies the Revisor of Statutes that (i) the upgrades to the Controlled Substances Reporting System (CSRS) database described in subdivisions (1) and (2) of subsection (a) of Section 12F.7 of S.L. 2016-94 have been completed and (ii) the upgraded CSRS database is fully operational within the Department of Information Technology and connected to the statewide health information exchange.





HOUSE BILL 243: Strengthen Opioid Misuse Prevention (STOP)Act.

2017-2018 General Assembly

Committee:

House Health. If favorable, re-refer to Date:

March 29, 2017

Introduced by:

Appropriations Reps. Murphy, Davis, Malone, Horn

Prepared by: Augustus D. Willis

Analysis of:

PCS to First Edition

Committee Counsel

H243-CSTY-1

OVERVIEW: The PCS to House Bill 243 would (i) extend the statewide standing order for opioid antagonists to allow practitioners to prescribe an opioid antagonist to any governmental or nongovernmental agency (ii) designate certain Schedule II and III drugs as "targeted controlled substances and make changes to the laws governing the prescribing of those targeted controlled substances, (iii) clarify the allowable funds for syringe exchange programs, (iv) make changes to the statutes governing the Controlled Substance Reporting System (CSRS) database, and (v) amend language in the 2015 budget to facilitate the interstate connectivity of the CSRS database.

BILL ANALYSIS:

Part I. TITLE OF ACT

Section 1 sets forth the title of the act as the Strengthen Opioid Misuse Prevention (STOP) Act of 2017.

Part II. EXTEND STANDING ORDERS FOR OPIOID ANTAGONIST TO COMMUNITY HEALTH **GROUPS**

G.S. 90-12.7 sets forth statutes governing the prescribing of opioid antagonists for treatment of a drug overdose. These statutes allow a practitioner to, either directly or by standing order, prescribe an opioid antagonist to a person at risk of experiencing an opiate-related overdose, or their family member, friend, or other person in a position to assist such a person. In 2016, the General Assembly expanded this to allow the State Health Director to issue prescriptions to such persons by way of a statewide standing order.

Section 2 would amend the statutes on the treatment of overdoses with opioid antagonist to (1) allow the State Health Director to name a designee to prescribe an opioid antagonist by statewide standing order, and (2) allow practitioners to either directly, or by standing order, prescribe an opioid antagonist to any governmental or nongovernmental organization for the purpose of distribution to persons at risk of experiencing an opiate-related overdose or to a family member, friend, or other person in a position to assist such a person. Any organization distributing the opioid antagonist would be required to include with it basic instruction and information on how to administer it.

PART III. IMPROVE OPIOID PRESCRIBING PRACTICES

Current law authorizes licensed physician assistants and nurse practitioners to write prescriptions so long as a supervising physician has provided written instructions for prescribing drugs and a written policy for periodic review by the physician of drugs prescribed.

Karen Cochrane-Brown Director



Legislative Analysis Division 919-733-2578

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Absent an emergency situation, the dispensing of Schedule II controlled substances generally requires a written prescription, made out no more than 6 months prior to the date the substance is dispensed, with an exception that no prescription is needed if the substance is dispensed directly by a practitioner to an ultimate user. Prescriptions for Schedule II controlled substances may not be refilled. Schedule III and IV controlled substances require a prescription no older than 6 months old and may not be refilled more than five times after the date of the prescription.

Section 3 would define the new term "targeted controlled substance" to include certain controlled substances currently included in Schedule II and Schedule III of the Controlled Substances Act.

Section 4 would amend the statutes authorizing physician assistants to write prescriptions by requiring a physician assistant to consult with the supervising physician prior to prescribing controlled substances included in the newly defined term "targeted controlled substance" if the therapeutic use of the targeted controlled substance will or is expected to exceed a period of 30 days. For as long as a targeted controlled substance is continuously prescribed to the same patient, the physician assistant must consult with the supervising physician at least once every 90 days to verify that the prescription remains medically appropriate for the patient.

Section 5 would amend the statutes authorizing nurse practitioners to write prescriptions by including the same requirements in Section 4.

Section 6 would require electronic prescriptions for all controlled substances included in the newly defined term "targeted controlled substance" unless the prescription is issued by:

- A practitioner who is dispensing directly to an ultimate user.
- A practitioner who orders a controlled substance to be administered in a hospital, nursing home, hospice facility, or residential care facility.
- A practitioner who experiences temporary technological or electrical failure, or other extenuating circumstance that prevents the prescription from being transmitted electronically and the reason for this exception is documented in the patient's medical record.
- A practitioner who writes a prescription to be dispensed by a pharmacy located on federal property and the reason for this exception is documented in the patient's medical record.

Prescriptions for targeted controlled substances would be limited to no more than a 5 day supply upon the initial consultation and treatment of a patient for acute pain, unless the prescription is for post-operative acute pain relief immediately following a surgical procedure, in which case the practitioner may not prescribe more than a 7-day supply. Upon any subsequent consultation for the same pain, the practitioner may issue any appropriate renewal, refill, or new prescription for a targeted controlled substance. The terms "acute pain," "chronic pain," and "surgical procedure" are defined. Dispensers are not required to verify that a practitioner falls within one of the exceptions from the requirement that all targeted controlled substances be e-prescribed and dispensers may continue to dispense targeted controlled substances from valid written, oral, or facsimile prescriptions that are otherwise consistent with applicable laws. Dispensers are further immune from civil or criminal liability or disciplinary action from the Board of Pharmacy for dispensing a prescription written by a prescriber in violation of G.S. 90-106.

Section 7 would require any hospice or palliative care provider who prescribes a targeted controlled substance to be administered to a patient in the patient's home to provide oral and written information to the patient and the patient's family regarding the proper disposal of the controlled substance.

PART IV: CLARIFY ALLOWABLE FUNDS FOR SYRINGE EXCHANGE PROGRAMS

Page 3

Section 8 would clarify language in the statute authorizing needle and syringe exchange programs to prohibit the use of State funds to purchase needles, hypodermic syringes, or other injection supplies. Non-State public funds could still be used for this purpose.

PART V: STRENGTHEN CONTROLLED SUBSTANCES REPORTING SYSTEM

The Controlled Substances Reporting System (CSRS) is a database maintained by the Department of Health and Human Services that tracks prescriptions for Schedule II through V controlled substances. Dispensers are required to report certain information on prescriptions they fill within 3 days after the prescription is delivered, but are encouraged to report such information within 24 hours. Such information is confidential and may only be accessed by certain persons for specific purposes set forth by statute.

Section 9 would make technical changes to the definitions used in the CSRS laws, remove veterinarians from the exemption relating to CSRS laws, and define the term "pharmacy" as a person or entity who holds a valid pharmacy permit.

Section 10 would require dispensers to report required information by the close of the next business day after filling a prescription unless the system is temporarily not operational and the inability to report is documented in the dispenser's records. Section 10 also updates the information dispensers are required to report to include information for the owner of the animal for animal prescriptions and the name of the supervising physician if the prescription is written by a physician assistant or nurse practitioner. The Department of Health and Human Services would be required to assess civil penalties of up to \$100 for a first violation, up to \$250 for a second violation, and up to \$500 for each subsequent violation, not to exceed \$5,000 per pharmacy in a calendar year to pharmacies found to have failed to report required information within a reasonable period of time after being informed that such information is missing or incomplete.

Section 11 would amend the laws governing the confidentiality of CSRS data to allow the Department to notify practitioners and their respective licensing boards of prescribing behavior that increases risk of diversion of controlled substances, increases risk of harm to the patient, or is an outlier among other practitioner behavior.

Section 12 would add the following new sections to Article 5E of Chapter 90 of the General Statutes governing the CSRS:

- <u>90-113.74B</u>: would require recipients of new or renewed pharmacist licenses to demonstrate to the NC Board of Pharmacy registration for access to the CSRS within 30 days of licensure.
- 90-113.74C: would require practitioners to review a patient's 12-month history in the CSRS prior to prescribing "targeted controlled substance" and review the patient's 12-month history in the CSRS every three months while the targeted controlled substance remains part of the patient's medical care plan. These reviews would have to be documented in the patient's medical records, along with the occasion of any CSRS outage that prevents such a review; the practitioner would be required to review the 12-month history upon restoration of the CSRS after an outage. In addition, a practitioner would be able to, but not required to, review a patient's CSRS history if:

 (1) the controlled substance is to be administered to the patient in a hospital or other health care facility; (2) the controlled substance is for the treatment of cancer or a cancer-associated condition; or (3) the controlled substance is prescribed to a patient in hospice care.
- <u>90-113.74D</u>: would require a dispenser to review an individual's 12-month history in the CSRS prior to dispensing a targeted controlled substance whenever: 1) the dispenser believes the individual is seeking controlled substances for reasons other than treatment of a medical condition; 2) the prescriber is located outside of the usual area the dispenser serves; 3) the

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individual lives outside the usual area the dispenser serves; 4) the individual pays with cash when there is an insurance plan on file with the dispenser; or 5) the individual demonstrates potential misuse of a controlled substance. A dispenser would be required to withhold delivery of a prescription until verified if the dispenser believes it to be duplicative or fraudulent. Dispensers would be immune from civil or criminal liability for actions authorized by this section and failure to review the system prior to dispensing a controlled substance would not constitute medical negligence.

- 90-113.75A: would create a special revenue fund in DHHS for use in administering the CSRS.
- 90-113.75C: would require DHHS to make annual reports starting November 1, 2019, to the Joint Legislative Oversight Committee on Health and Human Services, the North Carolina Medical Board, the North Carolina Board of Podiatry Examiners, the North Carolina Board of Nursing, the North Carolina Dental Board, the North Carolina Veterinary Medicine Board, and the North Carolina Board of Pharmacy. The reports would be required to include specified data on targeted controlled substances reported to the CSRS database during the preceding calendar year.

Section 13 would amend language from the 2015 budget to facilitate the establishment of interstate connectivity for the CSRS database and require DHHS use any grant funding received for the purpose of establishing CSRS interstate connectivity to reimburse the General Fund for costs associated with establishing interstate connectivity for the CSRS database.

EFFECTIVE DATE: Sections 1, 2, 3, 4, 5, 7, 8, 11, and 13 would become effective July 1, 2017. The new subsections of G.S. 90-106 dealing with e-prescribing in Section 6 would become effective January 1, 2020. The new subsections of G.S. 90-106 establishing limits on initial prescriptions for acute pain in Section 6 would become effective January 1, 2018. The portion of Section 12 creating the new statutes G.S. 90-113.75A through G.S. 90-113.75C would become effective September 1, 2017. The portion of Section 10 updating the information required to be reported to the CSRS database by dispensers becomes effective 30 days after the date the Chief Information Officer notifies the Revisor of Statutes that the CSRS database has the capability to record the information required. The remainder of the act would become effective when it becomes law and would apply to acts committed on or after the date the State Chief Information Officer notifies the Revisor of Statutes that (i) the upgrades to the CSRS database described in subdivisions (1) and (2) of subsection (a) of Section 12F.7 of S.L. 2016-94 have been completed and (ii) the upgraded CSRS database is fully operational within the Department of Information Technology and connected to the statewide health information exchange.

GENERAL ASSEMBLY OF NORTH CAROLINA **SESSION 2017**

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HOUSE BILL 243*

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Short Title:

Strengthen Opioid Misuse Prevention (STOP)Act.

(Public)

Sponsors:

Representatives Murphy, Davis, Malone, and Horn (Primary Sponsors).

For a complete list of sponsors, refer to the North Carolina General Assembly web site.

Referred to:

Health, if favorable, Appropriations

March 6, 2017

A BILL TO BE ENTITLED AN ACT STRENGTHENING OPIOID MISUSE PREVENTION BY EXTENDING STANDING ORDERS FOR OPIOID ANTAGONIST TO COMMUNITY HEALTH GROUPS; REQUIRING SUPERVISING PHYSICIANS TO PERSONALLY CONSULT WITH PHYSICIAN ASSISTANTS AND NURSE PRACTITIONERS WHO PRESCRIBE SCHEDULE II THROUGH V CONTROLLED SUBSTANCES FOR LONG-TERM USE; REQUIRING ELECTRONIC PRESCRIBING OF SCHEDULE II THROUGH CONTROLLED SUBSTANCES; ESTABLISHING MAXIMUM LIMITS FOR INITIAL PRESCRIPTIONS OF SCHEDULE II THROUGH V CONTROLLED SUBSTANCES; CLARIFYING ALLOWABLE FUNDS FOR SYRINGE EXCHANGE PROGRAMS; REQUIRING VETERINARIAN PARTICIPATION IN THE CONTROLLED SUBSTANCES REPORTING SYSTEM: ESTABLISHING CIVIL PENALTIES FOR PHARMACIES THAT EMPLOY DISPENSERS WHO IMPROPERLY REPORT INFORMATION TO THE CONTROLLED SUBSTANCES REPORTING SYSTEM (CSRS); EXPANDING THE ROLE OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (DHHS) IN USING CSRS DATA TO DETECT AND PREVENT FRAUD AND MISUSE; MANDATING DISPENSER REGISTRATION FOR ACCESS THE CSRS; TO MANDATING DISPENSER AND PRACTITIONER USE OF THE CSRS; REQUIRING DHHS TO REPORT PRACTITIONERS WHO FAIL TO PROPERLY USE THE CSRS; CREATING A SPECIAL REVENUE FUND TO SUPPORT THE CSRS; IMPOSING AN ANNUAL FEE ON PRACTITIONERS TO BE DEPOSITED INTO THE CSRS SPECIAL REVENUE FUND; REQUIRING AN ANNUAL REPORT FROM DHHS ON THE CSRS; AND APPROPRIATING FUNDS FOR COMMUNITY-BASED SUBSTANCE USE DISORDER TREATMENT AND RECOVERY SERVICES.

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PART I. TITLE OF ACT

The General Assembly of North Carolina enacts:

SECTION 1. This act shall be known and may be cited as the "Strengthen Opioid Misuse Prevention Act of 2017" or the "STOP Act."

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PART II. EXTEND STANDING ORDERS FOR OPIOID ANTAGONIST TO **COMMUNITY HEALTH GROUPS**

SECTION 2. G.S. 90-12.7 reads as rewritten:

"§ 90-12.7. Treatment of overdose with opioid antagonist; immunity.



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- (a) As used in this section, "opioid antagonist" means naloxone hydrochloride that is approved by the federal Food and Drug Administration for the treatment of a drug overdose.
- (b) The following individuals may prescribe an opioid antagonist in the manner prescribed by this subsection:
 - (1) A practitioner acting in good faith and exercising reasonable care may directly or by standing order prescribe an opioid antagonist to (i) a person at risk of experiencing an opiate-related overdose or (ii) a family member, friend, or other person in a position to assist a person at risk of experiencing an opiate-related overdose. As an indicator of good faith, the practitioner, prior to prescribing an opioid under this subsection, may require receipt of a written communication that provides a factual basis for a reasonable conclusion as to either of the following:
 - a. The person seeking the opioid antagonist is at risk of experiencing an opiate-related overdose.
 - b. The person other than the person who is at risk of experiencing an opiate-related overdose, and who is seeking the opioid antagonist, is in relation to the person at risk of experiencing an opiate-related overdose:
 - 1. A family member, friend, or other person.
 - 2. In the position to assist a person at risk of experiencing an opiate-related overdose.
 - (2) The State Health Director <u>or a designee</u> may prescribe an opioid antagonist pursuant to subdivision (1) of this subsection by means of a statewide standing order.
 - (3) A practitioner acting in good faith and exercising reasonable care may directly or by standing order prescribe an opioid antagonist to any governmental or nongovernmental organization, including a local health department, a law enforcement agency, or an organization that promotes scientifically proven ways of mitigating health risks associated with substance use disorders and other high-risk behaviors, for the purpose of distributing, through its agents, the opioid antagonist to (i) a person at risk of experiencing an opiate-related overdose or (ii) a family member, friend, or other person in a position to assist a person at risk of experiencing an opiate-related overdose.
- (c) A pharmacist may dispense an opioid antagonist to a person described in subdivision (b)(1) of this section or organization pursuant to a prescription issued pursuant to in accordance with subsection (b) of this section. For purposes of this section, the term "pharmacist" is as defined in G.S. 90-85.3.
- (c1) A governmental or nongovernmental organization, including a local health department, a law enforcement agency, or an organization that promotes scientifically proven ways of mitigating health risks associated with substance use disorders and other high-risk behaviors may, through its agents, distribute an opioid antagonist obtained pursuant to a prescription issued in accordance with subdivision (3) of subsection (b) of this section to (i) a person at risk of experiencing an opiate-related overdose or (ii) a family member, friend, or other person in a position to assist a person at risk of experiencing an opiate-related overdose. An organization, through its agents, shall include with any distribution of an opioid antagonist pursuant to this subsection basic instruction and information on how to administer the opioid antagonist.
- (d) A person who receives an opioid antagonist that was prescribed pursuant to subsection (b) of this section or distributed pursuant to subsection (c1) of this section may administer an opioid antagonist to another person if (i) the person has a good faith belief that the other person is experiencing a drug-related overdose and (ii) the person exercises reasonable care in administering the drug to the other person. Evidence of the use of reasonable care in administering the drug shall include the receipt of basic instruction and information on how to administer the opioid antagonist.

- (e) All of the following individuals are immune from any civil or criminal liability for actions authorized by this section:
 - (1) Any practitioner who prescribes an opioid antagonist pursuant to subsection (b) of this section.
 - (2) Any pharmacist who dispenses an opioid antagonist pursuant to subsection (c) of this section.
 - (3) Any person who administers an opioid antagonist pursuant to subsection (d) of this section.
 - (4) The State Health Director acting pursuant to subsection (b) of this section.
 - (5) Any organization, or agent of the organization, that distributes an opioid antagonist pursuant to subsection (c1) of this section."

PART III. IMPROVE OPIOID PRESCRIBING PRACTICES

SECTION 3. G.S. 90-18.1(b) is amended by adding a new subdivision to read:

"(5) If the prescription is for a controlled substance included in Schedule II through V of Article 5 of Chapter 90 of the General Statutes and therapeutic use of the controlled substance will or is expected to exceed a period of 30 days, the physician assistant shall personally consult with the supervising physician prior to prescribing the controlled substance to verify that the prescription is medically appropriate for the patient. For as long as a Schedule II through V controlled substance is continuously prescribed to the same patient, the physician assistant shall consult with the supervising physician at least once every 90 days to verify that the prescription remains medically appropriate for the patient."

SECTION 4. G.S. 90-18.2(b) is amended by adding a new subdivision to read:

"(5) If the prescription is for a controlled substance included in Schedule II through V of Article 5 of Chapter 90 of the General Statutes and therapeutic use of the controlled substance will or is expected to exceed a period of 30 days, the nurse practitioner shall personally consult with the supervising physician prior to prescribing the controlled substance to verify that the prescription is medically appropriate for the patient. For as long as a Schedule II through V controlled substance is continuously prescribed to the same patient, the nurse practitioner shall consult with the supervising physician at least once every 90 days to verify that the prescription remains medically appropriate for the patient."

SECTION 5. G.S. 90-106 reads as rewritten:

"§ 90-106. Prescriptions and labeling.

- (a) Except when dispensed directly by a practitioner, other than a pharmacist, to an ultimate user, no controlled substance included in Schedule II of this Article may be dispensed without the written prescription of a practitioner. No Schedule II substance shall be dispensed pursuant to a written or electronic prescription more than six months after the date it was prescribed.
- (a1) Unless otherwise exempted by this subsection, a practitioner shall electronically prescribe all controlled substances included in Schedule II through V of this Article. This subsection does not apply to prescriptions for Schedule II through V controlled substances issued by any of the following:
 - (1) A practitioner, other than a pharmacist, who dispenses directly to an ultimate user.
 - (2) A practitioner who orders a controlled substance to be administered in a hospital, nursing home, hospice facility, or residential care facility as defined in G.S. 14-32.2.

- (3) A practitioner who experiences temporary technological or electrical failure that prevents the prescription from being transmitted electronically; provided, however, that the practitioner documents the reason for this exception in the patient's medical record.
- <u>(4)</u>
 - A practitioner who writes a prescription to be dispensed by a pharmacy located on federal property; provided, however, that the practitioner documents the reason for this exception in the patient's medical record.
 A dispenser is not required to verify that a practitioner properly falls under one of the
- (a2) A dispenser is not required to verify that a practitioner properly falls under one of the exceptions specified in subsection (a1) of this section prior to dispensing a controlled substance included in Schedule II through V of this Article. A dispenser may continue to dispense controlled substances included in Schedules II through V of this Article from valid written, oral, or facsimile prescriptions that are otherwise consistent with applicable laws.
- (a3) A practitioner may not prescribe more than a five-day supply of any controlled substance included in Schedule II through V of this Article upon the initial consultation and treatment of a patient for acute pain, unless the prescription is for immediate post-operative pain relief. A practitioner may not prescribe more than a seven-day supply of any controlled substance included in Schedule II through V of this Article for immediate post-operative pain relief. Upon any subsequent consultation for the same pain, the practitioner may issue any appropriate renewal, refill, or new prescription for a Schedule II through V controlled substance.
 - (a4) As used in this subsection, the following terms have the following meanings:
 - (1) Acute pain. Pain, whether resulting from disease, accident, intentional trauma, or other cause, that the practitioner reasonably expects to last for three months or less. The term does not include chronic pain or pain being treated as part of cancer care, hospice care, palliative care, or medication-assisted treatment for substance use disorder.
 - (2) <u>Chronic pain. Pain that typically lasts for longer than three months or that lasts beyond the time of normal tissue healing.</u>
- (b) In emergency situations, as defined by rule of the Commission, Schedule II drugs may be dispensed upon oral prescription of a practitioner, reduced promptly to writing and filed by the dispensing agent. Prescriptions shall be retained in conformity with the requirements of G.S. 90-104. No prescription for a Schedule II substance may be refilled.
- (c) Except when dispensed directly by a practitioner, other than a pharmacist, to an ultimate user, no controlled substance included in Schedules III or IV, except paregoric, U.S.P., as provided in G.S. 90-91(e)1, may be dispensed without a prescription, and oral prescriptions shall be promptly reduced to writing and filed with the dispensing agent. Such prescription may not be filled or refilled more than six months after the date thereof or be refilled more than five times after the date of the prescription.
- (d) No controlled substance included in Schedule V of this Article or paregoric, U.S.P., may be distributed or dispensed other than for a medical purpose.
- (e) No controlled substance included in Schedule VI of this Article may be distributed or dispensed other than for scientific or research purposes by persons registered under, or permitted by, this Article to engage in scientific or research projects.
- (f) No controlled substance shall be dispensed or distributed in this State unless such substance shall be in a container clearly labeled in accord with regulations lawfully adopted and published by the federal government or the Commission.
- (g) When a copy of a prescription for a controlled substance under this Article is given as required by G.S. 90-70, such copy shall be plainly marked: "Copy for information only." Copies of prescriptions for controlled substances shall not be filled or refilled.
- (h) A pharmacist dispensing a controlled substance under this Article shall enter the date of dispensing on the prescription order pursuant to which such controlled substance was dispensed.

 (i) A manufacturer's sales representative may distribute a controlled substance as a complimentary sample only upon the written request of a practitioner. Such request must be made on each distribution and must contain the names and addresses of the supplier and the requester and the name and quantity of the specific controlled substance requested. The manufacturer shall maintain a record of each such request for a period of two years."

SECTION 6. Article 5 of Chapter 90 of the General Statutes is amended by adding a new section to read:

"§ 90-106.3. Disposal of residual pain prescriptions following death of hospice or palliative care patient.

Any hospice or palliative care provider who prescribes a controlled substance included in Schedule II through V of this Article to be administered to a patient in his or her home for the treatment of pain as part of in-home hospice or palliative care shall make diligent efforts to ensure that any residual portion of the controlled substance is safely disposed of following the death of the patient. The hospice or palliative care provider shall comply with all applicable State and federal laws in carrying out the requirements of this section."

SECTION 7. Article 51 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"§ 58-51-56. Limitation on co-payments for limited, initial opioid prescriptions.

Every health benefit plan delivered or issued for delivery in this State that provides coverage for prescription drugs subject to co-payment shall charge a co-payment for a limited, initial prescription of a Schedule II through V controlled substance prescribed in accordance with G.S. 90-106(a3) in an amount that is (i) proportional between the co-payment charged for a 30-day supply of the controlled substance and the amount of the controlled substance prescribed to the beneficiary or (ii) equivalent to the co-payment for a 30-day supply of the controlled substance; provided, however, that the health benefit plan shall not subject the beneficiary to any additional co-payments for any additional prescriptions of the same controlled substance for the remainder of the 30-day supply."

PART IV. CLARIFY ALLOWABLE FUNDS FOR SYRINGE EXCHANGE PROGRAMS SECTION 8. G.S. 90-113.27(b)(2) reads as rewritten:

"(2) Needles, hypodermic syringes, and other injection supplies at no cost and in quantities sufficient to ensure that needles, hypodermic syringes, and other injection supplies are not shared or reused. No <u>public-State</u> funds may be used to purchase needles, hypodermic syringes, or other injection supplies."

PART V. STRENGTHEN CONTROLLED SUBSTANCES REPORTING SYSTEM SECTION 9. G.S. 90-113.72 reads as rewritten:

"§ 90-113.72. Definitions.

The following definitions apply in this Article:

- (1) "Commission" means the Commission. The Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services established under Part 4 of Article 3 of Chapter 143B of the General Statutes.
- (2) "Controlled substance" means a Controlled Substance. A controlled substance as defined in G.S. 90-87(5).
- (3) "Department" means the Department. The Department of Health and Human Services.
- (4) "Dispenser" means a Dispenser. A person who delivers a Schedule II through V controlled substance to an ultimate user in North Carolina, but does not include any of the following:
 - a. A licensed hospital or long-term care pharmacy that dispenses such substances for the purpose of inpatient administration.

G.S. 90-85.21 or G.S. 90-85.21A.

"Ultimate user" means a Ultimate user. – A person who has lawfully obtained, and who possesses, a Schedule II through V controlled substance for the

person's own use, for the use of a member of the person's household, or for the

use of an animal owned or controlled by the person or by a member of the

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person's household." **SECTION 10.** G.S. 90-113.73 reads as rewritten:

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"§ 90-113.73. Requirements for controlled substances reporting system.system; civil penaltics for failure to properly report.

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(a) The Department shall establish and maintain a reporting system of prescriptions for all Schedule II through V controlled substances. Each dispenser shall submit the information in accordance with transmission methods and frequency established by rule by the Commission. The Department may issue a waiver to a dispenser who is unable to submit prescription information by electronic means. The waiver may permit the dispenser to submit prescription information by paper form or other means, provided all information required of electronically submitted data is submitted. The dispenser shall report the information required under this section no later than the close of business three business days after the day when the prescription was delivered, beginning the next day after the delivery date; however, dispensers are encouraged to report the information no later than 24 hours after the prescription was delivered. The information shall be submitted in a format as determined annually by the Department based on the format used in the majority of the states operating a controlled substances reporting system.

(b) The Commission shall adopt rules requiring dispensers to report the following information. The Commission may modify these requirements as necessary to carry out the purposes of this Article. The dispenser shall report:

(1) The dispenser's DEA number.

- (2) The name of the patient for whom the controlled substance is being dispensed, and the patient's:
 - a. Full address, including city, state, and zip code,
 - b. Telephone number, and
 - c. Date of birth.
- (3) The date the prescription was written.
- (4) The date the prescription was filled.
- (5) The prescription number.
- (6) Whether the prescription is new or a refill.
- (7) Metric quantity of the dispensed drug.
- (8) Estimated days of supply of dispensed drug, if provided to the dispenser.
- (9) National Drug Code of dispensed drug.
- (10) Prescriber's DEA number.
- (11) Method of payment for the prescription.

(c) A dispenser shall not be required to report instances in which a controlled substance is provided directly to the ultimate user and the quantity provided does not exceed a 48-hour supply.

(d) A dispenser shall not be required to report instances in which a Schedule V non-narcotic, non-anorectic Schedule V controlled substance is provided directly to the ultimate user for the purpose of assessing a therapeutic response when prescribed according to indications approved by the United States Food and Drug Administration.

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The Department shall assess, against any pharmacy that employs dispensers found to have failed to report information in the manner required by this section within a reasonable period of time after being informed by the Department that the required information is missing or incomplete, a civil penalty of not more than two hundred fifty dollars (\$250.00) for a first violation and five hundred dollars (\$500.00) for each subsequent violation if the pharmacy fails to report as required under this section, up to a maximum of ten thousand dollars (\$10,000) per pharmacy per calendar year. Each day of a continuing violation shall constitute a separate violation. The clear proceeds of penalties assessed under this section shall be deposited to the Civil Penalty and Forfeiture Fund in accordance with Article 31A of Chapter 115C of the General Statutes. The Commission shall adopt rules to implement this subsection that include factors to be considered in determining the amount of the penalty to be assessed."

SECTION 11. G.S. 90-113.74(b1) reads as rewritten:

- The Department may review the prescription information data in the controlled substances reporting system and upon review may:
 - Notify practitioners of prescribing behavior that (i) increases risk of diversion (1a) of controlled substances, (ii) increases risk of harm to the patient, or (iii) is an outlier among other practitioner behavior.

SECTION 12. G.S. 90-113.74(c) reads as rewritten:

- The Department shall release data in the controlled substances reporting system to the "(c) following persons only:
 - (11)Any third-party payer or pharmacy benefits manager acting as agent of a third-party payer, for the purposes of (i) claimant case management, (ii) detection of inappropriate prescribing of a controlled substance to a claimant, or (iii) detection of misuse or diversion of a controlled substance by a claimant."

SECTION 13. Article 5E of Chapter 90 of the General Statutes is amended by adding new sections to read:

"§ 90-113.74A. Mandatory dispenser registration for access to controlled substances reporting system.

Within 30 days after obtaining an initial or renewal license to practice pharmacy, the licensee shall demonstrate to the satisfaction of the North Carolina Board of Pharmacy that he or she is registered for access to the controlled substances reporting system. A violation of this section may constitute cause for the Board of Pharmacy to suspend or revoke the license.

"§ 90-113.74B. Practitioner use of controlled substances reporting system; mandatory reporting of violations.

(a) Prior to initially prescribing a Schedule II through V controlled substance to a patient, a practitioner shall review the information in the controlled substances reporting system pertaining to the patient for the 12-month period preceding the initial prescription. For every subsequent three-month period that the controlled substance remains a part of the patient's medical care, the practitioner shall review the information in the controlled substances reporting system pertaining to the patient for the 12-month period preceding the determination that the controlled substance should remain a part of the patient's medical care. Each instance in which the practitioner reviews the information in the controlled substances reporting system pertaining to the patient shall be documented in the patient's medical record. In the event the practitioner is unable to review the information in the controlled substances reporting system pertaining to the patient because the system is not operational or there is some other electrical or technological failure, this inability shall be documented in the patient's medical record. Once the electrical or technological failure has been resolved, the practitioner shall review the information in the controlled substances

General Assembly Of North Carolina Session 2017 reporting system pertaining to the patient and the review shall be documented in the patient's 1 2 medical record. 3 (b) A practitioner may, but is not required to, review the information in the controlled 4 substances reporting system pertaining to a patient prior to prescribing a Schedule II through V 5 controlled substance to the patient in any of the following circumstances: 6 The controlled substance is to be administered to a patient in a health care (1) 7 setting, hospital, nursing home, or residential care facility as defined in 8 G.S. 14-32.2. 9 The controlled substance is prescribed for the treatment of cancer or another (2) 10 condition associated with cancer. The controlled substance is prescribed to a patient in hospice care or palliative 11 (3) 12 13 The controlled substance is prescribed in an amount indicated for a period not (4) 14 to exceed five days and does not allow a refill, or for a period not to exceed 15 seven days if the prescription indicates the controlled substance is for 16 immediate post-operative pain relief. 17 The Department shall conduct periodic audits of the review of the controlled (c) 18 substances reporting system by prescribers. The Department shall determine a system for selecting 19 a subset of prescriptions to examine during each auditing period. The Department shall report to 20 the appropriate licensing board any prescriber found to be in violation of this section. A violation 21 of this section may constitute cause for the licensing board to suspend or revoke a prescriber's 22 license. 23 "§ 90-113.74C. Dispenser use of controlled substances reporting system. 24 Prior to dispensing a Schedule II through V controlled substance, a dispenser shall 25 review the information in the controlled substances reporting system pertaining to the patient for 26 the preceding 12-month period and document this review whenever: The dispenser has a reasonable belief that the ultimate user may be seeking a 27 (1) Schedule II through V controlled substance for any reason other than the 28 29 treatment of the ultimate user's existing medical condition. The prescriber is located outside of the usual geographic area served by the 30 (2) 31 dispenser. 32 (3) The ultimate user resides outside of the usual geographic area served by the 33 dispenser. 34 (4) The ultimate user pays for the prescription with cash when the patient has 35 prescription insurance on file with the dispenser. The ultimate user demonstrates potential misuse of a controlled substance by 36 (5) 37 any one or more of the following: Over-utilization of the controlled substance. 38 a. 39 Requests for early refills. <u>b.</u> Utilization of multiple prescribers. 40 C.

> An appearance of being overly sedated or intoxicated upon presenting a d. prescription.

> A request by an unfamiliar ultimate user for an opioid drug by a specific e. name, street name, color, or identifying marks.

If a dispenser has reason to believe a prescription for a Schedule II through V controlled substance is fraudulent or duplicative, the dispenser shall withhold delivery of the prescription until the dispenser is able to contact the prescriber and verify that the prescription is medically appropriate. A dispenser shall be immune from any civil or criminal liability for actions authorized by this subsection.

"\$ 90-113.75A. Creation of Controlled Substances Reporting System Fund.

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- (a) The Controlled Substances Reporting System Fund is created within the Department as a special revenue fund. The Department shall administer the Fund. The Department shall use the Fund only for operation of the controlled substances reporting system and to carry out the provisions of this Article.
 - (b) The Fund shall consist of the following:
 - (1) Moneys transmitted to the Fund pursuant to G.S. 90-113.75B.
 - (2) Any moneys appropriated to the Fund by the General Assembly.
 - (3) Any moneys received from State, federal, private, or other sources for deposit into the Fund.
- (c) All interest that accrues to the Fund shall be credited to the Fund. Any balance remaining in the Fund at the end of any fiscal year shall remain in the Fund and shall not revert to the General Fund.

"§ 90-113.75B. Controlled substances reporting system fee.

- (a) Beginning January 1, 2018, each licensing board authorized to issue an initial or renewal license that confers upon the licensee the authority to prescribe a controlled substance for the purpose of providing medical care for a patient shall impose an annual controlled substances reporting system fee in the amount of twenty dollars (\$20.00) on the licensee. This fee shall be in addition to any other initial or renewal license fee the licensing board is authorized to collect from the licensee under Chapter 90 of the General Statutes. The licensing board shall collect the fee required by this subsection at the same time it collects the initial or renewal license fee imposed on the licensee. Each licensing board shall retain ten percent (10%) of the total amount of moneys collected for the controlled substances reporting system fee pursuant to this subsection to cover the costs incurred by the licensing board for collecting and providing an accounting of all moneys received as payment of this fee. On the first day of each calendar quarter, each licensing board shall transmit ninety percent (90%) of the total amount of moneys collected pursuant to this subsection during the preceding calendar quarter to the Controlled Substances Reporting System Fund created in G.S. 90-113.75A.
- (b) This section shall not be construed to apply to an individual licensed to practice veterinary medicine pursuant to Article 11 of Chapter 90 of the General Statutes.

"§ 90-113.75C. Annual report to General Assembly and licensing boards.

Annually on November 1, beginning November 1, 2018, the Department shall report to the Joint Legislative Oversight Committee on Health and Human Services, the North Carolina Medical Board, the North Carolina Board of Nursing, the North Carolina Dental Board, the North Carolina Veterinary Medical Board, and the North Carolina Board of Pharmacy on data reported to the controlled substances reporting system. The report shall include at least all of the following information about Schedule II through V controlled substances reported to the system during the preceding calendar year:

- (1) The total number of prescriptions dispensed, broken down by Schedule.
- (2) Demographics about the ultimate users to whom prescriptions were dispensed.
- (3) Statistics regarding the number of pills dispensed per prescription.
- (4) The number of ultimate users who were prescribed a controlled substance by two or more practitioners.
- (5) The number of ultimate users to whom a prescription was dispensed in more than one county.
- (6) The categories of practitioners prescribing controlled substances and the number of prescriptions authorized by each category of practitioner. For the purpose of this subdivision, medical doctors and surgeons shall be treated as distinct categories of practitioners.
- (7) Prescribing behavior of practitioners that (i) increases risk of diversion of controlled substances, (ii) increases risk of harm to the patient, or (iii) is an outlier among other practitioner behavior.

(8)

Any other data deemed appropriate and requested by the Joint Legislative Oversight Committee on Health and Human Services, the North Carolina Medical Board, the North Carolina Board of Nursing, the North Carolina Dental Board, the North Carolina Veterinary Medical Board, or the North Carolina Board of Pharmacy."

PART VI. APPROPRIATION FOR COMMUNITY-BASED SUBSTANCE USE DISORDER TREATMENT AND RECOVERY SERVICES

SECTION 14. There is appropriated from the General Fund to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, the sum of ten million dollars (\$10,000,000) for the 2017-2018 fiscal year and the sum of ten million dollars (\$10,000,000) for the 2018-2019 fiscal year. These funds shall not be used for any purpose other than to increase the availability of community-based treatment and recovery services for substance use disorders, including medication-assisted treatment. These funds shall not supplant existing funds for community-based treatment and recovery services for substance use disorders.

PART VII. EFFECTIVE DATE

SECTION 15.(a) Sections 1, 2, 3, 4, 6, 8, and 14 of this act become effective July 1, 2017.

SECTION 15.(b) Sections 5 and 7 of this act become effective July 1, 2018.

SECTION 15.(c) G.S. 90-113.75A through G.S. 90-113.75C, as enacted by Section 13 of this act, become effective September 1, 2017.

SECTION 15.(d) The remainder of this act is effective when it becomes law and applies to acts committed on or after the date the State Chief Information Officer notifies the Revisor of Statutes that (i) the upgrades to the Controlled Substances Reporting System (CSRS) database described in subdivisions (1) and (2) of subsection (a) of Section 12F.7 of S.L. 2016-94 have been completed and (ii) the upgraded CSRS database is fully operational within the Department of Information Technology and connected to the statewide health information exchange.

GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2017

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HOUSE BILL 425 PROPOSED COMMITTEE SUBSTITUTE H425-CSSH-9 [v.3]

03/28/2017	05:18:49	PM
03/20/201/	03.10.77	T TAT

Short Title:	Improve Utilization of MH Professionals.	(Public
Sponsors:		
Referred to:		

March 22, 2017

A BILL TO BE ENTITLED

AN ACT ALLOWING LICENSED CLINICAL ADDICTION SPECIALISTS TO FORM A PROFESSIONAL CORPORATION WITH A PHYSICIAN AND AUTHORIZING THE SECRETARY OF HEALTH AND HUMAN SERVICES TO ALLOW LICENSED PROFESSIONAL COUNSELORS AND LICENSED MARRIAGE AND FAMILY THERAPISTS TO CONDUCT INITIAL (FIRST-LEVEL) EXAMINATIONS FOR THE INVOLUNTARY COMMITMENT OF INDIVIDUALS WITH A MENTAL ILLNESS OR SUBSTANCE USE DISORDER.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 55B-14(c)(4) reads as rewritten:

"(4) A physician, a licensed psychologist, a licensed clinical social worker, or each of them and a certified clinical specialist in psychiatric and mental health nursing, a licensed marriage and family therapist, a licensed professional counselor, a licensed clinical addictions specialist, or each of them, to render psychotherapeutic and related services that the respective stockholders are licensed, certified, or otherwise approved to provide."

SECTION 2. G.S. 122C-263.1(a) reads as rewritten:

- "(a) The Secretary of Health and Human Services may, upon request of an LME, waive the requirements of G.S. 122C-261 through G.S. 122C-263 and G.S. 122C-281 through G.S. 122C-283 pertaining to initial (first-level) examinations by a physician or eligible psychologist of individuals meeting the criteria of G.S. 122C-261(a) or G.S. 122C-281(a), as applicable, as follows:
 - (1) The Secretary has received a request from an LME to substitute for a physician or eligible psychologist, a licensed clinical social worker, a licensed professional counselor, a licensed marriage and family therapist, a master's level psychiatric nurse, or a master's level certified clinical addictions specialist in accordance with subdivision (8) of this subsection to conduct the initial (first-level) examinations of individuals meeting the criteria of G.S. 122C-261(a) or G.S. 122C-281(a). In making this type of request, the LME shall specifically describe all of the following:
 - a. How the purpose of the statutory requirement would be better served by waiving the requirement and substituting the proposed change under the waiver.
 - b. How the waiver will enable the LME to improve the delivery or management of mental health, developmental disabilities, and substance abuse services.



D

Ge	neral Asseml	bly Of North Carolina	Session 2017
1 —		c. How the health, safety, and welfare of individu	uals will continue to be
2		at least as well protected under the waiver	as under the statutory
3		requirement.	
4	•••	•	
5	(5)	In no event shall the substitution of a licensed of	clinical social worker,
6		licensed professional counselor, a licensed marriage	and family therapist,
7		master's level psychiatric nurse, or master's level certi-	ified clinical addictions
8		specialist under a waiver granted under this sec	tion be construed as
9		authorization to expand the scope of practice of the	
0		worker, the licensed professional counselor, the l	icensed marriage and
1		family therapist, the master's level psychiatric nurse	e, or the master's level
2		certified clinical addictions specialist.	
3		•	
4	(8)	A master's level certified clinical addiction addictions	specialist shall only be
5	, ,	authorized to conduct the initial examination of in	dividuals meeting the
6		criteria of G.S. 122C-281(a).	
7	11	• •	
Q	SFC'	TION 3 This act becomes effective October 1 2017	

Page 2 House Bill 425 H425-CSSH-9 [v.3]



HOUSE BILL 425: Improve Utilization of MH Professionals.

2017-2018 General Assembly

Committee:

House Health

Introduced by: Reps. Dobson, Dollar, Murphy, Earle

Analysis of:

PCS to First Edition

H425-CSSH-9

Date:

March 28, 2017

Prepared by: Theresa Matula

Committee Staff

OVERVIEW: House Bill 425 would allow a licensed clinical addictions specialist to be a member of a professional corporation that provides psychotherapeutic and related services and includes a licensed professional counselor in the list of professionals that can substitute for a physician or eligible psychologist in providing initial examinations for involuntary commitment of individuals with a mental illness or substance use disorder when requested by a local management entity and approved by the Secretary. The bill would become effective October 1, 2017.

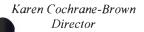
The PCS adds licensed marriage and family therapists to the amendments in Section 2 of the bill that add licensed professional counselors and makes technical changes to correct the references to licensed clinical additions specialist.

CURRENT LAW: Chapter 55B is the Professional Corporation Act. G.S. 55B-2(5) defines a "professional corporation" as a corporation engaged in rendering the professional services as specified and defined, pursuant to a certificate of registration issued by the Licensing Board regulating the profession or practice, and which has as its shareholders only those individuals permitted, designates itself as may be required by this statute, and is organized under the provisions of Chapter 55B and of Chapter 55, the North Carolina Business Corporation Act. G.S. 55B-14(c) allows a professional corporation to be formed by and between or among various professionals. G.S. 55B-14(c)(4) specifically allows a professional corporation to be formed by a physician, a licensed psychologist, a licensed clinical social worker, or each of them and a certified clinical specialist in psychiatric and mental health nursing, a licensed marriage and family therapist, a licensed professional counselor, or each of them, to render psychotherapeutic and related services that the respective stockholders are licensed, certified, or otherwise approved to provide.

G.S. 122C-261.1(a)(1) allows the Secretary to waive statutory requirements when he or she has received a request from a Local Management Entity to substitute for a physician or eligible psychologist, a licensed clinical social worker, a master's level psychiatric nurse, or a master's level certified clinical addictions specialist when conducting (first level) examinations and when the LME has specifically described three prescribed criteria.

BILL ANALYSIS: Section 1 of House Bill 425 would amend G.S. 55B-14(c)(4) to allow a professional corporation that renders psychotherapeutic and related services to include a licensed clinical addictions specialist.

¹ Chapter 122C, Article 5, Part 7 Involuntary Commitment of the Mentally III: G.S. 122C-261, G.S. 122C-262, G.S. 122C-263 and Part 8 Involuntary Commitment of Substance Abusers: G.S. 122C-281, G.S. 122C-282, G.S. 122C-283.





Legislative Analysis Division 919-733-2578

Page 2

Section 2 of the PCS would amend G.S. 122C-263.1(a)(1) to include a licensed professional counselor and a licensed marriage and family therapist in the list of professionals that can be substituted for a physician or eligible psychologist conducting initial (first-level) examinations for involuntary commitment of individuals with a mental illness or a substance use disorder when requested by the Local Management Entity and approved by the Secretary.

A conforming change is made to subdivision (5) to include the licensed professional counselor and licensed marriage and family therapist.

Additionally subdivision (8) is amended by the PCS to reference clinical "addictions" specialist to conform to the term used in Chapter 90, Article 5C: North Carolina Substance Abuse Practice Act.

EFFECTIVE DATE: House Bill 425 would become effective October 1, 2017.

GENERAL ASSEMBLY OF NORTH CAROLINA **SESSION 2017**

H

HOUSE BILL 425

1

Short Title: Improve Utilization of MH Professionals. (Public) Sponsors: Representatives Dobson, Dollar, Murphy, and Earle (Primary Sponsors). For a complete list of sponsors, refer to the North Carolina General Assembly web site. Referred to: Health March 22, 2017

A BILL TO BE ENTITLED AN ACT ALLOWING LICENSED CLINICAL ADDICTION SPECIALISTS TO FORM A PROFESSIONAL CORPORATION WITH A PHYSICIAN AND AUTHORIZING THE SECRETARY OF HEALTH AND HUMAN SERVICES TO ALLOW LICENSED PROFESSIONAL COUNSELORS TO CONDUCT INITIAL (FIRST-LEVEL) EXAMINATIONS FOR THE INVOLUNTARY COMMITMENT OF INDIVIDUALS WITH A MENTAL ILLNESS OR SUBSTANCE USE DISORDER.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 55B-14(c)(4) reads as rewritten:

A physician, a licensed psychologist, a licensed clinical social worker, or each of them and a certified clinical specialist in psychiatric and mental health nursing, a licensed marriage and family therapist, a licensed professional counselor, a licensed clinical addiction specialist, or each of them, to render psychotherapeutic and related services that the respective stockholders are licensed, certified, or otherwise approved to provide."

SECTION 2. G.S. 122C-263.1(a) reads as rewritten:

- The Secretary of Health and Human Services may, upon request of an LME, waive "(a) the requirements of G.S. 122C-261 through G.S. 122C-263 and G.S. 122C-281 through G.S. 122C-283 pertaining to initial (first-level) examinations by a physician or eligible psychologist of individuals meeting the criteria of G.S. 122C-261(a) or G.S. 122C-281(a), as applicable, as follows:
 - (1)The Secretary has received a request from an LME to substitute for a physician or eligible psychologist, a licensed clinical social worker, a licensed professional counselor, a master's level psychiatric nurse, or a master's level certified clinical addictions specialist in accordance with subdivision (8) of this subsection to conduct the initial (first-level) examinations of individuals meeting the criteria of G.S. 122C-261(a) or G.S. 122C-281(a). In making this type of request, the LME shall specifically describe all of the following:
 - How the purpose of the statutory requirement would be better served by waiving the requirement and substituting the proposed change under the waiver.
 - How the waiver will enable the LME to improve the delivery or b. management of mental health, developmental disabilities, and substance abuse services.



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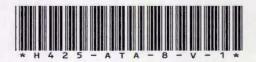
Ge	ral Assembly Of North Carolina Session 2017
1	c. How the health, safety, and welfare of individuals will continue to be
2	at least as well protected under the waiver as under the statutory
3	requirement.
4	
5	(5) In no event shall the substitution of a licensed clinical social worker,
6	licensed professional counselor, master's level psychiatric nurse, or master's
7	level certified clinical addictions specialist under a waiver granted under this
8	section be construed as authorization to expand the scope of practice of the
9	licensed clinical social worker, the licensed professional counselor, the
0	master's level psychiatric nurse, or the master's level certified clinical
1	addictions specialist.
2	
3	SECTION 3. This act becomes effective October 1, 2017.

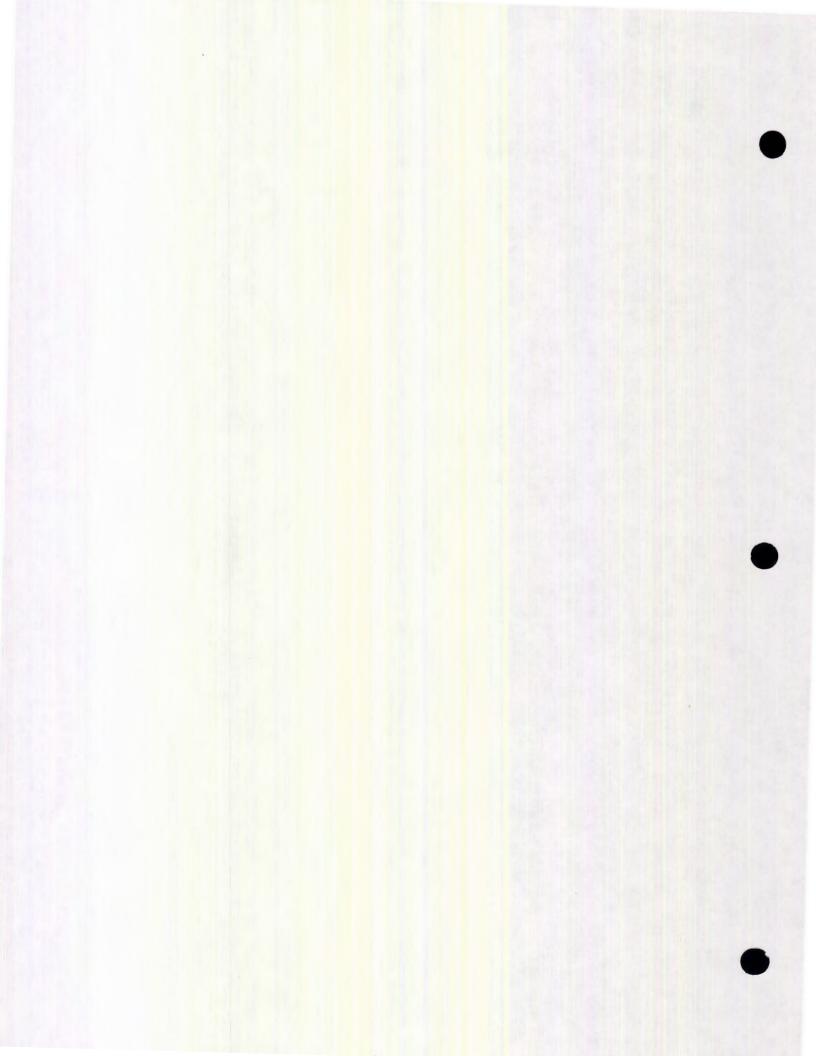


NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT House Bill 425

AMENDMENT NO.

	H425-ATA-8 [v.1]		,	be filled in Principal Cler	
	11425-A1A-6 [V.1]			Tinoipai Cici	Page 1 of 1
	Amends Title [NO] H425-CSSH-9		Date	3- 29	,2017
	Representative Insko				
1 2 3 4 5 6 7 8	moves to amend the b	ill on page 1, lines 5-6 b	y rewriting those li	ines to read:	
	PROFESSIONAL EXAMINATIONS FO	COUNSELORS TO OR THE;	CONDUCT	INITIAL	(FIRST-LEVEL)
	And on page 1, line 25, by rewriting the line to read: "licensed professional counselor, a";				
9 10 11	and on page 2, Line 6, by rewriting the line to read: "licensed professional counselor,"				
12 13 14 15	and on page 2, lines 10 and 11 by rewriting those line to read: "worker, the licensed professional counselor, the master's level psychiatric nurse, or the master's level".				
16					
	SIGNED Ves	Amendment Spo	nsor		
	SIGNEDCommit	tee Chair if Senate Com	mittee Amendmen	t	
	ADOPTED	FAILED		TABLEI)





NORTH CAROLINA GENERAL ASSEMBLY HOUSE OF REPRESENTATIVES

HEALTH COMMITTEE REPORT

Representative Justin P. Burr, Co-Chair Representative Josh Dobson, Co-Chair Representative Bert Jones, Co-Chair Representative Donny Lambeth, Co-Chair Representative Gregory F. Murphy, MD, Co-Chair

FAVORABLE COM SUB, UNFAVORABLE ORIGINAL BILL

HB 425 Improve Utilization of MH Professionals.

Draft Number: H425-PCS40312-SH-9

Serial Referral: None
Recommended Referral: None
Long Title Amended: Yes
Floor Manager: Dobson

FAVORABLE COM SUB, UNFAVORABLE ORIGINAL BILL AND RE-REFERRED

HB **243** Strengthen Opioid Misuse Prevention (STOP)Act.

Draft Number: H243-PCS10185-TY-1

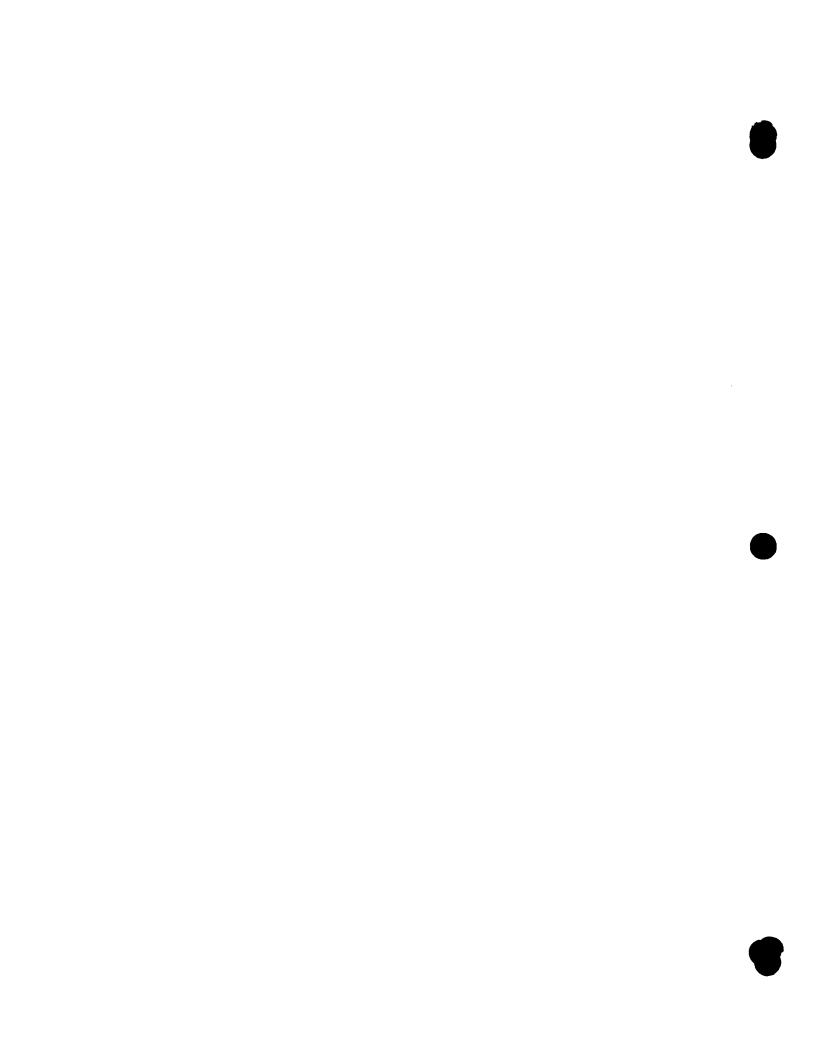
Serial Referral: APPROPRIATIONS

Recommended Referral: None Long Title Amended: Yes

Floor Manager: Murphy

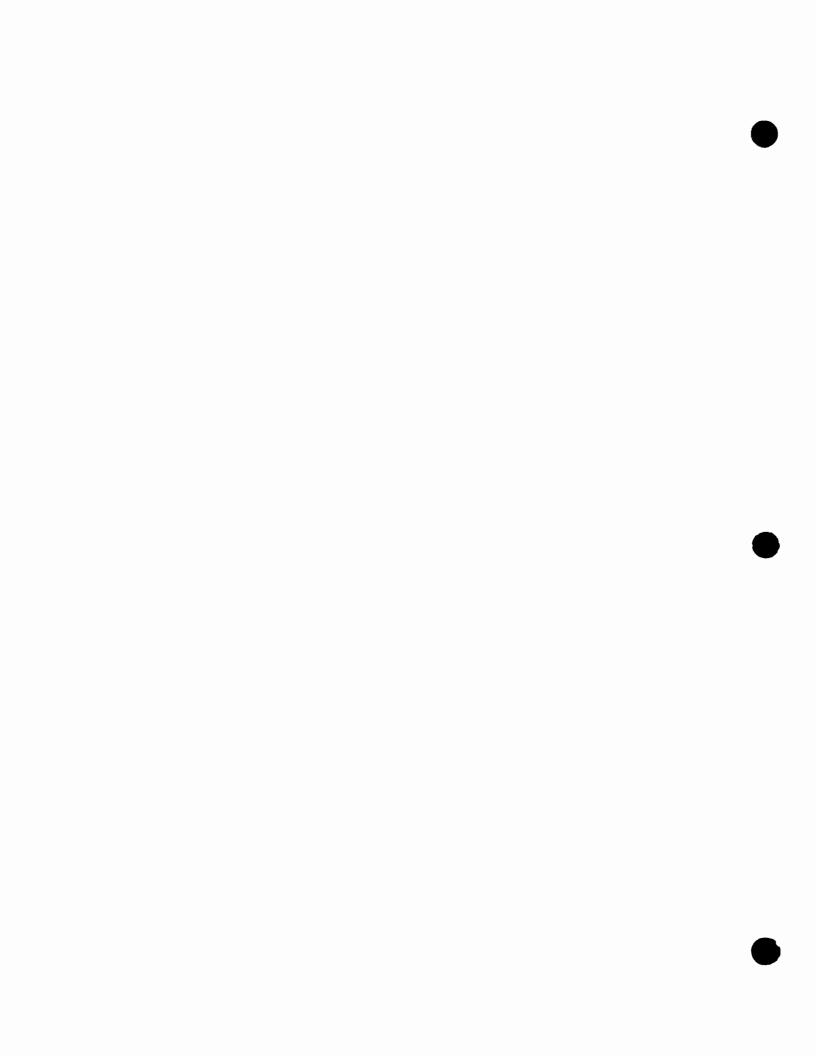
TOTAL REPORTED: 2





Committee Sergeants at Arms

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DATE: _	03/29/17	Room:	643	
		House Sgt-At A	rms:	
1. Name:	Young Bae	*** **********************************		
2. Name:	Jim Moran		andra aggraph when the term a transmission and the second	
3. Name:	David Linthic	cum		
4. Name:	Rex Foster			
5. Name:				
		Senate Sgt-At A	<u>1ms:</u>	
. Name:				
2. Name:			·	
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Hou Pages Assignments Wednesday, March 29, 2017 Session: 2:00 PM

Committee	Room	Time	Staff	Comments	Member
State and Local Government	544	10:00 AM	Jon Edmonston		Rep. Grier Martin
			Brenton Lanier		Rep. Brenden Jones
			William Patterson, II		Rep. Holly Grange
			Greyson Siderio		Rep. Chris Malone
Alcoholic Beverage Control	544	11:00 AM	Troy Elbert		Rep. Marvin Lucas
			Benjamin Williams		Rep. Marvin Lucas
Health	643	11:00 AM	Situna Taliau		Rep. Speaker Tim Moore
			Naiia Pullen		Rep. Speaker Tim Moore
			Anthony Vincent		Rep. Speaker Tim Moore
			Diamond Smith		Rep. Speaker Tim Moore
Pensions and Retirement	415	12:00 PM	Sydney Todd		Rep. Speaker Tim Moore
			Megan Hammaker		Rep. Kevin Corbin
		40.00.514			
Judiciary III	421	12:30 PM	Ubaldo Velasco-		Rep. Speaker Tim Moore
		44444	Lopez		
			Christopher Tucker		Rep. Speaker Tim Moore
Judiciary I	415	1:00 PM	Darius Bellamy		Rep. Speaker Tim Moore
			Hunter Freeman		Rep. Speaker Tim Moore

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House Comm. on Health

03/29/17

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Gry Griggs NCAFP	
Hay Tal MAC	
Josh Lovies . SAL	
Midulle Frazier SML	
Mort Erzell APMC	
Steven Marge NC DOJ	
Evelyn Contre NC Medical Board	
Amy Hawkins NCAMP	
Mary Bethel NecoA	

House Comm. on Health

03/29/17

NAME	FIRM OR AGENCY AND ADDRESS
Thomas Blaunt, MD	MC Peds
Sara Sender MD	NO Pediatic Society
Erin Sulinu	NC Peds
Christoph Drasio MD	Sandhills Pediation
Becky Sunpkin MD	NC Peds + Sandhill's Pediatrics
MichAEL W. RODERS, DAS	NC ACADEMY of PED'ATRIC DENTISTRY &
Tracy Kimbrale	Pancer Poe.
Rebecca Forbes	NC Women Por Cannabis
Kenya Mc Neal-Toise	
Luri Trice	NC Pediatric Society Culbreth Middle School
Jak SiM	NCEPL

House Comm. on Health

03/29/17

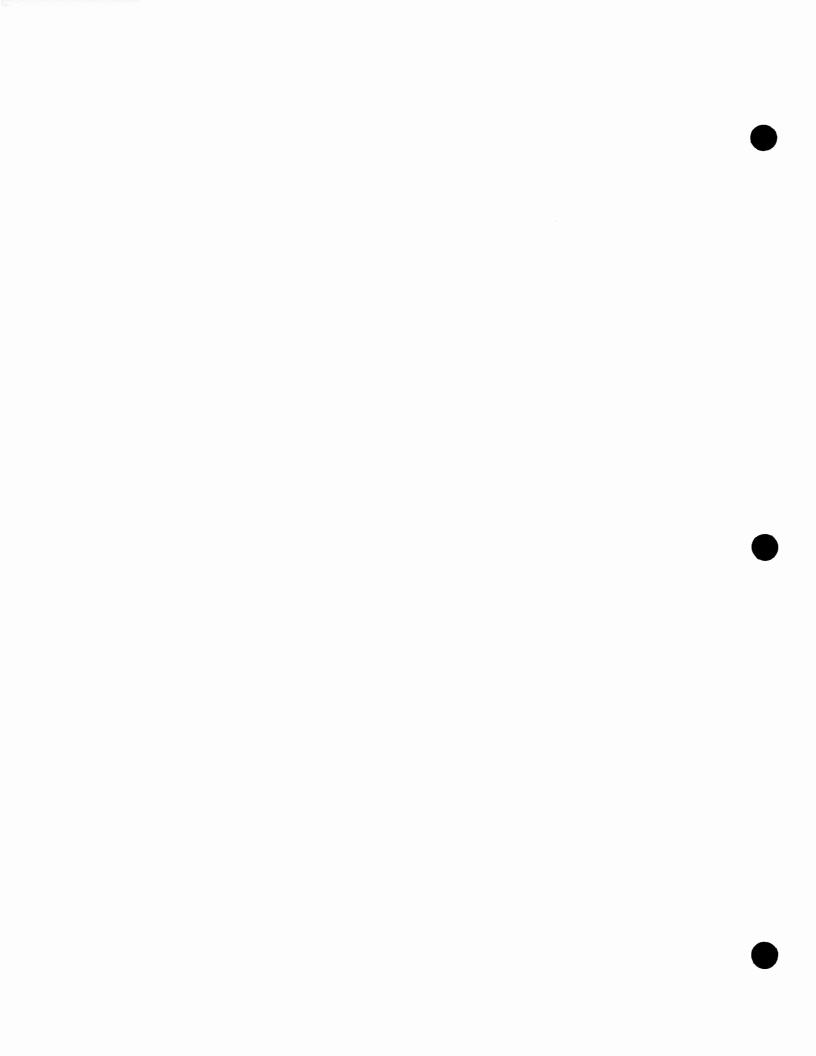
NAME	FIRM OR AGENCY AND ADDRESS
Forrest Heming	City of Morganton
Kelly Kulinski	DHHS
LT M'Crimman	BHHS
Mark Currings ans	ECo Pediaties
Laura Johnson, DDS	ECU Pediatric Dertity
Jorge Arriagada, DMO	ECU Rediatric Dentistry
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House Comm. on Health

03/29/17

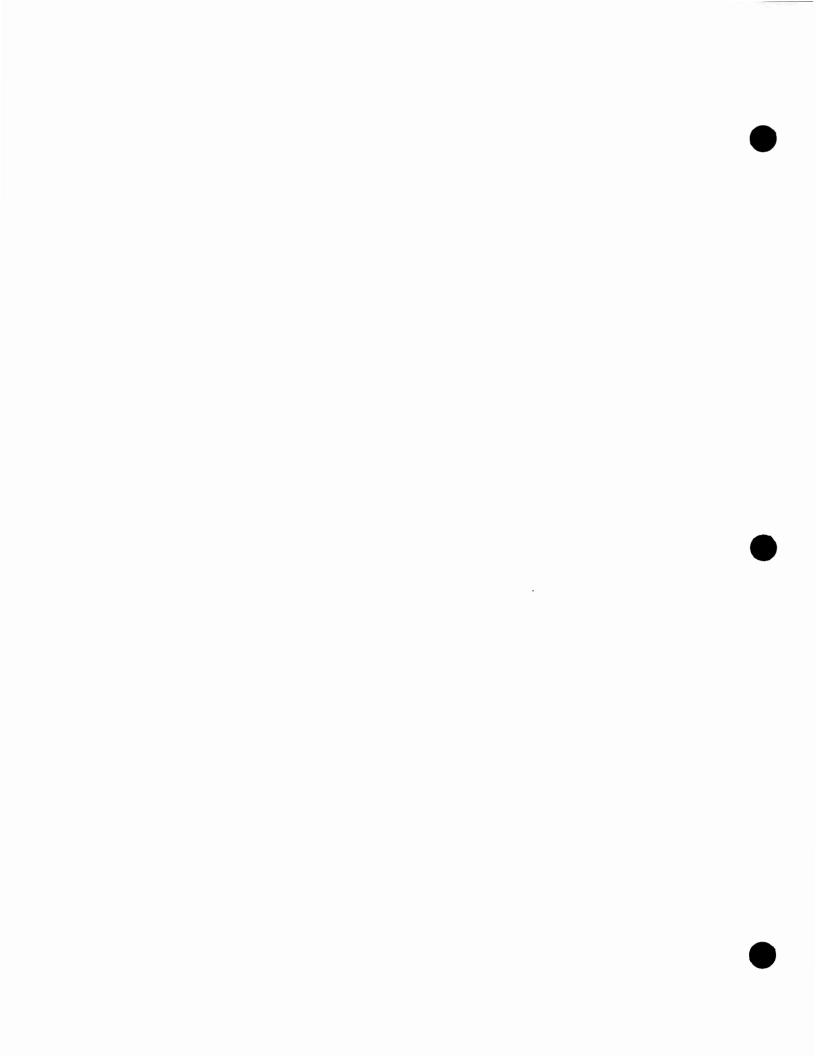
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Symethe John	NCPHA
Eller Hele.	Ncleds
Jana	
Anna Ruderman, MD	NC Peds
Juliana Dia, mo	NC Peds
Gentry Byrd, DOS	NC Peds
SIGGI SAEMUNOSSAN DOS	UNC-PEDIATRIC DENTISTRY - CHAPEL HILL
Bhavna Pahel, DDS	UNC - Pediatric Dentistry, Chapel Hill
SmAm Forrest	NCMS.
ALAN DELLAPENNA	OPH
Dome B. Classe	MARIE



House Comm. on Health

03/29/17

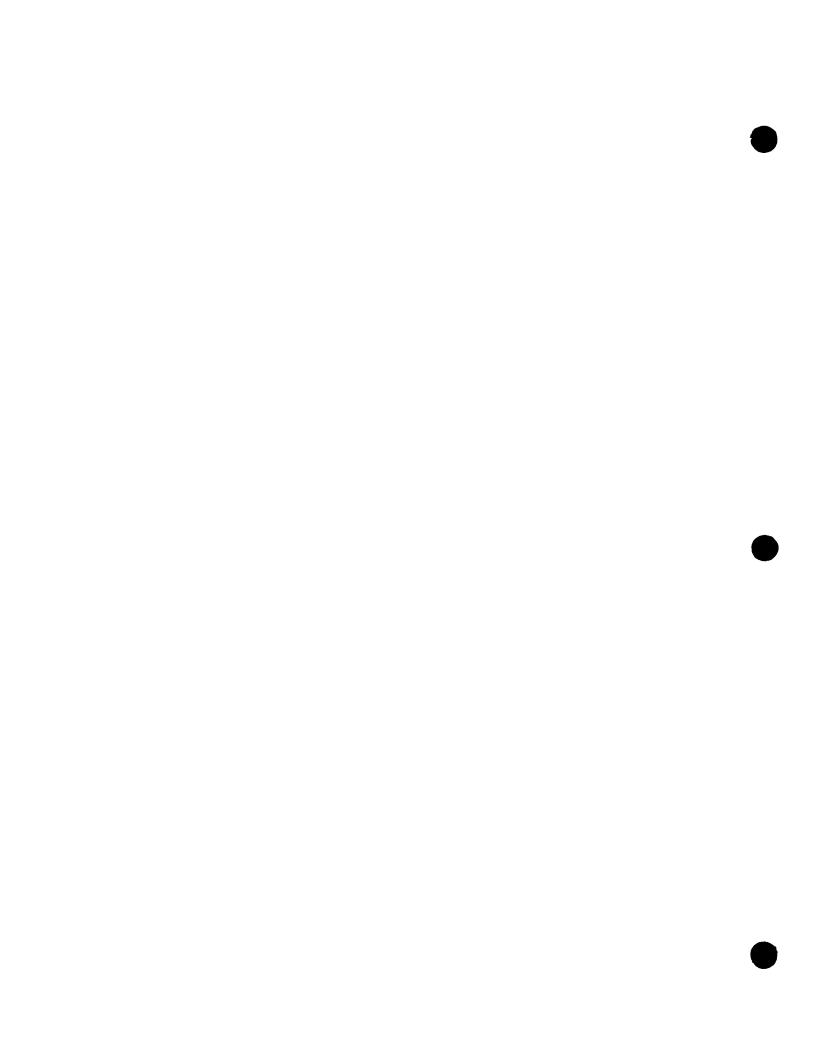
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House Comm. on Health

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House Comm. on Health

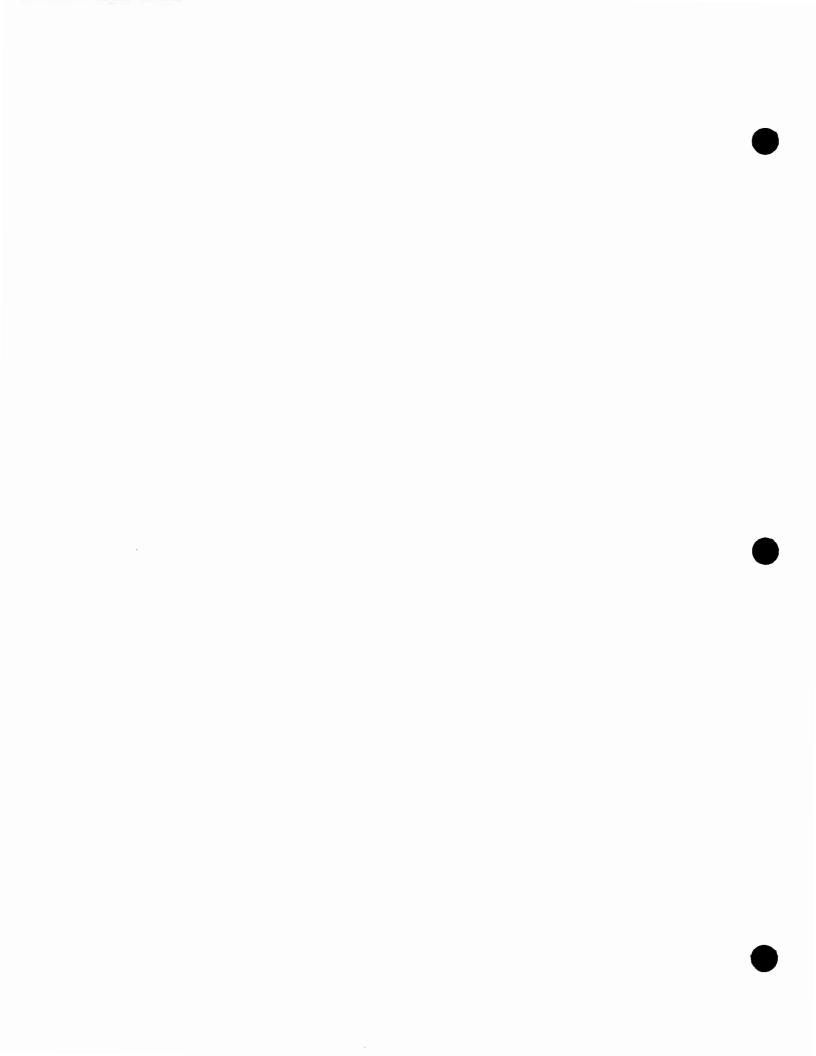
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VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

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FIRM OR AGENCY AND ADDRESS

Brion Perkins	Allimic BHC
Rick Zechini	Williams Muller
MK=JAmos	REP
John	TPG
Andy Ellen	NCRMA
Markad M'Ceneu	Carolinas Health Cone Syp
RyanBladdalye	ConeHealth
Susan Murray	BCBSNC
Mark Flery	BERETE
Cary Pickett	BOBSNC
Helly Vosel	PIPC
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House Comm. on Health

03/29/17

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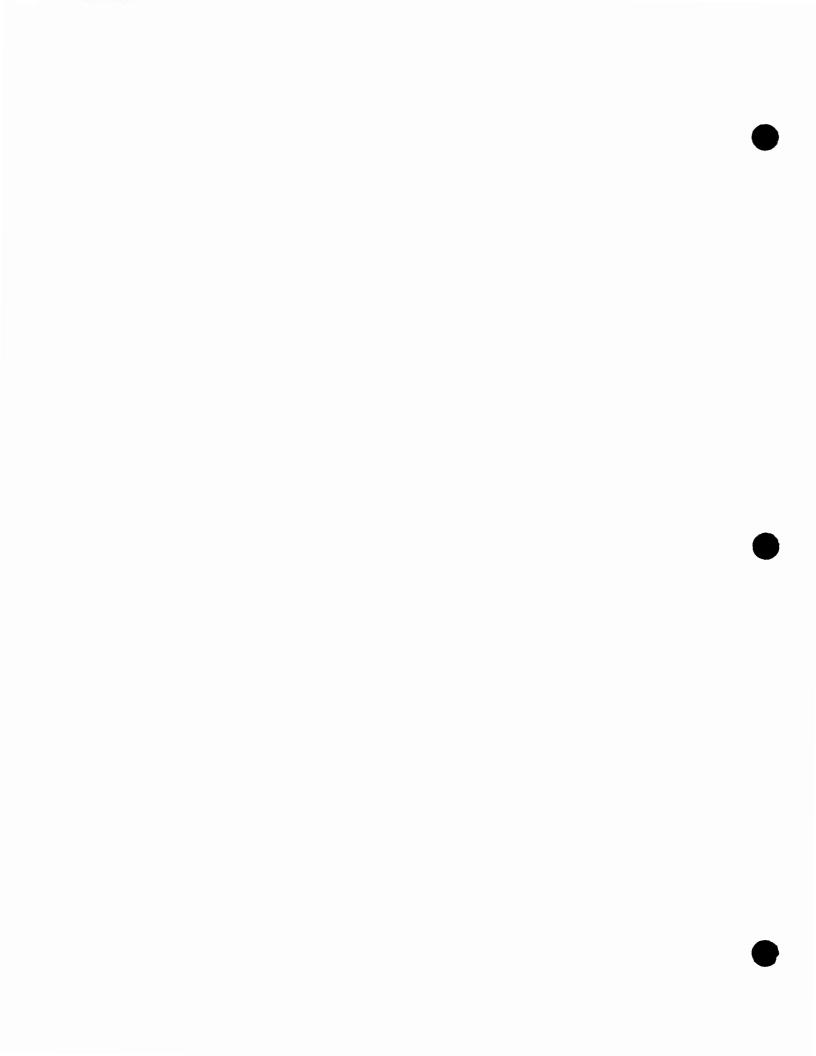
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Tony Adams	Agams and assa.
Ida Stole	NCHIFA
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House Comm. on Health

03/29/17

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Doda Renfer	CCI
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Cathy Womack	NCAMET
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House Comm. on Health

03/29/17

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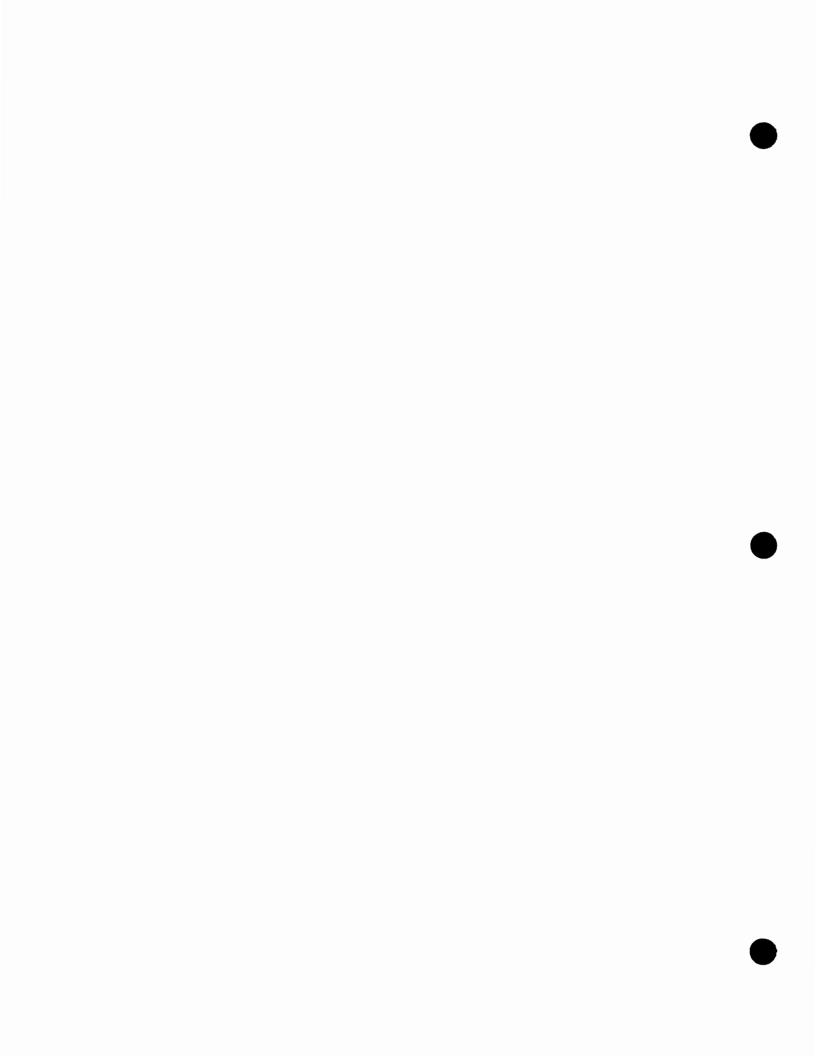
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House Comm. on Health

03/29/17

Date

NAME	FIRM OR AGENCY AND ADDRESS
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	Granude NC = 7834
Bryan Cobb Marine som Icecls	Bryon Cohb DDS 2600 A DAKMERT AU Green show NC 20400
Marthe Son Cecls	Maitha Ann Keels DOS PWD 2711 N. DUKE 8+ Durham, NL 27+04



House Comm. on Health

03/29/17

NAME	FIRM OR AGENCY AND ADDRESS
Ben Poplar	DHHS
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House Committee on Health Wednesday, April 5, 2017 at 11:00 AM Room 643 of the Legislative Office Building

MINUTES

The House Committee on Health met at 11:00 AM on April 5, 2017 in Room 643 of the Legislative Office Building. Representatives Adcock, Ball, Blackwell, Boswell, Burr, Carney, Cunningham, Dobson, Dulin, Earle, Farmer-Butterfield, Ford, Howard, Hunter, Insko, Bert Jones, Lambeth, Lucas, Murphy, Potts, Rogers, Setzer, Shepard, Szoka, White, Yarborough, and Zachary attended.

Representative Donny Lambeth, Chair, presided.

The following bills were considered:

HB 283 DHHS Recommend Telemedicine Policy. (Representatives Lambeth, Insko, Murphy, Dobson)

Representative Lambeth motioned for the PCS be before the committee and hearing no objections explains the bill. Representative Adcock offered an Amendment and the amendment passes. Representative Farmer-Butterfield motioned for a favorable report as amended rolled into a new PCS unfavorable to the original bill with a serial referral to Insurance.

Resources from the Center for Connected Health Policy(National Telehealth Policy Resource Center) and State Telehealth Laws and Medicaid Policy Programs from Kansas, Rhode Island, Alabama and Nebraska.(Attachment 1)

HB 358 Modernize Respiratory Care Practice Act. (Representatives Burr, Goodman, Boles)

Representative Burr was recognized to explain the bill. Representative Setzer motioned for a favorable report with a serial referral to Finance.

HB 422 Raise Awareness About Alzheimer's & Dementias. (Representatives Murphy, Dobson, Boswell)

Representative Murphy was recognized to explain the bill. Representative Carney motioned for a favorable report with a serial referral to Appropriations.

HB 464 Revise Schedule of Controlled Substances. (Representatives Horn, Murphy, Malone)

Representative Horn motioned for the PCS be before the committee and hearing no objections explains the bill. Representative Murphy offered an Amendment. The amendment passes.

Representative Farmer-Butterfield motion for a favorable report as amended rolled into a new PCS unfavorable to the original bill with a serial referral to Judiciary I.

HB 478 Required Experience for MH/DD/SAS QPs. (Representatives Dobson, S. Martin, K. Hall, Brisson)

Representative Jones motioned for the PCS be before the committee hearing none objections Representative Dobson was recognized to explain the bill. Representative Adcock motioned for a favorable report unfavorable the original bill.

The meeting adjourned at 11:58.

Representative Donny Lambeth, Chair

Presiding

Theresa Lopez, Committee Clerk

NORTH CAROLINA HOUSE OF REPRESENTATIVES COMMITTEE MEETING NOTICE AND BILL SPONSOR NOTIFICATION 2017-2018 SESSION

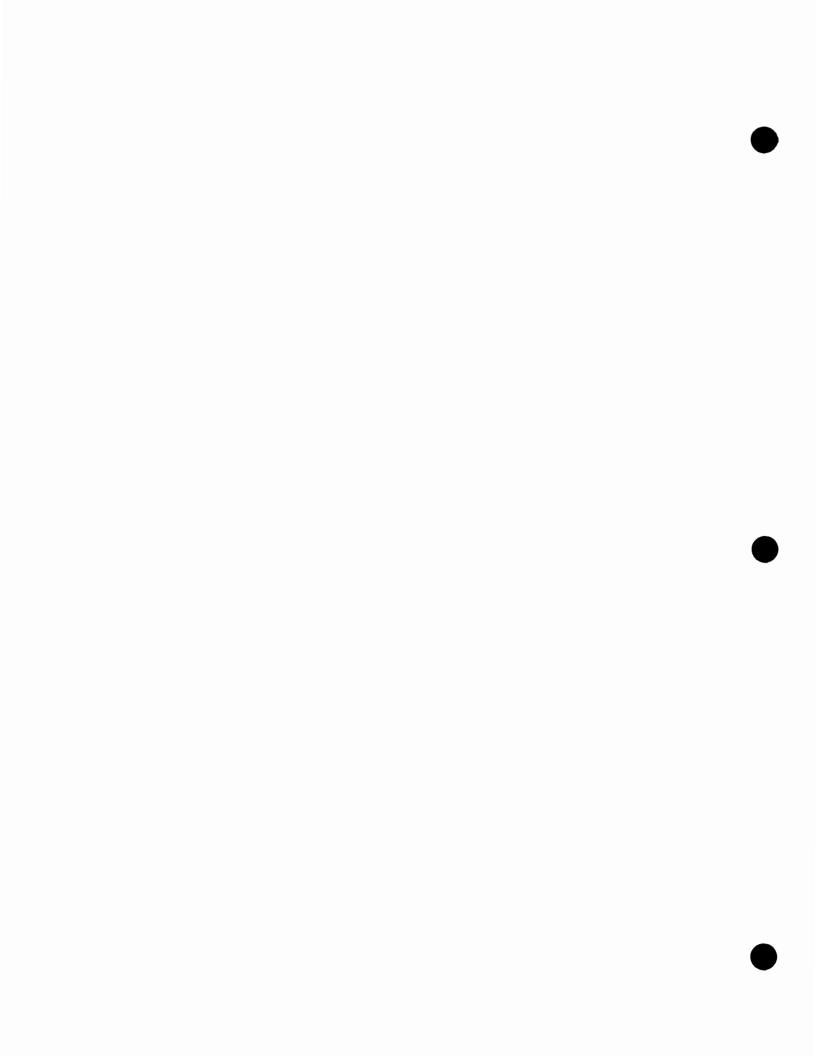
You are hereby notified that the House Committee on Health will meet as follows:

DAY & DATE: Wednesday, April 5, 2017

TIME: 11:00 AM LOCATION: 643 LOB

The following bills will be considered:

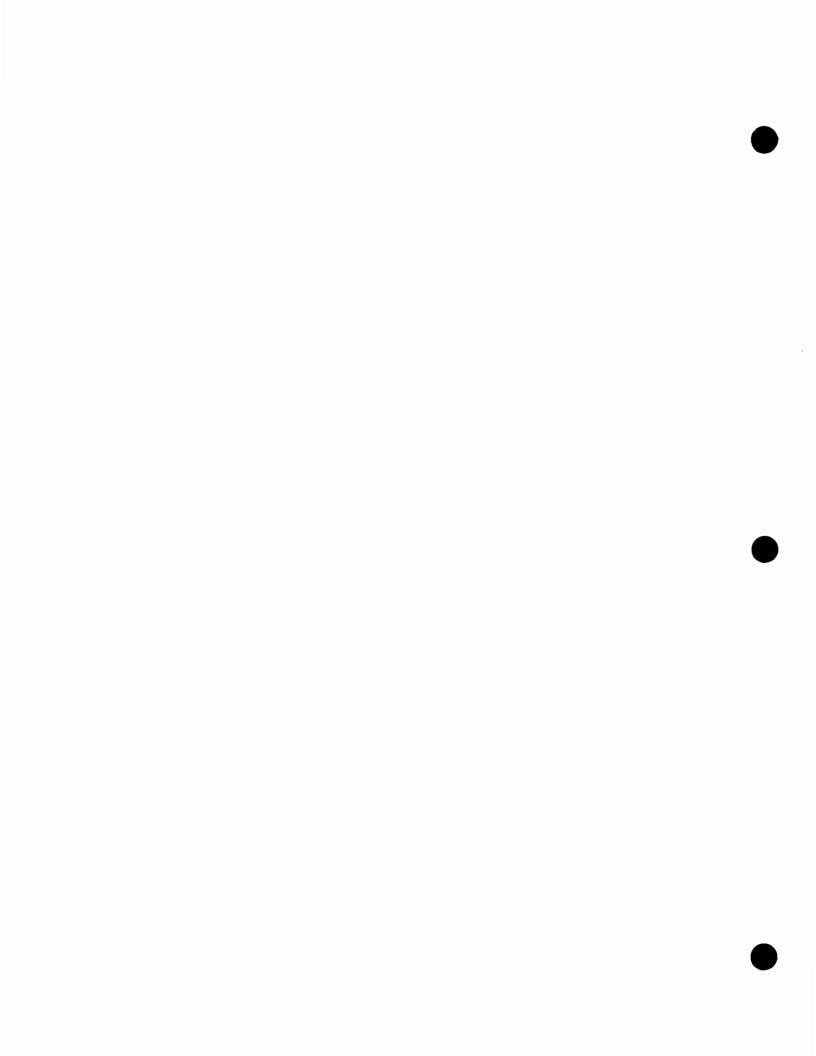
BILL NO. HB 283	SHORT TITLE Telehealth Fairness Act.	SPONSOR Representative Lambeth
		Representative Insko
		Representative Murphy
		Representative Dobson
HB 358	Modernize Respiratory Care Practice	Representative Burr
	Act.	Representative Goodman
		Representative Boles
HB 422	Raise Awareness About Alzheimer's &	Representative Murphy
	Dementias.	Representative Dobson
		Representative Boswell
HB 464	Revise Schedule of Controlled	Representative Horn
	Substances.	Representative Murphy
		Representative Malone
HB 478	Required Experience for MH/DD/SA	Representative Dobson
	QPs.	Representative S. Martin
		Representative K. Hall
		Representative Brisson



Respectfully,

Representative Justin P. Burr, Co-Chair Representative Josh Dobson, Co-Chair Representative Bert Jones, Co-Chair Representative Donny Lambeth, Co-Chair Representative Gregory F. Murphy, MD, Co-Chair

I hereby certify this notice was filed by the committee assistant at the following offices at 3:08 PM or Tuesday, April 04, 2017.
Principal Clerk Reading Clerk – House Chamber
Brenda Olls (Committee Assistant)



House Committee on Health Wednesday, April 5, 2017, 11:00 AM 643 Legislative Office Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

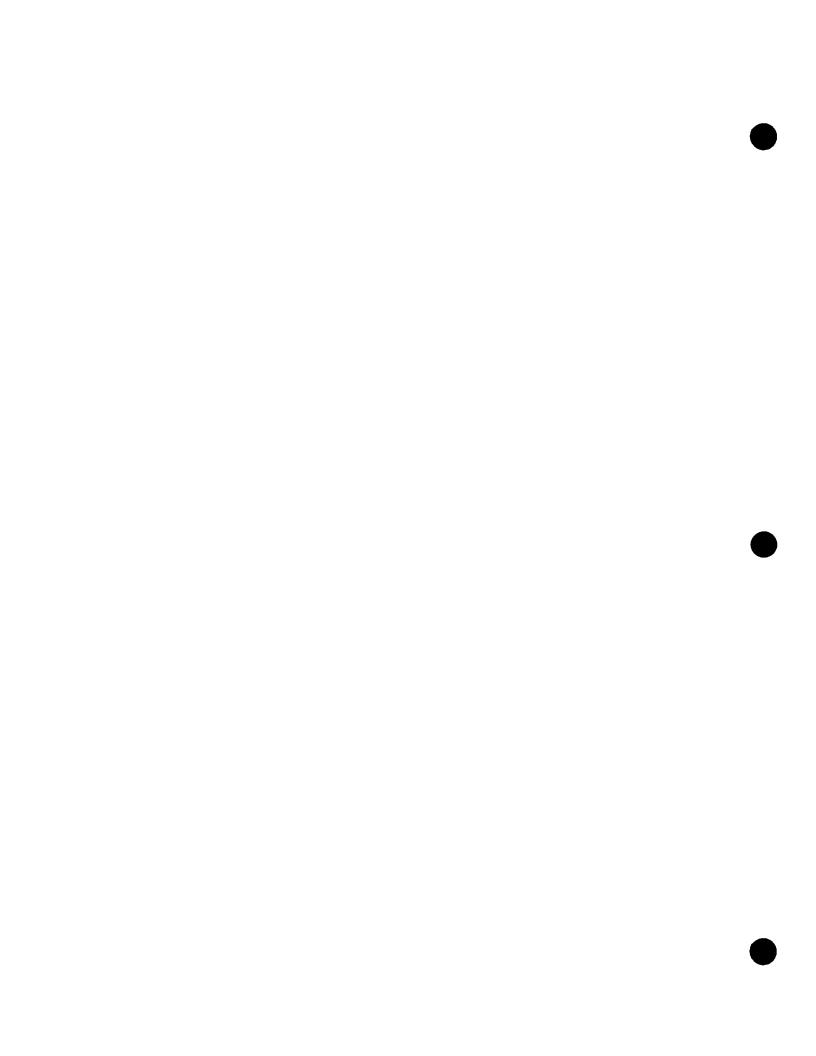
Bills

BILL NO.	SHORT TITLE	SPONSOR
HB 283	Telehealth Fairness Act.	Representative Lambeth
		Representative Insko
		Representative Murphy
		Representative Dobson
HB 358	Modernize Respiratory Care Practice	Representative Burr
	Act.	Representative Goodman
		Representative Boles
HB 422	Raise Awareness About Alzheimer's &	Representative Murphy
	Dementias.	Representative Dobson
		Representative Boswell
HB 464	Revise Schedule of Controlled	Representative Horn
	Substances.	Representative Murphy
		Representative Malone
HB 478	Required Experience for MH/DD/SA	Representative Dobson
	QPs.	Representative S. Martin
		Representative K. Hall
		Representative Brisson

Presentations

Other Business

Adjournment



NORTH CAROLINA GENERAL ASSEMBLY HOUSE OF REPRESENTATIVES

HEALTH COMMITTEE REPORT

Representative Justin P. Burr, Co-Chair Representative Josh Dobson, Co-Chair Representative Bert Jones, Co-Chair Representative Donny Lambeth, Co-Chair Representative Gregory F. Murphy, MD, Co-Chair

FAVORABLE AND RE-REFERRED

HB 358 Modernize Respiratory Care Practice Act.

> Draft Number: None Serial Referral: FINANCE Recommended Referral: None Long Title Amended: No

Floor Manager: Burr

HB 422 Raise Awareness About Alzheimer's & Dementias.

> Draft Number: None

Serial Referral: APPROPRIATIONS

Recommended Referral: None Long Title Amended: No Floor Manager: Murphy

FAVORABLE COM SUB, UNFAVORABLE ORIGINAL BILL

HB 478 Required Experience for MH/DD/SA QPs.

> Draft Number: H478-PCS40355-TR-2

Serial Referral: None Recommended Referral: None Long Title Amended: Yes Floor Manager: Dobson

FAVORABLE COM SUB, UNFAVORABLE ORIGINAL BILL AND RE-REFERRED

Revise Schedule of Controlled Substances. 464 HB

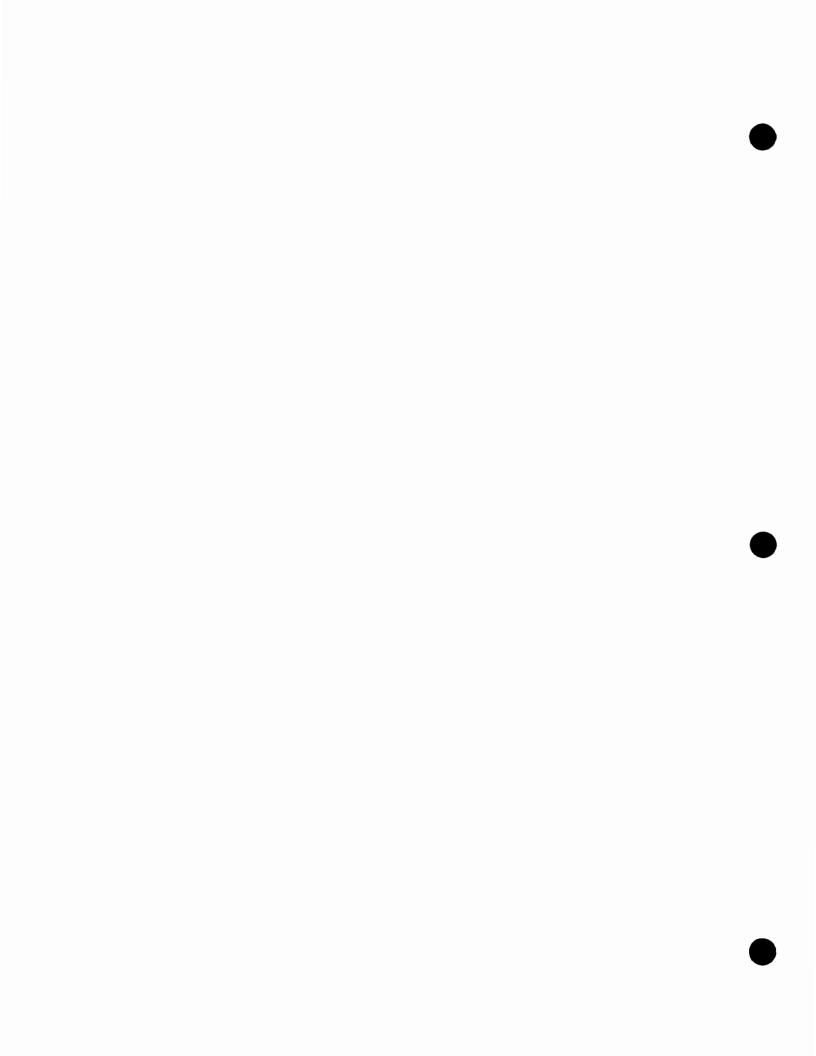
> H464-PCS30262-TY-4 Draft Number:

Serial Referral: JUDICIARY I

Recommended Referral: None Long Title Amended: No Floor Manager: Horn

TOTAL REPORTED: 4





NORTH CAROLINA GENERAL ASSEMBLY HOUSE OF REPRESENTATIVES

HEALTH COMMITTEE REPORT

Representative Justin P. Burr, Co-Chair Representative Josh Dobson, Co-Chair Representative Bert Jones, Co-Chair Representative Donny Lambeth, Co-Chair Representative Gregory F. Murphy, MD, Co-Chair

FAVORABLE COM SUB, UNFAVORABLE ORIGINAL BILL AND RE-REFERRED

HB **283** Telehealth Fairness Act.

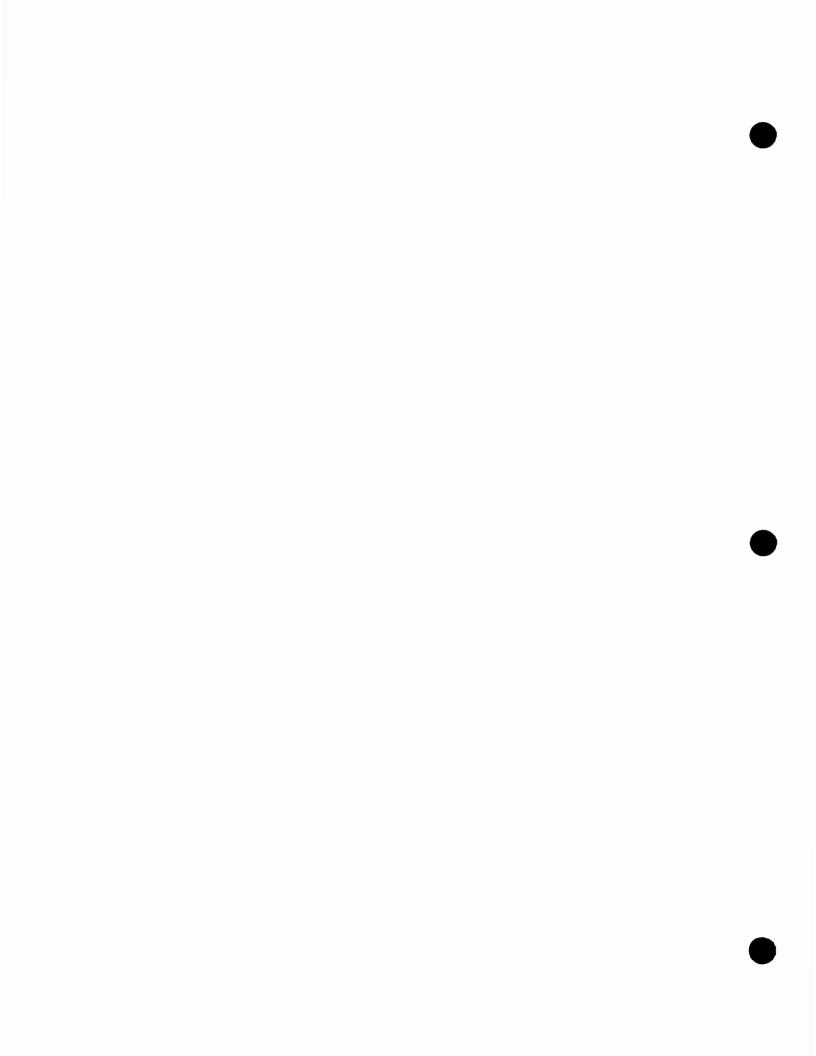
Draft Number: H283-PCS40357-SH-11

Serial Referral: INSURANCE

Recommended Referral: None Long Title Amended: Yes Floor Manager: Lambeth

TOTAL REPORTED: 1

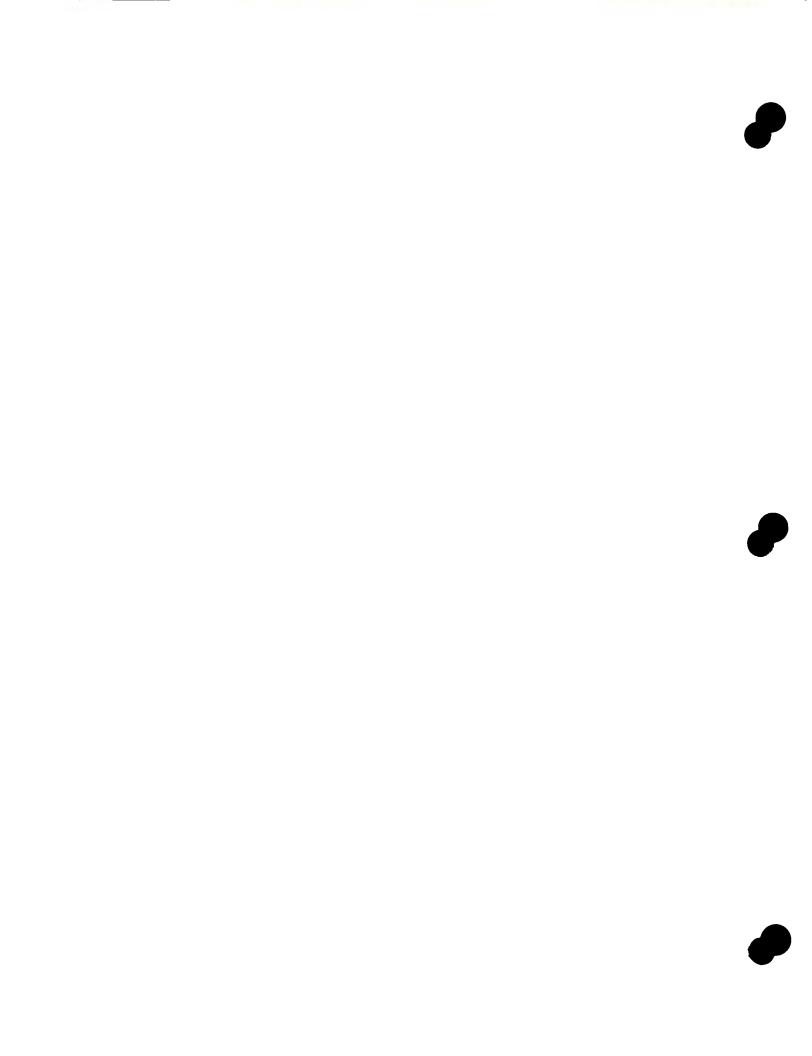




NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

(Please type or use ballpoint pen)

H. B. No. 283	DATE 4/5/17
S. B. No	Amendment No.
COMMITTEE SUBSTITUTE	(to be filled in by Principal Clerk)
Rep.) Nachk	
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3 0 11. <i>)</i>	
moves to amend the bill on page	(, line
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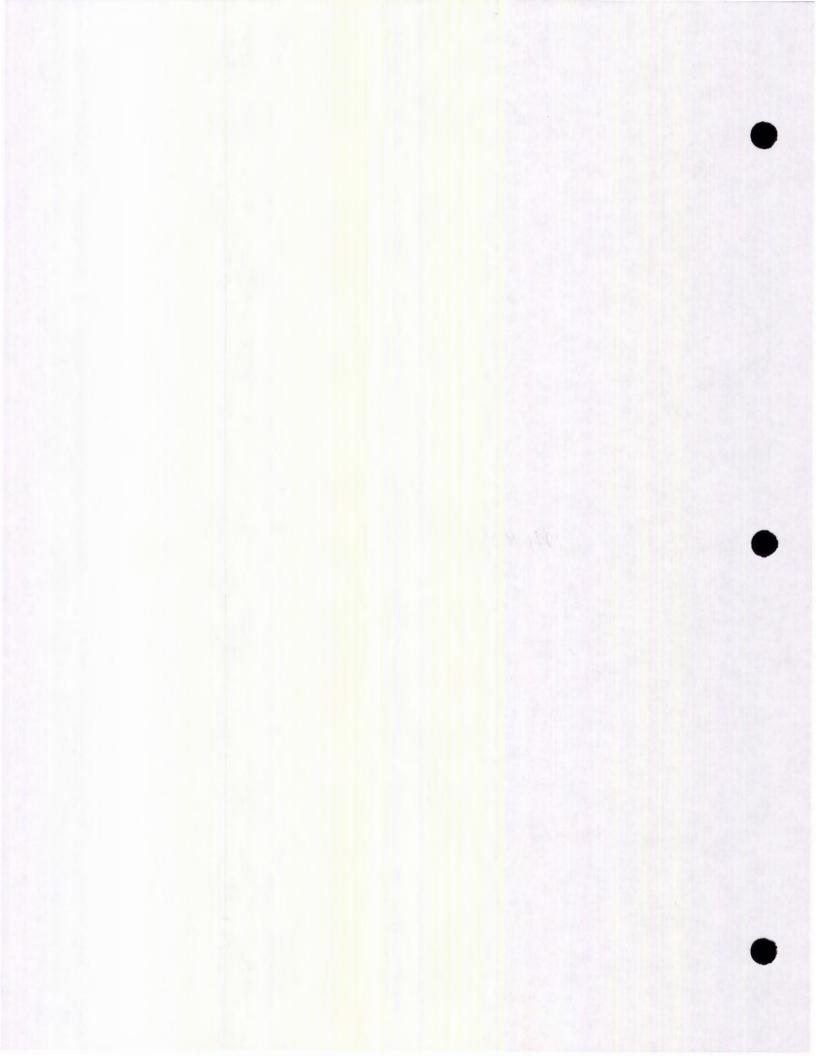


NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT House Bill 464*

AMENDMENT NO.

	H464-ATY-13 [v	v.11		(to be filled in by Principal Clerk)	
				,	Page 1 of 1
	Amends Title [No	0]	Date _	4/5/	,2017
	Representative M	<u>furphy</u>			
1	moves to amend	the bill on page 15, line 2	29 by rewriting the li	ne to read:	
2 3 4 5 6	"(4)	Anticonvulsants. – Unl in".	less specifically exer	mpted or excluded of	or unless listed
	are) WPD	MAURAHV			
	SIGNED	Amendment	Sponsor		
	SIGNED	· · · · · · · · · · · · · · · · · · ·			
	Cor	mmittee Chair if Senate (Committee Amendm	ent	
	ADOPTED	FAILE	D	TABLED	







HOUSE BILL 283: DHHS Recommend Telemedicine Policy.

2017-2018 General Assembly

Committee: House Health. If favorable, re-refer to Date: April 4, 2017

Insurance

Introduced by: Reps. Lambeth, Insko, Murphy, Dobson **Prepared by:** Theresa Matula

Analysis of: PCS to First Edition Committee Staff

H283-CSSH-11

OVERVIEW: The Proposed Committee Substitute (PCS) for HB 283 would require the Department of Health and Human Services to study and recommend a telemedicine policy to the Joint Legislative Oversight Committee on Health and Human Services on or before October 1, 2017. The bill would become effective when it becomes law.

CURRENT LAW: Currently, North Carolina does not have laws pertaining to telemedicine that provide the policy for the State, including any limitations and safeguards for protecting the public. There are several references to telemedicine in current statutes as they pertain to particular programs.¹

BILL ANALYSIS:

Section 1 of the PCS would require the Department of Health and Human Services to study and recommend a telemedicine policy for consideration by the General Assembly. At a minimum, the Department shall examine the elements below as contained in telemedicine/telehealth laws in other states and make recommendations for NC.

- A definition of the term telemedicine.
- The scope of services that can be covered by telemedicine.
- Acceptable communication and data transfer standards necessary to ensure the privacy of health information and appropriate for insurance reimbursement.
- Informed consent standards.
- Online prescribing limitations.
- Telemedicine provider licensing standards.
- Private payer telemedicine reimbursement standards.

The Department is required to solicit input from relevant stakeholders and from the Department of Insurance on the potential insurance impact of telemedicine policy elements. During the study, the Department may examine services reimbursed under the Medicaid policy, but the recommendations shall not include changes to the State's Medicaid policy.

Section 2 of the PCS contains the reporting requirement. On or before October 1, 2017, the Department of Health and Human Services is required to submit a report containing findings and recommendations and a proposed telemedicine policy to the Joint Legislative Oversight Committee on Health and Human

¹ G.S. 130A-125 and G.S. 122C-263(c).





Legislative Analysis Division 919-733-2578

House PCS 283

Page 2

Services. Based on the Department's report, the Committee must consider making a recommendation to the 2018 General Assembly.

EFFECTIVE DATE: The bill would become effective when it becomes law.

BACKGROUND:

The range of polices on telehealth/telemedicine varies by State. Within a given state, the health policy covers a range of options including: what constitutes telehealth/telemedicine, how it is defined, what services and providers are eligible. The National Conference of State Legislatures has compiled a good bit of information and a number of reports on telehealth services. The Center for Connected Health Policy has produced a document on State Telehealth Laws and Medicaid Program Policies, A Comprehensive Scan of the 50 States and District of Columbia. This document demonstrates the array of options that exist in each state and may serve as a starting point for the Department's study.

GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2017

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HOUSE BILL 283 PROPOSED COMMITTEE SUBSTITUTE H283-CSSH-11 [v.1]

04/04/2017 04:43:15 PM

Short Title: DHHS Recommend Telemedicine Policy. (Public)

Sponsors:

Referred to:

March 9, 2017

A BILL TO BE ENTITLED
AN ACT TO REQUIRE THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO STUDY AND RECOMMEND A TELEMEDICINE POLICY.

The General Assembly of North Carolina enacts:

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SECTION 1. The Department of Health and Human Services shall study and recommend a telemedicine policy for consideration by the General Assembly. At a minimum, the Department shall examine telemedicine/telehealth laws in other states as they pertain to the elements outlined below and recommend standards for the State.

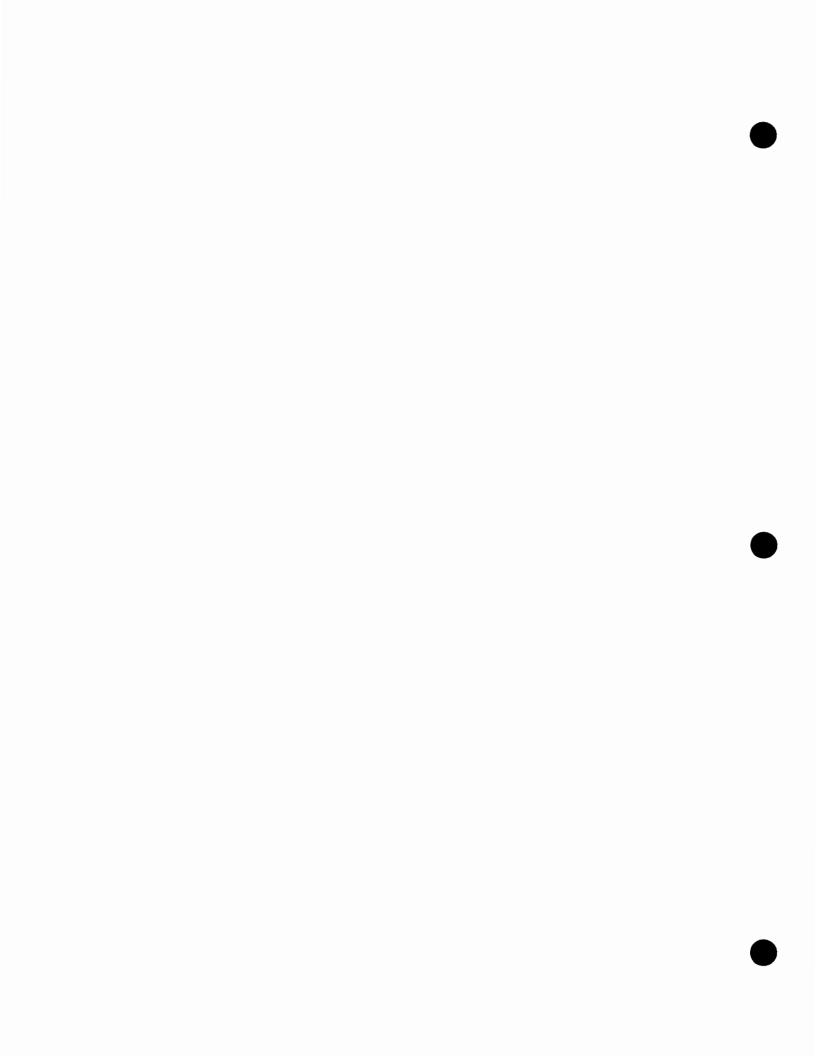
- (1) A definition of the term telemedicine.
- (2) The scope of services that can be covered by telemedicine.
- (3) Acceptable communication and data transfer standards necessary to ensure the privacy of health information and appropriate for insurance reimbursement.
- (3) Informed consent standards.
 - (4) Online prescribing limitations.
 - (5) Telemedicine provider licensing standards.
 - (6) Private payer telemedicine reimbursement standards.

The Department shall solicit input from relevant stakeholders and from the Department of Insurance on the potential insurance impact of particular telemedicine policy elements. While conducting this study, the Department may examine services reimbursed under the Medicaid policy, but the recommendations shall not include changes to the State's Medicaid policy.

SECTION 2. On or before October 1, 2017, the Department of Health and Human Services shall submit a report containing findings and recommendations and a proposed telemedicine policy to the Joint Legislative Oversight Committee on Health and Human Services. Based on the Department's report, the Committee shall consider making a recommendation to the 2018 General Assembly.

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





GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2017

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HOUSE BILL 283

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Short Title: Telehealth Fairness Act. (Public)

Sponsors: Representatives Lambeth, Insko, Murphy, and Dobson (Primary Sponsors).

For a complete list of sponsors, refer to the North Carolina General Assembly web site.

Referred to: Health, if favorable, Insurance

March 9, 2017

A BILL TO BE ENTITLED

AN ACT TO REQUIRE HEALTH INSURANCE COVERAGE FOR TELEMEDICINE SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. Article 50 of Chapter 58 of the General Statutes is amended by adding a

SECTION 1. Article 50 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"§ 58-50-305. Coverage for services provided via telemedicine.

- (a) As used in this section, the following definitions apply:
 - (1) Insurer. As defined in G.S. 58-3-167(a).
 - (2) Telemedicine. The use of interactive audio, video, or other electronic media for the purposes of diagnosis, consultation, or treatment.
- (b) Every health benefit plan shall provide coverage for health care services that are provided via telemedicine if the health care service would be covered were it provided through in-person consultation or in-person delivery of services between an insured and a health care provider. A health benefit plan may not exclude services provided via telemedicine from coverage under the plan solely because the service is not provided through an in-person consultation or in-person delivery of services.
- (c) A health care provider shall not be required to document a barrier to an in-person visit prior to the delivery of services via telemedicine.
- (d) For purposes of coverage for services provided via telemedicine, an insurer shall not limit the type of setting where services may be provided to the patient or by the health care provider.
- (e) Coverage of services provided via telemedicine shall be at a rate no less than the applicable rate for health care services provided through in-person consultation or in-person delivery of services. A health benefit plan may contain a provision for a deductible, co-payment, or coinsurance requirement for a health care service provided via telemedicine so long as the deductible, co-payment, or coinsurance does not exceed the deductible, co-payment, or coinsurance applicable to an in-person consultation or in-person delivery of services."
- **SECTION 2.** This act becomes effective October 1, 2017, and applies to insurance contracts issued, renewed, or amended on or after that date.



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HOUSE BILL 358: Modernize Respiratory Care Practice Act.

2017-2018 General Assembly

Committee: House Health. If favorable, re-refer to **Date:** March 30, 2017

Finance

Introduced by: Reps. Burr, Goodman, Boles Prepared by: Jason Moran-Bates

Analysis of: First Edition Committee Co-Counsel

OVERVIEW: House Bill 358 would amend the Respiratory Care Practice Act by 1) making technical changes to the Definitions section; 2) adding several new definitions to the Definitions section; 3) replacing the Board member representing and appointed by the North Carolina Association of Medical Equipment Services with a member representing and appointed by the Atlantic Coast Medical Equipment Services Association; 4) changing the agency providing background check information on license applicants from the Department of Public Safety to the Department of Justice; 5) granting the Board the power to adopt rules defining education and credential requirements; 6) modifying some licensure requirements; and 7) repealing statutes allowing temporary and provisional licenses.

CURRENT LAW: Under current law, the North Carolina Respiratory Care Board administers the Respiratory Care Act, but does not have specific authority to adopt rules defining the education and credentialing requirements for applicants for a respiratory care license. There is no requirement that applicants have a specific degree. The North Carolina Association of Medical Equipment Services appoints one member to the Board, and background checks for the Board are carried out by the Department of Public Safety.

BILL ANALYSIS:

Section 1 of the bill would make several technical corrections to definitions in G.S. 90-648 as well as add definitions for "Advanced practice" and "Endorsement."

Sections 2 and 3 would replace the Board member appointed by and representing the North Carolina Association of Medical Equipment Services (NCAMES) with a member appointed by the Atlantic Coast Medical Equipment Services Association (ACMESA). This change is necessary because NCAMES voted to expand its membership to provide regional coverage in November 2016. As a result of that expansion, the association's name was changed to ACMESA.

Section 4 would require the Department of Justice, rather than the Department of Public Safety, to provide background check information to the Board. Section 4 would also grant the Board the authority to establish and adopt rules defining educational and credential requirements for license applicants.

Section 5 would require the Board to state the terms and conditions of use of a license to licensees, and re-codify the requirement that applicants consent to a criminal background check from G.S. 90-652 to G.S. 90-653. Section 5 would require applicants to submit proof of an associate's degree in respiratory





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House Bill 358

Page 2

care education approved by the Commission on Accreditation for Respiratory Health Care¹ as well as proof they passed the Therapist Multiple-Choice exam given by the National Board for Respiratory Care.²

Sections 6 and 7 would repeal the statutes allowing for temporary and provisional licenses and remove the fees for those licenses.

EFFECTIVE DATE: This act would be effective October 1, 2017.

¹ The Board has required an associate's degree since 2002 when the last one-year programs in respiratory care education were phased out. This change merely codifies the existing practice.

phased out. This change merely codifies the existing practice.

In January 2015, the National Board for Respiratory Care changed the name and modified the format of the exam administered to applicants seeking the Registered Respiratory Therapist credential. The new name is the Therapist-Multiple Choice Exam, and its content is substantially similar to the old entry level exam.

GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2017

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HOUSE BILL 358

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Short Title: Modernize Respiratory Care Practice Act. (Public)

Sponsors: Representatives Burr, Goodman, and Boles (Primary Sponsors).

For a complete list of sponsors, refer to the North Carolina General Assembly web site.

Referred to: Health, if favorable, Finance

March 16, 2017

			Water 10, 2017				
1			A BILL TO BE ENTITLED				
2	AN ACT UPDATING THE RESPIRATORY CARE PRACTICE ACT.						
3	The General Ass	embly	of North Carolina enacts:				
4	SECTION 1. G.S. 90-648 reads as rewritten:						
5	"§ 90-648. Defin						
6	•		itions apply in this Article:				
7	(1)		anced practice Procedures that require formal training by rules				
8			ted pursuant to this Article.				
9	(1) (1a		d. – The North Carolina Respiratory Care Board.				
10	•••	_					
11	(3a)	Endo	prsement A certificate issued by the Board recognizing the person				
12		name	ed on the certificate as having met the requirements to perform				
13		respi	ratory care procedures as defined in this Article.				
14	•••						
15	(10)	Pract	tice of respiratory care As defined by the written order of a physician				
16		licen	sed under Article 1 of this Chapter, the observing and monitoring of				
17		signs	and symptoms, general behavior, and general physical response to				
18			ratory care treatment and diagnostic testing, including the determination				
19			hether such signs, symptoms, reactions, behavior, or general response				
20			exhibit abnormal characteristics, and the performance of diagnostic testing				
21		and t	herapeutic application of:				
22		a.	Medical gases, humidity, and aerosols including the maintenance use				
23			of associated apparatus, respiratory care equipment, except for the				
24			purpose of anesthesia.				
25		b.	Pharmacologic agents related to respiratory care procedures,				
26			including those agents necessary to perform hemodynamic				
27			monitoring.				
28		c.	Mechanical or physiological ventilatory support.				
29		d.	Cardiopulmonary resuscitation and maintenance of natural airways,				
30			the insertion and maintenance of artificial airways under the direct				
31			supervision of a recognized medical director in a health care				
32			environment which identifies these services within the scope of				
33			practice by the facility's governing board.				
34		e.	Hyperbaric oxygen therapy.				



f. New and innovative respiratory care and related support activities in appropriately identified environments and under the training and practice guidelines established by the American Association of Respiratory Care.

The term also means the interpretation and implementation of a physician's written or verbal order pertaining to the acts described in this subdivision.

(13) Support activities. – <u>Procedures Tasks</u> that do not require formal academic training, including the delivery, setup, and <u>routine maintenance and repair of apparatus.</u> <u>respiratory care equipment.</u> The term also includes giving instructions on the use, fitting, and application of <u>apparatus, respiratory care equipment</u>, but does not include therapeutic evaluation and <u>assessment</u>, assessment for an individual patient as defined in rules adopted by the Board."

SECTION 2. G.S. 90-649(a)(4) reads as rewritten:

"(4) One North Carolina member shall represent the North Carolina Association of Medical Equipment Services. Atlantic Coast Medical Equipment Services Association."

SECTION 3. G.S. 90-650(a)(7) reads as rewritten:

"(7) The North Carolina Association of Medical Equipment Services Atlantic Coast Medical Equipment Services Association shall appoint the member described in G.S. 90-649(a)(4)."

SECTION 4. G.S. 90-652 reads as rewritten:

"§ 90-652. Powers and duties of the Board.

(1)

The Board shall have the power and duty to:

Determine the qualifications and fitness of applicants for licensure, renewal of licensure, and reciprocal licensure. The Board shall, in its discretion, investigate the background of an applicant to determine the applicant's qualifications with due regard given to the applicant's competency, honesty, truthfulness, and integrity. The Department of Public Safety Justice may provide a criminal record check to the Board for a person who has applied for a license through the Board. The Board shall provide to the Department of Public Safety. Justice, along with the request, the fingerprints of the applicant, applicant and any additional information required by the Department of Public Safety, and a form signed by the applicant consenting to the check of the criminal record and to the use of the fingerprints and other identifying information required by the State or national repositories. Department of Justice. The applicant's fingerprints shall be forwarded to the State Bureau of Investigation for a search of the State's criminal history record file, and the State Bureau of Investigation shall forward a set of the fingerprints to the Federal Bureau of Investigation for a national criminal history check. The Board shall keep all information pursuant to this subdivision privileged, in accordance with applicable State law and federal guidelines, and the information shall be confidential and shall not be a public record under Chapter 132 of the General Statutes. The Board shall collect any fees required by the Department of Public Safety Justice and shall remit the fees to the Department of Public Safety Justice for expenses associated with conducting the criminal history record check.

House Bill 358-First Edition

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49 50 (14) Establish and adopt rules defining the education and credential requirements for persons seeking endorsement under this Article."

SECTION 5. G.S. 90-653 reads as rewritten:

"§ 90-653. Licensure requirements; examination.

- (a) Each applicant for licensure under this Article shall meet the following requirements: do all of the following:
 - (1) Submit a completed application as required by the Board. Board, including a form signed by the applicant consenting to a check of the applicant's criminal record and to the use of the applicant's fingerprints and other identifying information required by the State and national repositories.
 - (2) Submit any fees required by the Board.
 - Submit to the Board written evidence, verified by oath, that the applicant has successfully completed the minimal requirements of a an associate's degree in respiratory care education program as approved by the Commission for Accreditation of Allied Health Educational Programs, or the Canadian Council on Accreditation for Respiratory Therapy Education. Commission on Accreditation for Respiratory Care (CoARC) or its successor by arranging for the applicant's respiratory care education program to submit a verified transcript directly to the Board.
 - (4) Submit to the Board written evidence, verified by oath, that the applicant has successfully completed the minimal requirements for Basic Cardiac Life Support as recognized by the American Heart Association, the American Red Cross, or the American Safety and Health Institute.
 - (5) Pass the entry level-Submit to the Board written evidence, verified by oath, that the applicant passed the Therapist Multiple-Choice (TMC) examination given by the National Board for Respiratory Care, Inc., or its successor.
- (b) At least three times each year, the Board shall cause the examination required in subdivision (5) of subsection (a) of this section to be given to applicants at a time and place to be announced by the Board. Any applicant who fails to pass the first examination may take additional examinations in accordance with rules adopted pursuant to this Article.
- (b1) When issuing a license, the Board shall state the terms and conditions of the use of the license to the licensee."
 - SECTION 6. G.S. 90-660(b)(6) reads as rewritten:
 - "(6) For a license with a provisional or temporary an endorsement, a fee not to exceed fifty dollars (\$50.00)."
 - **SECTION 7.** G.S. 90-654 and G.S. 90-656 are repealed.
- **SECTION 8.** This act becomes effective October 1, 2017.





HOUSE BILL 422: Raise Awareness About Alzheimer's & Dementias.

2017-2018 General Assembly

Committee: House Health. If favorable, re-refer to Date: April 4, 2017

Appropriations

Introduced by: Reps. Murphy, Dobson, Boswell **Prepared by:** Theresa Matula

Analysis of: Second Edition Committee Staff

OVERVIEW: House Bill 422 would appropriate \$300,000 in FY 2017-2018 and \$200,000 in FY 2018-2019 to the Division of Aging and Adult Services (DAAS), Department of Health and Human Services (DHHS) to allocate to the Center of Outreach in Alzheimer's, Aging, and Community Health at North Carolina Agricultural and Technical State University (the Center). The Center must use the funding and consult with DHHS and others, to: i) develop workshops, support groups, conferences and materials; (ii) develop a comprehensive caregiver toolkit; and iii) implement a Connect the Family project to share information on Alzheimer's and related dementias and to support caregivers. The bill would become effective July 1, 2017.

[As introduced, this bill was identical to S305, as introduced by Sens. Robinson, Barefoot, Chaudhuri, which is currently in Senate Health Care.]

BILL ANALYSIS: House Bill 422 appropriates \$300,000 for FY 2017-2018 and \$200,000 for FY 2018-2019 from the General Fund to the Department of Health and Human Services (DHHS), Division of Aging and Adult Services (DAAS). The Department is directed to allocate these funds to the Center of Outreach in Alzheimer's, Aging, and Community Health at North Carolina Agricultural and Technical State University (the Center).

The funds will be used to develop and implement the items listed below.

- 1. Workshops, support groups, conferences, and materials The Center is required to develop evidence-based workshops, support groups, and conferences designed to improve awareness, literacy, and knowledge about Alzheimer's disease and related dementias. Requirements include:
- The model will be utilized in the 20 counties with the highest number of low-income families, specifically targeting underserved, underrepresented and rural populations.
- The materials developed must be culturally relevant and bilingual.
- The materials must be available free of charge to the general public on the Center's and the DHHS Internet Web sites in a format that can be downloaded.
- The Center must work with DHHS and other State agencies to develop training programs and awareness activities that are inclusive and engaging across all races, ethnicities, socioeconomic statuses, and educational levels. The Center is also encouraged to work with faith-based organizations to provide outreach to the community concerning brain health.
- 2. Comprehensive caregiver toolkit The Center is required to develop a toolkit to assist families caring for a loved one affected by Alzheimer's disease or related dementias. The caregiver toolkit must:
- Be informed by data from families impacted by Alzheimer's disease or related dementias.





Legislative Analysis Division 919-733-2578

House Bill 422

Page 2

- Address financial resources, legal planning, elder care, and care for the caregiver and provide guidance on local resources and resources specific to counties.
- Available free of charge to the general public on the DHHS Internet Web site in a format that can be downloaded.
- 3. "Connect the Family" project The Center must implement this project to increase awareness about Alzheimer's disease and related dementias and to inform the community about resources available to assist families caring for a loved one affected by Alzheimer's disease or related dementias. The Center must:
- Conduct a statewide caregiver's education conference to share up-to-date information on research as well as introduce the comprehensive caregiver toolkit.
- Conduct the conference remotely or in person, in each of the 20 rural counties identified in item 1 above.

EFFECTIVE DATE: House Bill 422 would become effective July 1, 2017.

BACKGROUND: The NC Institute of Medicine released the <u>Dementia-Capable North Carolina</u>: A <u>Strategic Plan for Addressing Alzheimer's Disease and Related Dementias</u> report in March 2016. The report was presented to the Joint Legislative Oversight Committee on Health and Human Services on March 8, 2016. The presentation included the following background information on Alzheimer's Disease and related dementias: It is the 5th leading cause of death in North Carolina; there are over 160,000 older adults diagnosed with Alzheimer's or related dementias currently and that number is expected to rise to 300,000 by 2030; and it is the only top 10 cause of death that cannot be cured, prevented, or slowed. By 2025, one in five North Carolinians will be 65 and older.

The report contained a number of recommendations. HB 422 is related to Recommendation 5.1: Promote integration and accessibility of dementia-specific resources through a comprehensive caregiver toolkit and a virtual resource center.

GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2017

H **HOUSE BILL 422*** Corrected Copy 3/31/17

(Public)

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Sponsors:

Short Title:

Raise Awareness About Alzheimer's & Dementias.

Representatives Murphy, Dobson, and Boswell (Primary Sponsors).

For a complete list of sponsors, refer to the North Carolina General Assembly web site.

Referred to:

Health, if favorable, Appropriations

March 22, 2017

A BILL TO BE ENTITLED

AN ACT APPROPRIATING FUNDS TO THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF AGING AND ADULT SERVICES, FOR IMPLEMENTATION OF CERTAIN RECOMMENDATIONS OF THE TASK FORCE ON ALZHEIMER'S DISEASE AND RELATED DEMENTIAS.

The General Assembly of North Carolina enacts:

SECTION 1. There is appropriated from the General Fund to the Department of Health and Human Services, Division of Aging and Adult Services, the sum of three hundred thousand dollars (\$300,000) for the 2017-2018 fiscal year and the sum of two hundred thousand dollars (\$200,000) for the 2018-2019 fiscal year. These funds shall be allocated to the Center of Outreach in Alzheimer's, Aging, and Community Health at North Carolina Agricultural and Technical State University ("the Center"), to be used exclusively for the following purposes:

- To utilize a lay-health advisor model to develop evidence-based workshops, (1) support groups, and conferences designed to improve awareness, literacy. and knowledge about Alzheimer's disease and related dementias in 20 counties of the State with the highest number of low-income families, specifically targeting underserved and underrepresented populations and, in particular, those residing in rural areas of North Carolina. The Center shall develop culturally relevant, bilingual informational materials for distribution at these workshops, support groups, and conferences. The materials shall also be made available free of charge to the general public on the Center's and the Department of Public Health Service's Internet Web sites in a format that can be downloaded. In developing the training programs authorized by this subdivision, the Center shall consult with the Department of Health and Human Services and any other relevant State agencies to ensure that awareness activities are inclusive and engaging across all races, ehricities, socioeconomic statuses, and educational levels and is encouraged to work with faith-based organizations to provide outreach to the community concerning brain health.
- To develop a comprehensive caregiver toolkit to assist families caring for a (2) loved one affected by Alzheimer's disease or related dementias. The design of the caregiver toolkit must (i) be informed by data from families impacted by Alzheimer's disease or related dementias and (ii) address financial resources, legal planning, elder care, and care for the caregiver and provide



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	eneral Assembly Of North Carolina Session 2017
1	guidance on local resources and resources specific to counties. The toolkit
2	must be made available free of charge to the general public on the
3	Department of Health and Human Service's Internet Web site in a format
4	that can be downloaded.
5	(3) To implement a "Connect the Family" project to increase awareness about
6	Alzheimer's disease and related dementias and to inform the community
7	about resources available to assist families caring for a loved one affected by
8	Alzheimer's disease or related dementias. As part of this project, the Center
9	shall conduct a statewide caregiver's education conference to share
10	up-to-date information on research as well as introduce the comprehensive
11	caregiver toolkit described in subdivision (3) of this section. The conference
12	shall be conducted in each of the 20 rural counties identified pursuant to
13	subdivision (1) of this section, either remotely or in person.
14	SECTION 3. This act becomes effective July 1, 2017.



HOUSE BILL 464: Revise Schedule of Controlled Substances.

2017-2018 General Assembly

Committee: House Health. If favorable, re-refer to Date: April 4, 2017

Judiciary I

Introduced by: Reps. Horn, Murphy, Malone Prepared by: Augustus D. Willis

Analysis of: First Edition Committee Counsel

OVERVIEW: House Bill 464 would (i) schedule a number of substances under the Controlled Substances Act, (ii) remove two substances containing dihydrocodeinone from Schedule III, (iii) reschedule "synthetic cannabinoids" from Schedule VI to Schedule I, (iv) re-schedule Buprenorphine from Schedule IV to Schedule III, and (v) amend the term "hydrocodone" to include any material, compound, mixture, or preparation which contains any quantity of hydrocodone.

[As introduced, this bill was identical to S347, as introduced by Sens. J. Davis, McInnis, which is currently in Senate Rules and Operations of the Senate.]

CURRENT LAW: Controlled substances regulated by the Controlled Substances Act are classified in Schedules I through VI pursuant to sections 89 through 94 of Chapter 90.

BILL ANALYSIS: House Bill 464 would make the following changes in the scheduling of controlled substances:

Schedule I. Section 2 of the bill would:

- Add Trans 3,4 dichloro N (2(dimethylamino)cyclohexyl) N methyl-benzamide (U47700) to Schedule I.
- Add "fentanyl derivatives" to Schedule I, specifically including the following:
 - o N (1 phenylethylpiperidin 4 yl) N phenylfuran 2 carboxamide (also known as Furanyl Fentanyl).
 - o N (1 phenethylpiperidin 4 yl) N phenylbutyramide; N (1 phenethylpiperidin 4 yl) N phenylbutanamide (also known as Butyryl Fentanyl).
 - o N-[1-[2-hydroxy-2-(thiophen-2-yl)ethyl]piperidin-4-yl]-N-phenylpropionamide;
 - o N [1 [2 hydroxy 2 (2 thienyl)ethyl] 4 piperidinyl] N phenylpropanamide (also known as Beta Hydroxythiofentanyl).
 - o N phenyl N [1 (2 phenylethyl)piperidin 4 yl] 2propenamide (also known as Acrylfentanyl).
 - o N phenyl N [1 (2 phenylethyl) 4 piperidinyl] pentanamide (also known as Valeryl Fentanyl).
 - o N-(2-fluorophenyl)-N-[1-(2-phenylethyl)-4-piperidinyl]-propanamide (also known as 2-fluorofentanyl).

Karen Cochrane-Brown Director



Legislative Analysis Division 919-733-2578

House Bill 464

Page 2

- o N (3 fluorophenyl) N [1 (2 phenylethyl) 4 piperidinyl]-propanamide (also known as 3-fluorofentanyl).
- o N-(1-phenethylpiperidin-4-yl)-N-phenyltetrahydrofuran-2-carboxamide (also known as tetrahydrofuran fentanyl).
- o N-(4-fluorophenyl)-2-methyl-N-[1-(2-phenylethyl)-4-piperidinyl]-propanamide (also known as 4-fluoroisobutyryl fentanyl, 4-FIBF).
- o N-(4-fluorophenyl)-N-[1-(2-phenylethyl)-4-piperidinyl]-butanamide (also known as 4 fluorobutyryl fentanyl, 4 FBF).
- Add the following hallucinogenic substances:
 - o BTCP (Benzothiophenylcyclohexylpiperidine).
 - Deschloroketamine.
 - o 3 MeO PCP (3 methoxyphencyclidine).
 - o 4 hydroxy MET.
 - o 4 OH MiPT (4 hydroxy N methyl N isopropyltryptamine).
 - 5 methoxy N methyl N propyltryptamine (5 MeO MiPT).
- Add the following systemic depressants:
 - o Etizolam.
 - Flubromazepam.
- Recodify "synthetic cannabinoids" from Schedule VI to Schedule I.

Schedule II. Section 3 of the bill would:

• Amend the term "hydrocodone" to include any material, compound, mixture, or preparation which contains any quantity of hydrocodone.

Schedule III. Section 4 of the bill would:

- Remove the following from Schedule III:
 - Not more than 300 milligrams of dihydrocodeinone per 100 milliliters or not more than
 15 milligrams per dosage unit with a four fold or greater quantity of an isoquinoline alkaloid of opium.
 - Not more than 300 milligrams of dihydrocodeinone per 100 millileters or not more than
 15 milligrams per dosage unit, with one or more active, nonnarcotic ingredients in recognized therapeutic amounts.
- Recodify Buprenorphine from Schedule IV to Schedule III.
- Add the following anabolic steroids to Schedule III:
 - o Boldione.
 - O Desoxymethyltesterone (17[alpha] methyl 5[alpha] androst 2 en 17[beta] ol) (also known as madol).
 - Methasterone.

House Bill 464

Page 3

o 19 nor 4, 9(10) androstadienedione (estra 4, 9(10) diene 3, 17 dione).

Schedule IV. Section 5 of the bill would:

- Add the following depressants to Schedule IV:
 - o Carisoprodol.
 - o Dichloralphenazone.
 - o Fospropol.
 - o Tramadol.
 - o Zopiclone.

Schedule V. Section 6 of the bill would:

- Add the following depressants to Schedule V:
 - o Ezogabine.
 - o Lacosamide.

EFFECTIVE DATE: This act is effective December 1, 2017 and applies to offenses committed on or after that date.

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GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2017

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HOUSE BILL 464*

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Short Title: Revise Schedule of Controlled Substances. (Public)

Sponsors: Representatives Horn, Murphy, and Malone (Primary Sponsors).

For a complete list of sponsors, refer to the North Caroling General Assembly web site.

Referred to: Health, if favorable, Judiciary 1

March 27, 2017

A BILL TO BE ENTITLED

AN ACT REVISING THE SCHEDULE OF CONTROLLED SUBSTANCES TO ADD SYNTHETIC FENTANYLS, DESIGNER HALLUCINOGENICS, SYNTHETIC CANNABINOIDS, SYSTEM DEPRESSANTS, AND OTHER SUBSTANCES.

The General Assembly of North Carolina enacts:

SECTION 1. This act shall be known and may be cited as the "Synthetic Opioid and Other Dangerous Drug Control Act."

SECTION 2. G.S. 90-89 reads as rewritten:

"§ 90-89. Schedule I controlled substances.

This schedule includes the controlled substances listed or to be listed by whatever official name, common or usual name, chemical name, or trade name designated. In determining that a substance comes within this schedule, the Commission shall find: a high potential for abuse, no currently accepted medical use in the United States, or a lack of accepted safety for use in treatment under medical supervision. The following controlled substances are included in this schedule:

- (1) <u>Opiates.</u> Any of the following opiates, including the isomers, esters, ethers, salts and salts of isomers, esters, and ethers, unless specifically excepted, or listed in another schedule, whenever the existence of such isomers, esters, ethers, and salts is possible within the specific chemical designation:
 - a. Acetyl-alpha-methylfentanyl (N[1-(1-methyl-2-phenethyl)-4/y-piperidinyl]-N-phenylacet amide).
 - b. Acetylmethadol.
 - c. Repealed by Session Laws 1987. c. 412, s. 2.
 - d. Alpha-methylthiofentanyl (N-[1-methyl-2-(2-thienyl)ethyl/y-4/y-piperidinyl]-N-phenylpropana mide).
 - e. Allylprodine.
 - f. Alphacetylmethadol.
 - g. Alphameprodine.
 - h. Alphamethadol.
 - i. Alpha-methylfentanyl (N-(1-(alpha-methyl-beta-phenyl) ethyl-4-piperidyl) propionalilide; 1(1-methyl-2-phenyl-ethyl)-4-(N-propanilido) piperidine).
 - j. Benzethidine.
 - k. Betacetylmethadol.



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	l.	Beta-hydroxfentanyl		
		(N-[1-(2-hydroxy-2-phenethyl)-4-piperidinyl]-	N-phenylpropanamide	
	m.	Beta-hydroxy-3-methylfentanyl		
		(N-[1-(2-hydroxy-2-phenethyl)-3-methyl-4-pip	peridinyl]-N-pheny	
		lpropanamide).	,	
	n.	Betameprodine.		
	0.	Betamethadol.		
	p.	Betaprodine.		
	q.	Clonitazene.		
	r.	Dextromoramide.		
	s.	Diampromide.		
	t.	Diethylthiambutene.		
	u.	Difenoxin.		
	v.	Dimenoxadol.		
	W.	Dimepheptanol.		
	х.	Dimethylthiambutene.		
	у.	Dioxaphetyl butyrate.		
	Z.	Dipipanone.		
	aa.	Ethylmethylthiambutene.		
	bb.	Etonitazene.		
	cc.	Etoxeridine.		
	dd.	Furethidine.		
	ee.	Hydroxypethidine.		
	ff.	Ketobemidone.		
	gg.	Levomoramide.		
	hh.	Levophenacylmorphan.		
	ii.	1-methyl-4-phenyl-4-propionoxypiperidine (M	PPP).	
	jj.	3-Methylfentanyl		
		(N-[3-methyl-1-(2-Phenylethyl)-4-Pi-peridyl]	J-N-Phenylpropanamid	
	1.1	e).		
	kk.	3-Methylthiofentanyl	13 N. 1 1	
		(N-[(3-methyl-1-(2-thienyl)ethyl/y-4-piperidin	yıj-iv-pnenyipropanam	
	11	ide).		
	ll.	Morpheridine. Noracymethadol.		
	mm.	· · · · · · · · · · · · · · · · · · ·		
	nn.	Norlevorphanol. Normethadone.		
	00.	Norpipanone.		
	pp.	Para-fluorofentanyl		
	qq.	(N-(4-fluorophenyl)-N-[1-(2-phen-ethyl)-4-pip	eridinyll-nr	
		opanamide.	enamyn pr	
	rr.	Phenadoxone.		
	SS.	Phenampromide.		
	tt.	1-(2-phenethyl)-4-phenyl-4-acetoxypiperidine	(PEPAP).	
	uu.	Phenomorphan.	()	
	vv.	Phenoperidine.		
	ww.	Piritramide.		
	XX.	Proheptazine.		
	уу.	Properidine.		
	ZZ.	Propiram.		

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1	i.	Etorphine (except hydrochloride salt).	
2	j.	Heroin.	
3	k.	Hydromorphinol.	
4	<i>l</i> .	Methyldesorphine.	
5	m.	Methyldihydromorphine.	
6	n.	Morphine methylbromide.	
7	0.	Morphine methylsulfonate.	
8	p.	Morphine-N-Oxide.	
9	q.	Myrophine.	
10	q. r.	Nicocodeine.	
11	S.	Nicomorphine.	
12		Normorphine.	
	t.	Pholcodine.	
13	u.		
14	V.	Thebacon.	
15	W.	Drotebanol.	
16		einogenic Substances. – Any material, co	-
17		ration which contains any quantity of the fo	
18		nces, including their salts, isomers, and sa	
19		ically excepted, or listed in another schedule,	
20		th salts, isomers, and salts of isomers is poss	sible within the specific
21	chemi	cal designation:	
22	a.	3, 4-methylenedioxyamphetamine.	
23	b.	5-methoxy-3, 4-methylenedioxyamphetamine	
24	c.	3, 4-Methylenedioxymethamphetamine (MD)	MA).
25	d.	3.4-methylenedioxy-N-ethylamphetamine	(also known as
26		N-ethyl-alpha-methyl-3,4-(methylenedioxy)p	henethylamine, N-ethyl
27		MDA, MDE, and MDEA).	
28	e.	N-hydroxy-3,4-methylenedioxyamphetamine	(also known as
29		N-hydroxy/y-alpha-methyl-3,4-(methylenedic	
30		and N-hydroxy MDA).	
31	f.	3, 4, 5-trimethoxyamphetamine.	
32	g.	Alpha-ethyltryptamine. Some trade or other	er names: etryptamine.
33	5.	Monase, alpha-ethyl-1H-indole-3- ethanar	
34		indole, alpha-ET, and AET.	
35	h.	Bufotenine.	
36	i.	Diethyltryptamine.	
37	j.	Dimethyltryptamine.	
	<i>J.</i> k.		
38	l.	4-methyl-2, 5-dimethoxyamphetamine.	
39		Ibogaine.	
40	m.	Lysergic acid diethylamide.	
41	n.	Mescaline.	the aloosified between
42:	0.	Peyote, meaning all parts of the plant present	
43		as Lophophora Williamsii Lemaire, whether	
44.		seeds thereof: any extract from any part of	
45		compound, manufacture, salt, derivative, m	exture or preparation of
46		such plant, its seed or extracts.	
47	p.	N-ethyl-3-piperidyl benzilate.	
48	q.	N-methyl-3-piperidyl benzilate.	
491	r.	Psilocybin.	
50	S.	Psilocin.	
51	t.	2, 5-dimethoxyamphetamine.	

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		alpha-N-methylamino- propiophenone, mo	henylpropan-1-one, conomethylproprion,
		ephedrone, N-methylcathinone, methylcathinone, AL-463, and UR1432.	AL-404, AL-422,
	e.	(+-)cis-4-methylaminorex	
		[(+-)cis-4.5-dihydro-4-methyl-5-phenyl-2-oxazola as 2-amino-4-methyl-5-phenyl-2-oxazoline).	mine] (also known
	f.		other names:
		N,N.alpha-tri- methylbe	enzeneethaneamine;
		N,N,alpha-trimethylphenethylamine.	
	g.	N-ethylamphetamine.	
	h.	4-methylmethcathinone (also known as mephedror	
	i.	3.4-Methylenedioxypyrovalerone (also known as)	
	j.	A compound, other than bupropion, that is structu	
		2-amino-1-phenyl-1-propanone by modification	_
		following ways: (i) by substitution in the phenyl	
		with alkyl, alkoxy, alkylenedioxy, haloalkyl, or	
		whether or not further substituted in the phenyl ri	-
		other univalent substituents: (ii) by substitution at	•
		an alkyl substituent; or (iii) by substitution at the	
		alkyl or dialkyl groups or by inclusion of the	ntrogen atom m a
	1.	cyclic structure.	
	k. <i>l</i> .	N-Benzylpiperazine.	
(6		2.5 – Dimethoxy-4-(n)-propylthiophenethylamine. Me Compounds. – Any material compound, mixt	
(6)	*		2 2
		h contains any quantity of the following substances, ers, and salts of isomers whenever the existence of	
		salts of isomers is possible within the specific ch	
		s specifically excepted or unless listed in another sch	_
	a.	25B-NBOMe	icatic.
	a.	(2C-B-NBOMe)-2-(4-Bromo-2,5-dimethoxypheny	JI)_N_(2_methovyh
		enzyl)ethanamine.	71)-11-(2-methoxy0
	b.	25C-NBOMe	
	υ.	(2C-C-NBOMe)-2-(4-Chloro-2,5-dimethoxypheny	/I)-N-(2-methoxyh
		enzyl)ethanamine.	71)-11-(2-methoxy0
	c.	25D-NBOMe	
	٠.	(2C-D-NBOMe)-2-(2.5-dimethoxy-4-methylpheny	vI)-N-(2-methoxyh
		enzyl)ethanamine.	/1)-11-(2-methoxy0
	d.	25E-NBOMe	
	u.	(2C-E-NBOMe)-2-(4-Ethyl-2,5-dimethoxyphenyl)	N-(2-methoxyben
		zyl)ethanamine.)-14-(2-methoxyben
	0	25G-NBOMe	
	e.	(2C-G-NBOMe)-2-(2,5-dimethoxy-3,4-dimethylpl	henvI)-N-(2-metho
		xybenzyl)ethanamine.	neny1)-14-(2-metho
	f.	25H-NBOMe	
	1.	(2C-H-NBOMe)-2-(2,5-dimethoxyphenyl)-N-(2-n	nethovyhenzyl)etha
		namine.	iction your zytjetila
	C.	251-NBOMe	
	g.	(2C-I-NBOMe)-2-(4-Iodo-2,5-dimethoxyphenyl)-	N. (2. methovuhenz
			r-(2-memoxybenz
		yl)ethanamine.	

indole ring to any extent, whether or not further substituted on the

cyclopropyl, cyclobutyl, or cyclopentyl rings to any extent.

Substances in this class include, but are not limited to: UR-144,

Indole carboxaldehydes. Any compound structurally derived from

1H-indole-3-carboxaldehyde or 1H-indole-2-carboxaldehyde

fluoro-UR-144, XLR-11, A-796,260, and A-834,735.

substituted in both of the following ways:

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naphthyl, adamantyl, or cyclopropyl ring. Substances in this

class include, but are not limited to: SDB-001 and STS-135.

1		whether or not the compound is further modified to any extent in the
2 3		following ways: (i) substitution to the indole ring to any extent, (ii)
		substitution to the phenyl, benzyl, naphthyl, adamantyl, cyclopropyl,
4		or propionaldehyde group to any extent, (iii) a nitrogen heterocyclic
5		analog of the indole ring, or (iv) a nitrogen heterocyclic analog of the
6		phenyl, benzyl, naphthyl, adamantyl, or cyclopropyl ring. Substances
7		in this class include, but are not limited to: PB-22 and fluoro-PB-22.
8	<u>n.</u>	Indazole carboxaldehydes. Any compound structurally derived from
9		1H-indazole-3-carboxaldehyde or 1H-indazole-2-carboxaldehyde
10		substituted in both of the following ways:
11		1. At the nitrogen atom of the indazole ring by an alkyl,
12		haloalkyl, cyanoalkyl, alkenyl, cycloalkylmethyl,
13		cycloalkylethyl, 1-(N-methyl-2-piperidinyl)methyl,
14		2-(4-morpholinyl)ethyl, 1-(N-methyl-2-pyrrolidinyl)methyl,
15		1-(N-methyl-3-morpholinyl)methyl,
16		tetrahydropyranylmethyl, benzyl, or halo benzyl group; and
17		2. At the carbon of the carboxaldehyde by a phenyl, benzyl,
18		whether or not the compound is further modified to any extent in the
19		following ways: (i) substitution to the indazole ring to any extent, (ii)
20		substitution to the phenyl, benzyl, naphthyl, adamantyl, cyclopropyl,
21		or propionaldehyde group to any extent, (iii) a nitrogen heterocyclic
22		analog of the indazole ring, or (iv) a nitrogen heterocyclic analog of
23		the phenyl, benzyl, naphthyl, adamantyl, or cyclopropyl ring.
24	<u>O.</u>	Indazole carboxamides. Any compound structurally derived from
25		1H-indazole-3-carboxamide or 1H-indazole-2-carboxamide
26		substituted in both of the following ways:
27		1. At the nitrogen atom of the indazole ring by an alkyl,
28		haloalkyl, cyanoalkyl, alkenyl, cycloalkylmethyl,
29		cycloalkylethyl, 1-(N-methyl-2-piperidinyl)methyl, 2-(4-morpholinyl)ethyl, 1-(N-methyl-2-pyrrolidinyl)methyl,
30 31		1-(N-methyl-3-morpholinyl)methyl,
32		tetrahydropyranylmethyl, benzyl, or halo benzyl group; and
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34		2. At the nitrogen of the carboxamide by a phenyl, benzyl, naphthyl, adamantyl, cyclopropyl, or propionaldehyde group;
35		whether or not the compound is further modified to any extent in the
36		following ways: (i) substitution to the indazole ring to any extent, (ii)
37		substitution to the phenyl, benzyl, naphthyl, adamantyl, cyclopropyl,
38		or propionaldehyde group to any extent, (iii) a nitrogen heterocyclic
39		analog of the indazole ring, or (iv) a nitrogen heterocyclic analog of
40		the phenyl, benzyl, naphthyl, adamantyl, or cyclopropyl ring.
41		Substances in this class include, but are not limited to: AKB-48,
42		fluoro-AKB-48, APINCACA, AB-PINACA, AB-FUBINACA,
43		ADB-FUBINACA, and ADB-PINACA.
44	<u>p.</u>	Indazole carboxylic acids. Any compound structurally derived from
45	<u>F.</u>	1H-indazole-3-carboxylic acid or 1H-indazole-2-carboxylic acid
46		substituted in both of the following ways:
47		1. At the nitrogen atom of the indazole ring by an alkyl,
48		haloalkyl, cyanoalkyl, alkenyl, cycloalkylmethyl,
49		cycloalkylethyl, 1-(N-methyl-2-piperidinyl)methyl,
50		2-(4-morpholinyl)ethyl, 1-(N-methyl-2-pyrrolidinyl)methyl,

1-(N-methyl-3-morpholinyl)methyl,
tetrahydropyranylmethyl, benzyl, or halo benzyl group; and
2. At the hydroxyl group of the carboxylic acid by a phenyl,
benzyl, naphthyl, adamantyl, cyclopropyl, or
propionaldehyde group;
whether or not the compound is further modified to any extent in the
following ways: (i) substitution to the indazole ring to any extent, (ii)
substitution to the phenyl, benzyl, naphthyl, adamantyl, cyclopropyl,
or propionaldehyde group to any extent, (iii) a nitrogen heterocyclic
analog of the indazole ring, or (iv) a nitrogen heterocyclic analog of

the phenyl, benzyl, naphthyl, adamantyl, or cyclopropyl ring."

SECTION 3. G.S. 90-90 reads as rewritten:

"§ 90-90. Schedule II controlled substances.

This schedule includes the controlled substances listed or to be listed by whatever official name, common or usual name, chemical name, or trade name designated. In determining that a substance comes within this schedule, the Commission shall find: a high potential for abuse; currently accepted medical use in the United States, or currently accepted medical use with severe restrictions; and the abuse of the substance may lead to severe psychic or physical dependence. The following controlled substances are included in this schedule:

- (1) Any of the following substances whether produced directly or indirectly by extraction from substances of vegetable origin, or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis, unless specifically excepted or unless listed in another schedule:
 - a. Opium and opiate, and any salt, compound, derivative, or preparation of opium and opiate, excluding apomorphine, nalbuphine, dextrorphan, naloxone, naltrexone and nalmefene, and their respective salts, but including the following:
 - 1. Raw opium.
 - 2. Opium extracts.
 - 3. Opium fluid extracts.
 - 4. Powdered opium.
 - 5. Granulated opium.
 - 6. Tincture of opium.
 - 7. Codeine.
 - 8. Ethylmorphine.
 - 9. Etorphine hydrochloride.
 - 10. Hydrocodone. Any material, compound, mixture, or preparation which contains any quantity of hydrocodone.
 - 11. Hydromorphone.
 - 12. Metopon.
 - 13. Morphine.
 - 14. Oxycodone.
 - 15. Oxymorphone.
 - 16. Thebaine.
 - 17. Dihydroetorphine.
 - b. Any salt, compound, derivative, or preparation thereof which is chemically equivalent or identical with any of the substances referred to in paragraph 1 of this subdivision, except that these substances shall not include the isoquinoline alkaloids of opium.
 - c. Opium poppy and poppy straw.

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Anabolic steroids. The term "anabolic steroid" means any drug or hormonal 1 2 substance, chemically and pharmacologically related to testosterone (other than estrogens, 3 progestins, and corticosteroids) that promotes muscle growth, including, but not limited to, the 4 following: 5 Methandrostenolone. 1. 6 2. Stanozolol. 7 3. Ethylestrenol, Nandrolone phenpropionate, 8 4. 9 Nandrolone decanoate. 5. 10 6. Testosterone propionate, Chorionic gonadotropin, 11 7. 12 8. Boldenone, 13 Boldione, 8a. 14 Chlorotestosterone (4-chlorotestosterone). 9. 15 10. Clostebol, Dehydrochlormethyltestosterone, 16 11. Desoxymethyltesterone 17 11a. 18 (17[alpha]-methyl-5[alpha]-androst-2-en-17[beta]-ol) (also known as 19 madol). 20 12. Dibydrostestosterone (4-dihydrotestosterone), Drostanolone, 21 13. Fluoxymesterone, 22 14. Formebulone (formebolone), 23 15. Mesterolene. 24 16. 25 17. Methandienone, 18. Methandranone. 26 27 19. Methandriol, 28 19a. Methasterone. 29 Methenolene, 20. 30 Methyltestosterone, 21. 31 22. Mibolerone, 32 23. Nandrolene, 33 24. Norethandrolene, 34 25. Oxandrolone, 35 26. Oxymesterone, Oxymetholone, 36 27. Stanolone, 37 28. 38 29. Testolactone, 39 30. Testosterone, 40 31. Trenbolone, and 41 31a. 19-nor-4, 9(10)-androstadienedione (estra-4, 9(10)-diene-3, 17-dione), and 42 32. Any salt, ester, or isomer of a drug or substance described or listed in this subsection, if that salt, ester, or isomer promotes muscle growth. Except 43 44 such term does not include (i) an anabolic steroid which is expressly intended for administration through implants to cattle or other nonhuman 45 species and which has been approved by the Secretary of Health and Human 46 Services for such administration or (ii) chorionic gonadotropin when 47 48 administered by injection for veterinary use by a licensed veterinarian or the 49 veterinarian's designated agent. If any person prescribes, dispenses, or

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distributes such steroid for human use, such person shall be considered to

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have prescribed, dispensed, or distributed an anabolic steroid within the meaning of this subsection.

SECTION 5. G.S. 90-92(a) reads as rewritten:

"(a) This schedule includes the controlled substances listed or to be listed by whatever official name, common or usual name, chemical name, or trade name designated. In

- "(a) This schedule includes the controlled substances listed or to be listed by whatever official name, common or usual name, chemical name, or trade name designated. In determining that a substance comes within this schedule, the Commission shall find: a low potential for abuse relative to the substances listed in Schedule III of this Article; currently accepted medical use in the United States; and limited physical or pyschological dependence relative to the substances listed in Schedule III of this Article. The following controlled substances are included in this schedule:
 - (1) Depressants. Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances, including its salts, isomers, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation:
 - a. Alprazolam.
 - b. Barbital.
 - c. Bromazepam.
 - d. Camazepam.
 - dl. Carisoprodol.
 - e. Chloral betaine.
 - f. Chloral hydrate.
 - g. Chlordiazepoxide.
 - h. Clobazam.
 - i. Clonazepam.
 - j. Clorazepate.
 - k. Clotiazepam.
 - l. Cloxazolam.
 - m. Delorazepam.
 - n. Diazepam.
 - n1. <u>Dichloralphenazone</u>.
 - o. Estazolam.
 - p. Ethchlorvynol.
 - q. Ethinamate.
 - r. Ethyl loflazepate.
 - s. Fludiazepam.
 - t. Flunitrazepam.
 - u. Flurazepam.
- ul. <u>Fospropol.</u>
- 41 v. Repealed by Session Laws 2000, c. 140, s. 92.2(c).
- 42 w. Halazepam.
 - x. Haloxazolam.
 - y. Ketazolam.
 - z. Loprazolam.
 - aa. Lorazepam.
- bb. Lormetazepam.
- 48 cc. Mebutamate.
- dd. Medazepam.
- ee. Meprobamate.
- ff. Methohexital.

SECTION 8. This act becomes effective December 1, 2017, and applies to

offenses committed on or after that date.

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HOUSE BILL 478: Required Experience for MH/DD/SA QPs.

2017-2018 General Assembly

House Health Committee:

Introduced by: Reps. Dobson, S. Martin, K. Hall, Brisson

PCS to First Edition Analysis of:

H478-CSTR-2

Date:

April 5, 2017 Prepared by: Jennifer Hillman

Staff Attorney

OVERVIEW: The PCS to House Bill 478 would require the Department of Health and Human Services (DHHS) to amend the qualifications for Qualified Professionals in the mental health, developmental disabilities, and substance abuse services (MH/DD/SAS) system of care to count all years of full-time MH/DD/SAS experience toward the required number of years' experience, regardless of when the experience was obtained.

CURRENT LAW: Administrative rule 10A N.C.A.C. 27G .0104 and the Medicaid State Plan state the qualifications for Qualified Professionals within the MH/DD/SAS system of care. Currently, Qualified Professionals must have either one, two, or four years of full-time MH/DD/SAS experience after completing educational requirements. The number of years of MH/DD/SAS experience required depends on the whether the level of education attained is a master's degree or a bachelor's degree and whether the degree is in a human services field.

BILL ANALYSIS: The PCS makes technical and clarifying changes to the bill.

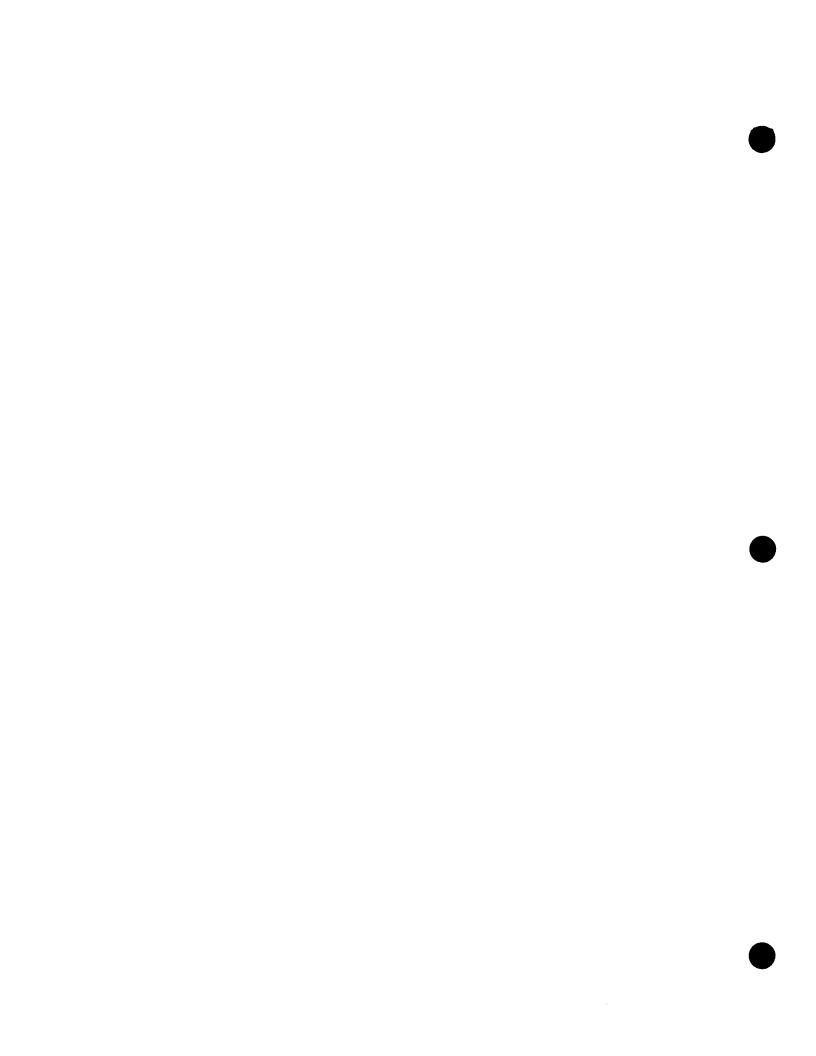
Section 1 directs DHHS to amend the qualifications for Qualified Professionals that are established in rule, Medicaid clinical coverage policy, and in the Medicaid State Plan, to count all years of full-time MH/DD/SAS experience toward the number of years of MH/DD/SAS experience required based on the type of degree held and the field of study, regardless of whether the experience was obtained before or after completion of the degree. DHHS is required to submit any necessary State Plan amendments to the Centers for Medicare and Medicaid Services (CMS) by October 1, 2017.

EFFECTIVE DATE: The bill would be effective when it becomes law, and the required changes to the qualifications for Qualified Professions would not be effective until CMS approves the necessary Medicaid State Plan amendments.

Karen Cochrane-Brown Director



Legislative Analysis Division 919-733-2578



GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2017

H D

HOUSE BILL 478 PROPOSED COMMITTEE SUBSTITUTE H478-CSTR-2 [v.5] 04/04/2017 06:21:27 PM

Short Title:	Required Experience for MH/DD/SA QPs.	(Public)

Sponsors:

Referred to:

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21 22 March 27, 2017

A BILL TO BE ENTITLED

1 2 AN ACT TO A

AN ACT TO ALLOW ALL YEARS OF FULL-TIME MENTAL HEALTH, DEVELOPMENTAL DISABILITY, AND SUBSTANCE ABUSE SERVICES (MH/DD/SAS) EXPERIENCE TO APPLY TO THE QUALIFICATIONS REQUIRED FOR MH/DD/SAS QUALIFIED PROFESSIONALS.

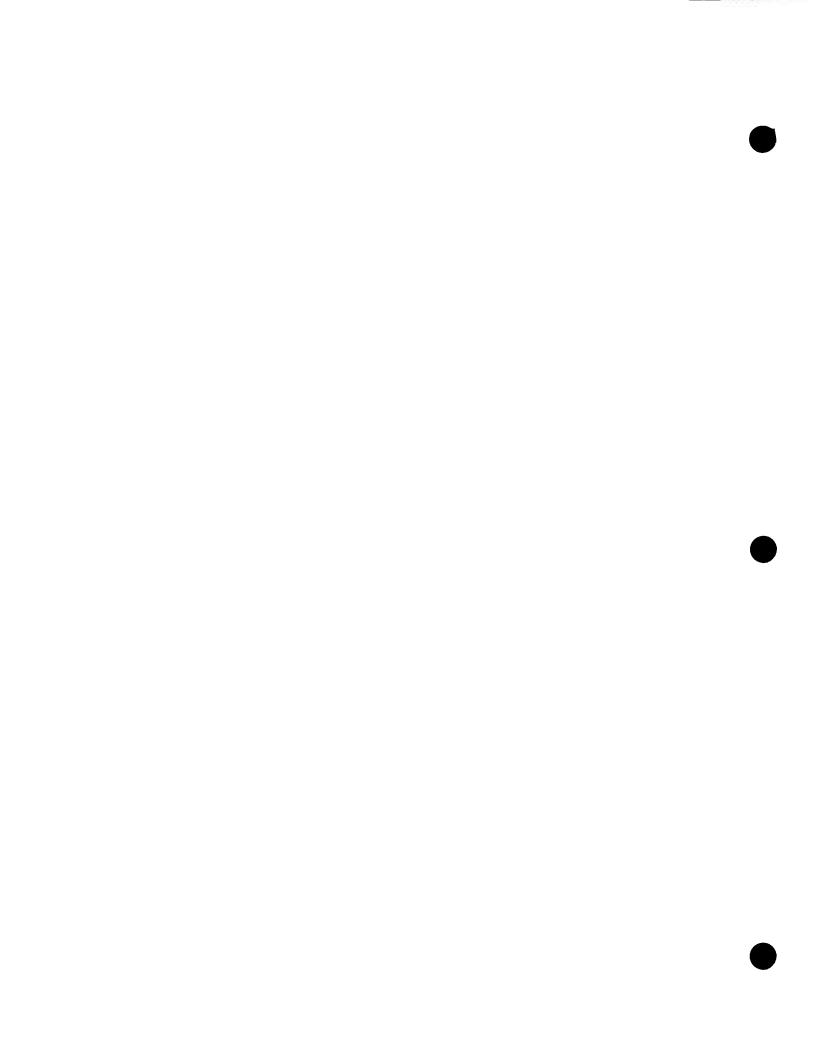
The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services (DHHS) shall amend the qualifications for Qualified Professionals within the mental health, developmental disability, and substance abuse services (MH/DD/SAS) system of care, as defined in rule, clinical care policies for the Medicaid program, and the North Carolina Medicaid State Plan. Qualifications for Qualified Professionals shall allow for all years of full-time MH/DD/SAS experience to qualify as years of experience, rather than limiting qualifying full-time MH/DD/SAS experience to only that experience which is obtained post-bachelor's degree or post-graduate degree. No later than October 1, 2017, any State Plan amendment necessary to effect these changes shall be submitted by DHHS to the Centers for Medicare and Medicaid Services (CMS).

SECTION 2. Any changes to clinical coverage policies and any changes to rules adopted by the Department of Health and Human Services relating to the qualifications for Qualified Professionals required under Section 1 of this act shall not become effective until DHHS has received CMS approval of the State Plan amendment required by Section 1 of this act

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





GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2017

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H HOUSE BILL 478

Short Title: Required Experience for MH/DD/SA QPs. (Public)

Sponsors: Representatives Dobson, S. Martin, K. Hall, and Brisson (Primary Sponsors).

For a complete list of sponsors, refer to the North Carolina General Assembly web site.

Referred to: Health

March 27, 2017

A BILL TO BE ENTITLED

1 2 AN ACT TO

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AN ACT TO ALLOW ALL YEARS OF FULL-TIME MENTAL HEALTH, DEVELOPMENTAL DISABILITY, AND SUBSTANCE ABUSE SERVICE TO APPLY TO THE QUALIFICATIONS REQUIRED BY THE MEDICAID PROGRAM FOR QUALIFIED PROFESSIONALS.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services (DHHS) shall amend the qualifications for Qualified Professionals within the mental health, developmental disability, and substance abuse (MH/DD/SA) system of care, as defined in rule, clinical care policies for the Medicaid program, and the North Carolina Medicaid State Plan. Qualifications for Qualified Professionals shall allow for all years of full-time MH/DD/SA service experience to qualify as years of service, rather than limiting qualifying full-time MH/DD/SA service to that which is obtained post-graduate degree only. No later than October 1. 2017. any necessary State Plan amendment to effect these changes shall be submitted by DHHS to the Centers for Medicare and Medicaid.

SECTION 2. Any changes to clinical coverage policies and any changes to rules adopted by the Department of Health and Human Services relating to the qualifications for Qualified Professionals required under Section 1 of this act shall not become effective until CMS approval of the State Plan amendments submitted by DHHS to effect these changes has been received.

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





State Telehealth Laws and Medicaid Program Policies

A Comprehensive Scan of the 50 States and District of Columbia

August 2016



State Telehealth Laws and Medicaid Program Policies

Introduction

The Center for Connected Health Policy's (CCHP) updated fourth annual edition of "State Telehealth Laws and Reimbursement Policies" offers policymakers, health advocates, and other interested health care professionals the most current summary guide of telehealth-related policies, laws, and regulations for all 50 states and the District of Columbia. States continue to pursue their own unique set of telehealth policies as more and more legislation is introduced each year. Some states have incorporated policies into law, while others have addressed issues such as definition, reimbursement policies, licensure requirements, and other important issues in their Medicaid Program Guidelines.

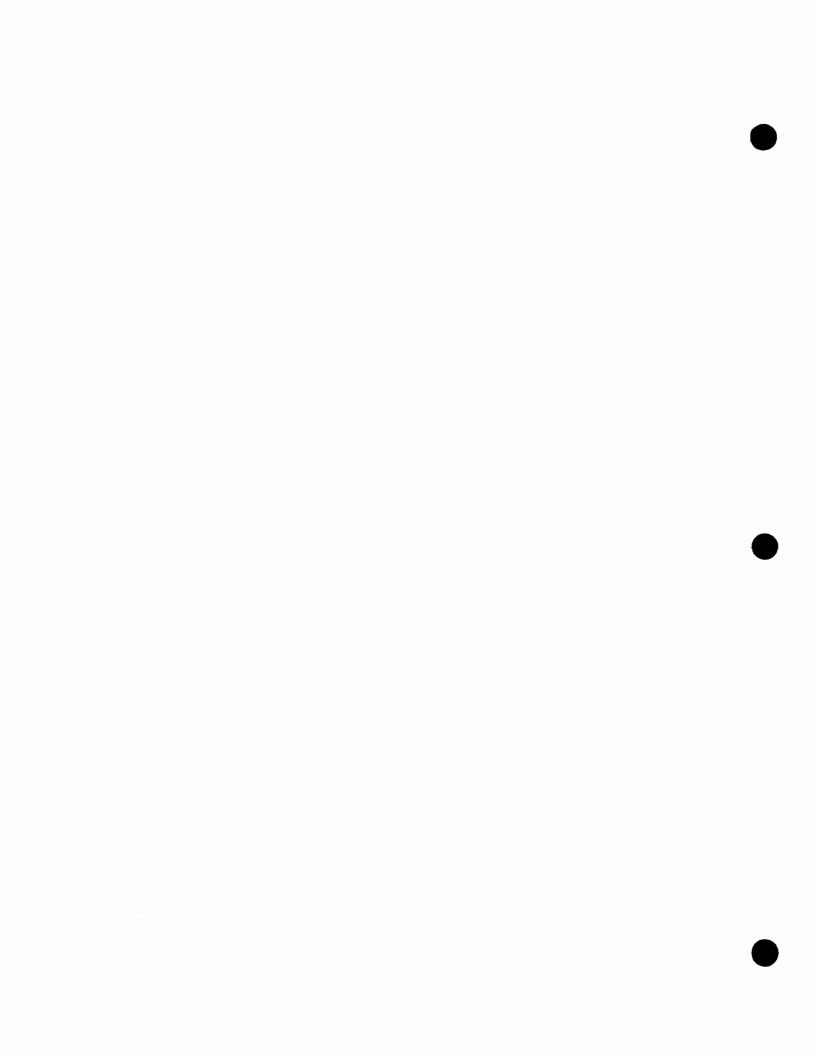
While this guide focuses primarily on Medicaid fee-for-service policies, information on managed care is noted in the report if it was available. The report also indicates any particular areas where we were unable to find information. Every effort was made to capture the most recent policy language in each state as of August 2016. Recently passed legislation and regulation have also been included in this version of the document with their effective date noted in the report. This information also is available electronically in the form of an interactive map and search tool accessible on our website echpea.org. Consistent with previous editions, the information will be continually updated, as laws, regulations and administrative policies are constantly changing.

Telehealth Policy Trends

While many states are beginning to expand telehealth reimbursement, others continue to restrict and place limitations on telehealth delivered services. Although each state's laws, regulations, and Medicaid program policies differ significantly, certain trends are evident when examining the various policies. Live video Medicaid reimbursement, for example, continues to far exceed reimbursement for store-and-forward and remote patient monitoring. However, over the past six months there has been a slight uptake in Medicaid policy allowing for store-and-forward as well as remote patient monitoring reimbursement, although generally on a limited basis. For example, Connecticut is allowing for store-and-forward reimbursement for physician-to-physician email consults (known as eConsult) exclusively, while Missouri has added store and forward and remote patient monitoring reimbursement, but limited it to specific specialties. Hawaii also made significant changes in July, passing one of the most comprehensive and progressive telehealth laws in the country. A unique element of their law is that as of Jan. 1, 2017, liability insurers in Hawaii will be required to provide malpractice coverage for providers delivering services via telehealth, equivalent to the rate they would charge for providers doing the same services inperson.

A few additional significant findings include:

 Forty-eight states and Washington DC provide reimbursement for some form of live video in Medicaid fee-for-service. This is up one state from CCHP's March 2016 edition of this report, due to Utah Medicaid restoring the telemedicine section in their provider manual, which was unintentionally left out of a prior version.



- Twelve state Medicaid programs reimburse for store and forward, up three states from March 2016
- Nineteen state Medicaid programs provide reimbursement for remote patient monitoring, up three states from March 2016.
- Seven state Medicaid programs (Alaska, Hawaii, Illinois, Minnesota, Mississippi, Missouri and Washington) reimburse for all three, although certain limitations apply. Also note that laws addressing Medicaid reimbursement in Hawaii and Missouri go into effect at a later date.

How to Use this Report

Telehealth policies are organized into eleven categories that address the distinct issues of definition, Medicaid reimbursement by type of service, licensing, and other related requirements. The first column indicates whether policy has been codified into law and/or in state regulation. The second column indicates whether the policy is defined administratively in the Medicaid program, unless otherwise noted. In many instances the specific policy is found in law and/or regulations and administrative policy, but that is not always the case. This report primarily addresses the individual state's policies that govern telehealth use when seeking Medicaid coverage for service. However, we have also included a specific category that describes whether a state has established any specific policies that require private insurers to pay for telehealth services. A glossary is also available at the end of the report.

We hope you find the report useful, and welcome your feedback and questions. You can direct your inquiries to Mei Kwong, Project Director of the CCHP National Telehealth Resource Center for Policy at meik@cchpca.org, or Christine Calouro, Project Coordinator, at christinec@cchpca.org. We would also like to thank our colleagues at each of the twelve HRSA-funded Regional Telehealth Resource Centers who contributed to ensuring the accuracy of the information in this document. For further information, visit meik@cchpca.org.

This report is for informational purposes only, and is not intended as a comprehensive statement of the law on this topic, nor to be relied upon as authoritative. Always consult with counsel or appropriate program administrators.

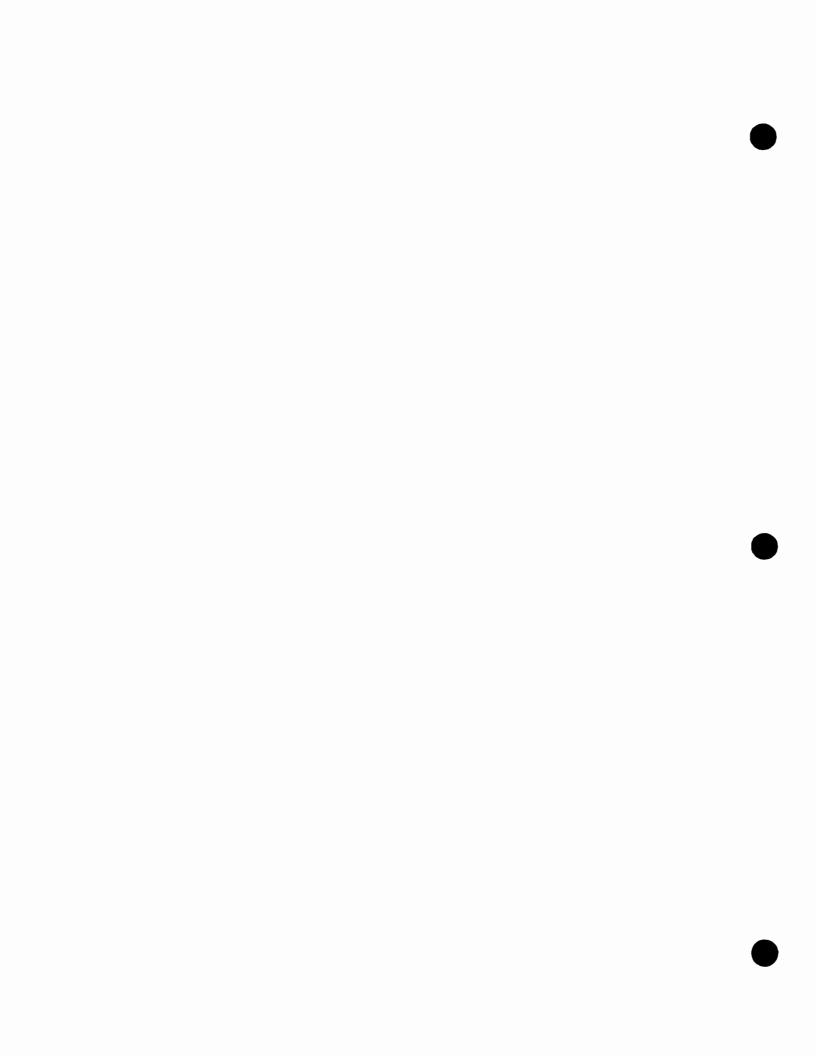
Mario Gutierrez Executive Director September 2016

This project was partially funded by The California HealthCare Foundation and The National Telehealth Policy Resource Center program is made possible by Grant #G22RH30365 from the Office for the Advancement of Telehealth, Health Resources and Services Administration, DHHS.





The Center for Connected Health Policy is a program of the Public Health Institute.



A Comprehensive Scan of the 50 States and the District of Columbia: Findings and Highlights

The Center for Connected Health Policy's (CCHP) annual updated report of state telehealth laws and Medicaid reimbursement policies is the fourth edition of this report. An interactive map version of the report is available on CCHP's website, cchpca.org. Due to constant changes in laws, regulations, and policies, CCHP will continue to update the information in both PDF and map formats throughout the year to keep it as accurate and timely as possible.

It should be noted that even if a state has enacted telehealth policies in statute and/or regulation, these policies may not have been incorporated into its Medicaid program. Throughout the report, CCHP has notated changes in law that have not yet been incorporated into the Medicaid program, as well as laws and regulations that have been approved, but not yet taken effect.

Methodology

CCHP examined state law, state administrative codes, and Medicaid provider manuals as the report's primary resources. Additionally, other potential sources such as releases from a state's executive office, Medicaid notices, transmittals or newsletters were also examined for relevant information. In a few cases, CCHP directly contacted state Medicaid personnel in order to clarify specific policy issues. Most of the information contained in this report specifically focuses on fee-for-service; however, information on managed care plans has also been included if available from the utilized sources. Newly approved regulations related to specific telehealth standards for various professions were noted in the "Comment" section of the state's page if found.

The survey focused on eleven specific telehealth-related policy areas. These areas were chosen based upon the frequency they have appeared in discussions and questions around telehealth reimbursement and laws. These areas are:

- Definition of the term telemedicine/telehealth
- Reimbursement for live video
- Reimbursement for store-and-forward
- Reimbursement for remote patient monitoring (RPM)
- Reimbursement for email/phone/fax
- Consent issues
- Location of service provided
- Reimbursement for transmission and/or facility fees

- Online prescribing
- Private payer laws
- Cross-state licensure

Key Findings

No two states are alike in how telehealth is defined and regulated. While there are some similarities in language, perhaps indicating states may have utilized existing verbiage from other states, noticeable differences exist. These differences are to be expected, given that each state defines its Medicaid policy parameters, but it also creates a confusing environment for telehealth participants to navigate, particularly when a health system provides health care services in multiple states. In some cases, states have duplicated aspects of Medicare's policy on telehealth, while others have developed their own policies for their Medicaid program.

Below are summarized key findings in each category area contained in the report.

Definitions

States alternate between using the term "telemedicine" or "telehealth". In some states both terms are explicitly defined in law and/or policy and regulations. In some cases, "telehealth" is used to reflect a broader definition, while "telemedicine" is used mainly to define the delivery of clinical services. Additional variations of the term, primarily utilizing the "tele" prefix are also becoming more prevalent. Specifically, the term "telepractice" is being used frequently as it relates to telehealth used specifically in physical and occupational therapy, behavioral therapy, and speech language pathology. "Telesychiatry" is also a term commonly used as an alternative when referring specifically to psychiatry services.

Some states put specific restrictions within the definitions, which often limits the term to "live" or "interactive", excluding store and forward and RPM from the definition and subsequently from reimbursement. The most common restriction states place on the term telemedicine/telehealth is the exclusion of email, phone, and/or fax from the definition. Forty-eight states and the District of Columbia have a definition in law, regulation, or their Medicaid program for telehealth, telemedicine, or both. Two states, Alabama and New Jersey, still lack a legal definition for both terms.

Medicaid Reimbursement

Forty-eight states and the District of Columbia have some form of reimbursement for telehealth in their public program. The two states that we determined did not have any written definitive reimbursement policies are:

- Massachusetts
- Rhode Island

Earlier this year, lowa's Medicaid program confirmed that they do provide reimbursement for telehealth. This policy change came as a result of IA Senate Bill 505 which required the Department of Human Services to adopt formal rules regarding their longstanding (although unwritten) policy to provide reimbursement for telehealth. However, the rule that was adopted simply states that "in person contact between a provider and patent is not required for payment for services otherwise covered and appropriately provided through telehealth as long as it meets the generally accepted health care practices and standards prevailing in the applicable professional community." Neither the legislation nor the rule provides a definition of telehealth, which leaves the policy vague and up for interpretation. Therefore, it is unclear whether store and forward or RPM services would fall under the umbrella of this telehealth policy.

In our previous edition, CCHP noted the absence of Utah's telemedicine policy, which had been inexplicably deleted from their provider manual. However, that section has now been restored and therefore Utah has been removed from CCHP's list of states lacking live video telemedicine reimbursement.

The researchers found that Florida's 2014 version of their Practitioner Provider Manual, which was previously available through FL's Medicaid website, is no longer accessible. Instead, a 2012 Practitioner Provider Manual is available that does not address FL Medicaid's telemedicine policy, as the 2014 manual does. However, CCHP continues to count Florida as a state that provides live video telehealth reimbursement, due to administrative code indicating FL Medicaid reimburses for real time interactive telemedicine.

It should be noted that Massachusetts employs managed care plans in its Medicaid program. We did not examine whether the participating managed care plans provided any form of telehealth reimbursement.

Live Video

The most predominantly reimbursed form of telehealth modality is live video, with every state offering some type of live video reimbursement in their Medicaid program (except for the two states listed above). However, what and how it is reimbursed varies widely. The spectrum ranges from a Medicaid program in a state like New Jersey, which will only reimburse for telepsychiatry services, to states like California, which reimburses for live video across a wide variety of medical specialties. In addition to restrictions on specialty type, many states have restrictions on:

- The type of services that can be reimbursed, e. g. office visit, inpatient consultation, etc.;
- The type of provider that can be reimbursed, e. g. physician, nurse, physician assistant, etc.; and
- The location of the patient, referred to as the originating site.

These restrictions have been noted within the report to the extent possible.

Store-and-Forward

Store-and-forward services are only defined and reimbursed by a handful of state Medicaid Programs. In many states, the definition of telemedicine and/or telehealth stipulates that the delivery of services must occur in "real time," automatically excluding store-and-forward as a part of telemedicine and/or telehealth altogether in those states. Of those states that do reimburse for store-and-forward services, some have limitations on what will be reimbursed. For example, California only reimburses for teledermatology, teleophthalmology and teledentistry. Currently, twelve states reimburse for store-and-forward. This number does not include states that only reimburse for teleradiology (which is commonly reimbursed, and not always considered 'telehealth'). Hawaii and Missouri both passed legislation in the 2016 legislative session to provide reimbursement for store and forward in their Medicaid programs, however both go into effect at a later date. States that do reimburse for store-and-forward include:

- Alaska
- Arizona
- Connecticut
- California
- Hawaii (Eff. Jan. 1, 2017)
- Illinois

- Minnesota
- Mississippi
- Missouri (eff. Nov. 26, 2016)
- New Mexico
- Virginia
- Washington

It should also be noted that Connecticut has limited reimbursement to a very specific type of store-andforward, they term "eConsult", which is a certain secure email system that allows healthcare providers to engage in email consultations with each other regarding a particular patient.

Remote Patient Monitoring (RPM)

Nineteen states have some form of reimbursement for RPM in their Medicaid programs, which is an increase of three states since CCHP's March 2016 edition. The policies in each of the three states added in this edition, (Hawaii, Kentucky and Missouri) go into effect at a later date. As with live video and store-and-forward reimbursement, many of the states that offer RPM reimbursement have a multitude of restrictions associated with its use. The most common of these restrictions include only offering reimbursement to home health agencies, restricting the clinical condition for which symptoms can be monitored, and limiting the type of monitoring device and information that can be collected.

For example, Colorado requires the patient to be receiving services for at least one of the following: congestive heart failure, chronic obstructive pulmonary disease, asthma, or diabetes. Further, the patient must still meet other conditions. In Minnesota, RPM reimbursement is only available for skilled nursing visits and in the Elderly Waiver and Alternative Care programs. Utah reimburses RPM through a Medicaid skilled nursing facility pilot program for diabetes patients living in rural areas only, and other conditions still apply. Utah also allows for outpatient long-term cardiac monitoring when there is prior authorization and additional criteria are met. Alaska's Medicaid program has the least restrictive RPM reimbursement policy, requiring only that services be provided by a telemedicine application based in the recipient's home with the provider only indirectly involved in service provision.

The states that currently offer some type of RPM reimbursement in their Medicaid program are:

- Alabama
- Alaska
- Colorado
- Hawaii (Eff. Jan. 1, 2017)
- Illinois
- Indiana
- Kansas

- Kentucky (Eff. July 1, 2017)
- Louisiana
- Maine
- Minnesota
- Mississippi
- Missouri (Eff. Nov. 26, 2016)

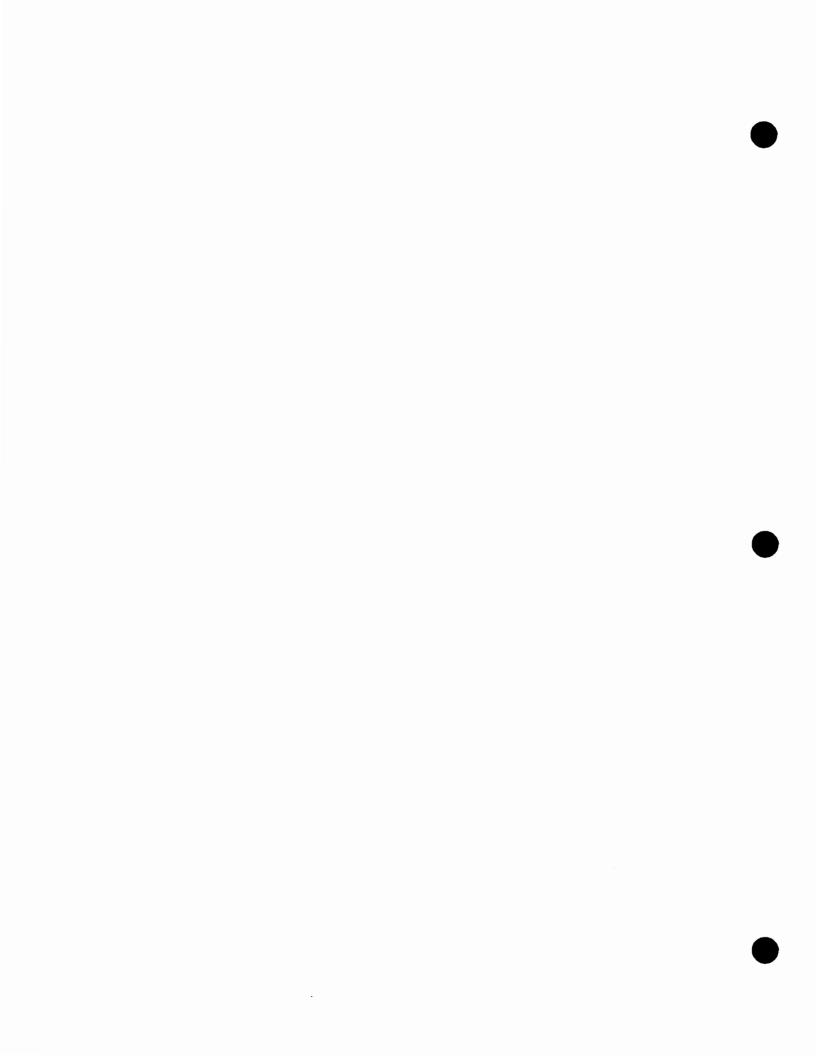
- New York
- South Carolina
- Texas
- Utah
- Vermont
- Washington

In addition to state Medicaid programs, Pennsylvania and South Dakota offer RPM reimbursement through their Department of Aging Services.

Note that the states listed are only for RPM in the home where some specific information related to technology or telecommunication could be found. Some states reimburse for home health services, but no further details of what modality was reimbursed could be located. Additionally, some states may already be reimbursing for tele-ICU (a form of RPM); however, these were not included.

Email/Phone/Fax

Email, telephone, and fax are rarely acceptable forms of delivery unless they are in conjunction with some other type of system. States either are silent or explicitly exclude these forms, sometimes even within the definition of telehealth and/or telemedicine.



Transmission/Facility Fee

Thirty states will reimburse either a transmission, facility fee, or both. Medicare also reimburses for a facility fee for the originating site provider.

Location of Service

Although the practice of restricting reimbursable telehealth services to rural or underserved areas, as is done in the Medicare program, is decreasing, some states continue to maintain this policy. Colorado's Medicaid program added language to their telemedicine webpage indicating that "clients can receive services through the use of telemedicine, whether they live in rural or urban areas". Yet their telemedicine manual states that Medicaid managed care organizations are prohibited from requiring a face to face visit in instances where the member resides in a county with 150,000 or fewer residents and the county has the technology necessary to provide telemedicine services. Other states are even more ambiguous in their geographical restrictions on telehealth. In South Dakota's Medicaid program, they simply state that an originating and distant site cannot be located in the same community. However, only nine states currently have these types of restrictions, and the overall trend is to eliminate such limitations. Three states that have removed such a policy in recent years are Idaho, Nevada and Missouri. Although Hawaii currently has a geographic restriction in their Medicaid program, this should be eliminated when recently passed legislation takes effect Jan. 1, 2017.

A more common practice is for state Medicaid programs to limit the type of facility that may be an originating site, often excluding the home as a reimbursable site, impacting RPM as a result. Currently twenty-five states have a specific list of sites that can serve as an originating site for a telehealth encounter, with ten states adding eligible originating site lists to their policy since July 2015. Some state Medicaid programs also require a licensed in-state provider to be physically located within the state in order to enroll as a Medicaid provider (for example California), while others have clarified that this is in fact not necessary (for example, Virginia).

Consent

Twenty-nine states include some sort of informed consent requirement in their statutes, administrative code, and/or Medicaid policies. This requirement can sometimes apply to the Medicaid program, a specific specialty or all telehealth encounters that occur in the state, depending on how and where the policy is written. States with informed consent policies include:

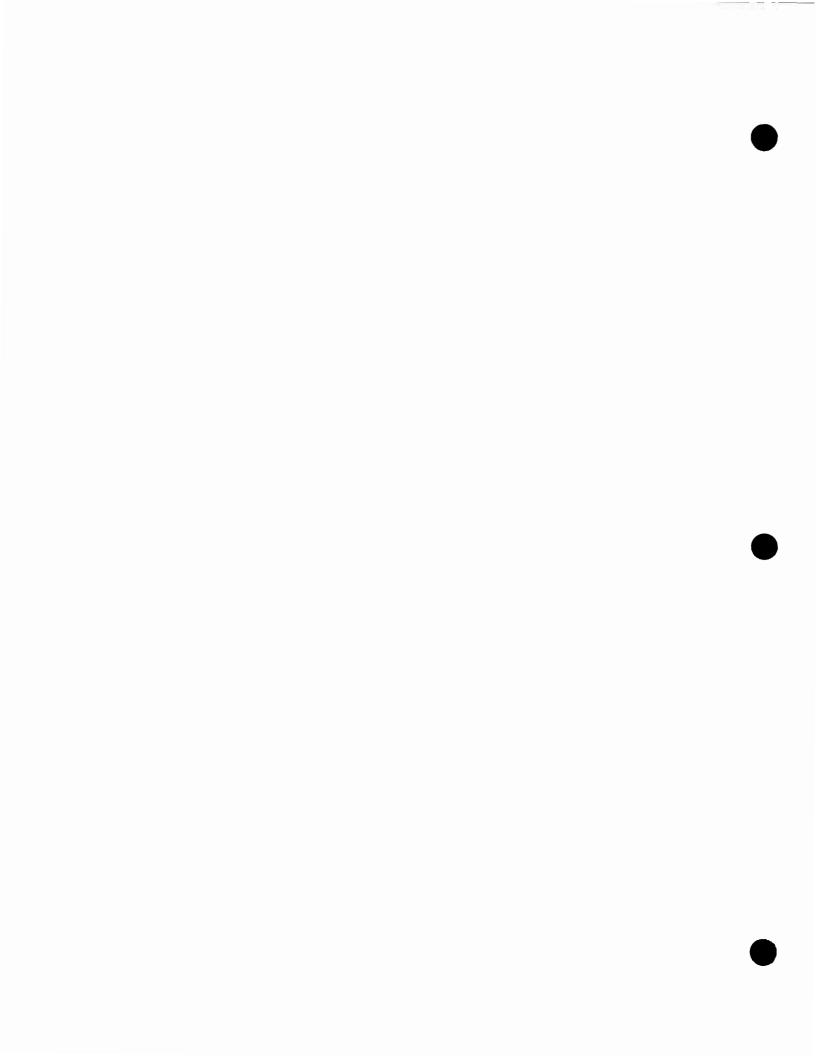
- Alabama
- Arizona
- California
- Colorado
- Connecticut
- Delaware
- Florida
- Georgia
- Idaho
- Indiana

- Kansas
- Kentucky
- Louisiana
- Maine
- Maryland
- Mississippi
- Missouri
- Nebraska
- Nevada
- New Jersey

- Ohio
- Oklahoma
- Pennsylvania
- Tennessee
- Texas
- Vermont
- Virginia
- West Virginia
- Wyoming

Licensure

Nine state medical (or osteopathic) boards issue special licenses or certificates related to telehealth. The licenses could allow an out-of-state provider to render services via telemedicine in a state where they are



not located, or allow a clinician to provide services via telehealth in a state if certain conditions are met (such as agreeing that they will not open an office in that state). States with such licenses are:

- Alabama
- Louisiana
- Maine
- New Mexico
- Ohio

- Minnesota
- Oregon
- Tennessee (Osteopathic Board only)
- Texas

Since March 2016, The Tennessee Medical Board eliminated their telemedicine license (effective Oct. 31, 2016). Individuals granted a telemedicine license under the former version of the rule may apply to have the license converted to a full license. Under certain circumstances individuals who do not convert to a full license can retain their telemedicine license.

Montana and Nevada have also both dropped their telemedicine special license in the past year, however unlike Tennessee, they adopted the Federation of State Medical Boards (FSMB)'s Interstate Medical Licensure Compact, along with fifteen other states. The compact allows for an Interstate Commission to form an expedited licensure process for licensed physicians to apply for licenses in other states. The specific details about how the compact will function are not yet available. States that have adopted the FSMB's Compact language include:

- Alabama
- Arizona
- Colorado
- Idaho
- Illinois
- lowa
- Kansas
- Minnesota

- Mississippi
- Montana
- Nevada
- New Hampshire
- South Dakota
- Utah
- West Virginia
- Wisconsin
- Wyoming

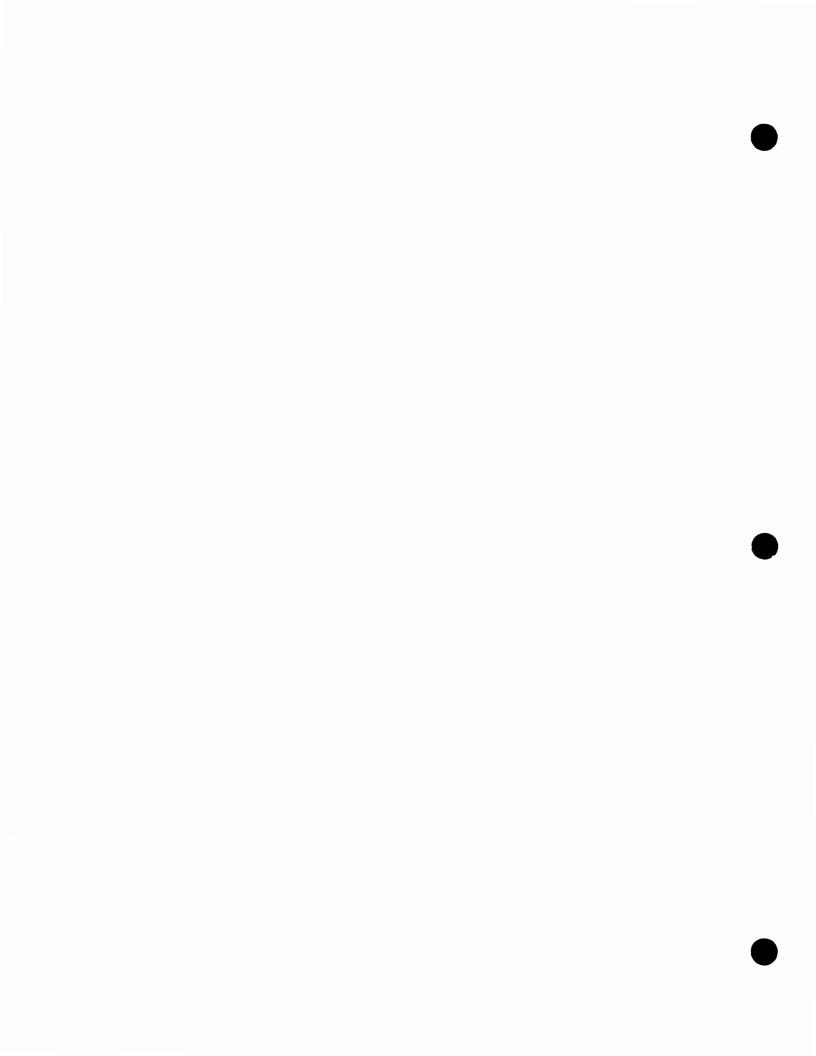
Still other states have laws that don't specifically address telehealth and/or telemedicine licensing, but make allowances for practicing in contiguous states, or in certain situations where a temporary license might be issued provided the specific state's licensing conditions are met.

Online Prescribing

There are a number of nuances and differences across the states. However, most states consider using only an internet/online questionnaire to establish a patient-provider relationship (needed to write a prescription in most states) as inadequate. States may also require that a physical exam be administered prior to a prescription being written, but not all states require an in-person examination, and some specifically allow the use of telehealth to conduct the exam.

Private Payers

Currently, thirty-five jurisdictions have laws that govern private payer telehealth reimbursement policies. However, Washington's private payer law does not go into effect until Jan. 1, 2017, and Rhode Island's law doesn't go into effect until Jan. 1, 2018. Not all of these laws mandate reimbursement. Additionally, some private payer laws require that the reimbursement amount for a telehealth-delivered service be equal to the amount that would have been reimbursed, had the same service been delivered in-person; however, this is not always the case.



Additional Findings

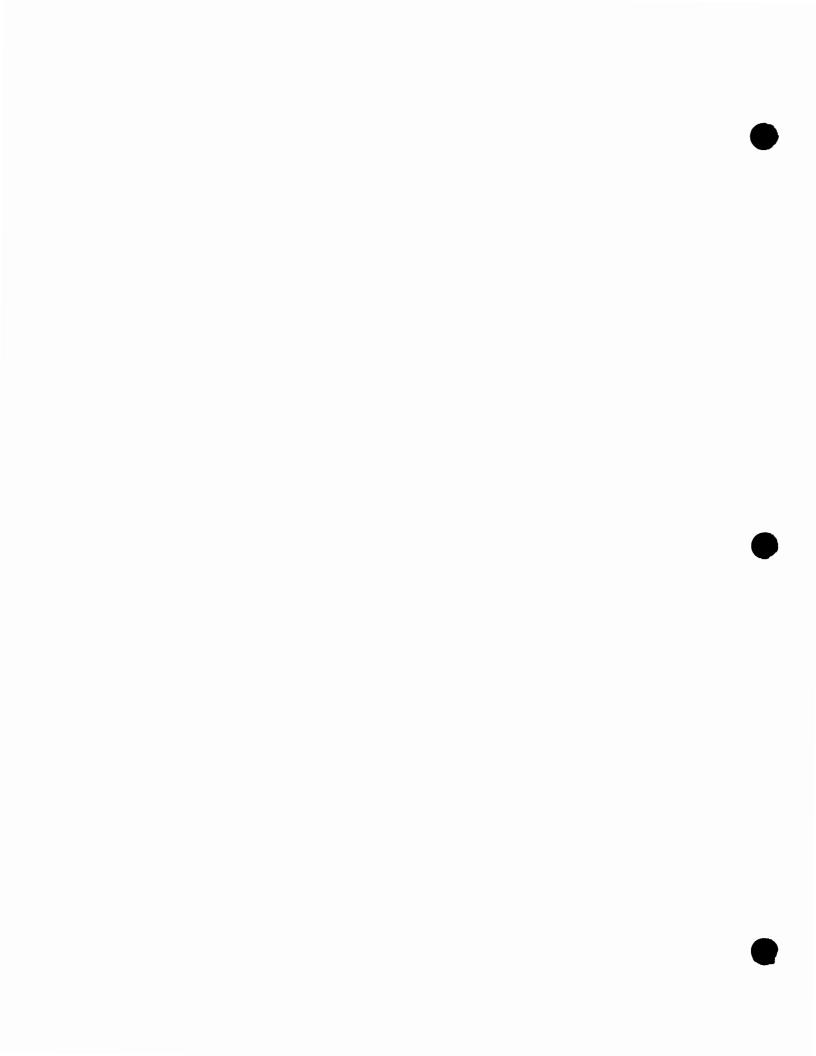
Although liability insurance is not a category tracked in this report, Hawaii's revised telehealth law (effective Jan. 1, 2017) addressing the subject warrants mentioning. The new law requires that liability insurers provide malpractice coverage for providers delivering services via telehealth, equivalent to the rate they would charge for providers doing the same services in-person. This may inspire other states to introduce similar legislation in the future.

Current Legislation

In the 2016 legislative session, forty-four states have introduced over 150 telehealth-related pieces of legislation. Many bills address different aspects of reimbursement in regards to both private payers and Medicaid, with some bills making changes to existing reimbursement laws. Many states have also proposed legislation that would adopt the Federation of State Medical Board's model language for an Interstate Medical Licensure Compact. Where appropriate, newly passed and/or approved legislation and regulations are noted for each state. However, many of these changes may not currently be in effect.

To learn more about state telehealth related legislation, visit CCHP's interactive map at cehpca.org.

This report is for informational purposes only, and is not intended as a comprehensive statement of the law on this topic, nor to be relied upon as authoritative. Always consult with counsel or appropriate program administrators.



Committee Sergeants at Arms

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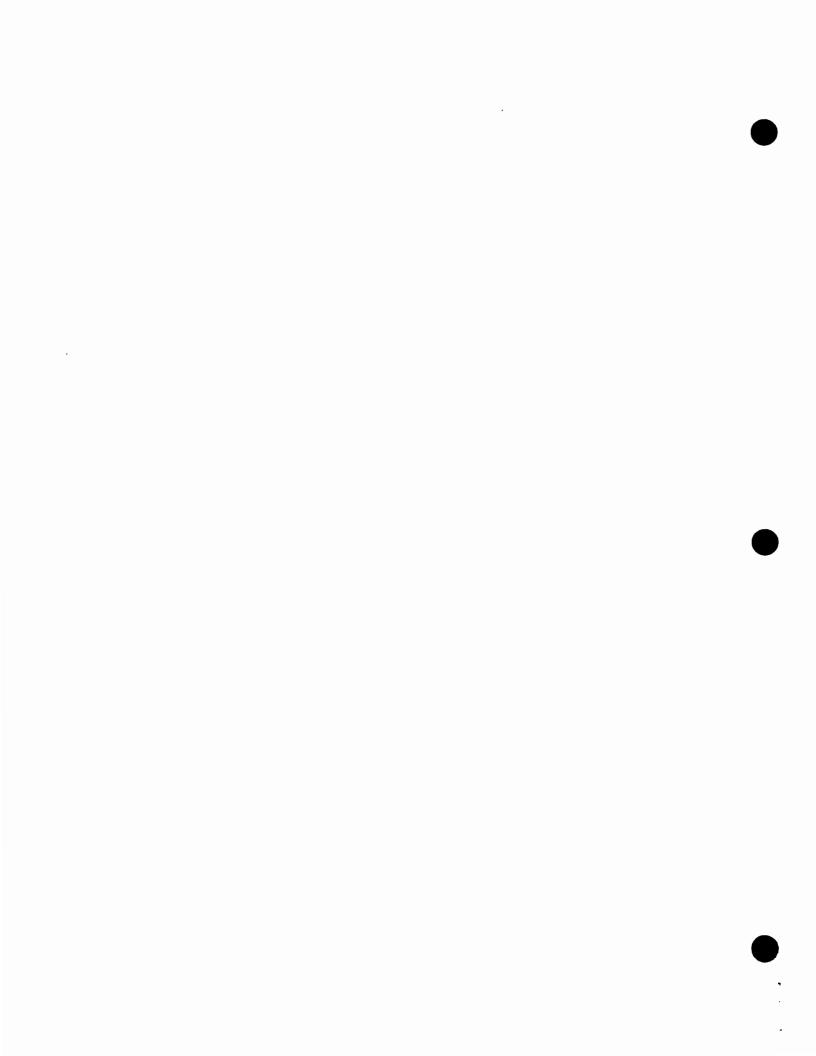
Hou Pages Assignments Wednesday, April 05, 2017 Session: 2:00 PM

Committee	Room	Time	Staff	Comments	Member
State and Local Government I	544	10:00 AM	Audra Cloer		Rep. Kevin Corbin
			Noah Ellington		Rep. Speaker Tim Moore
			Zina Hockaday		Rep. Yvonne Lewis Holley
			Jenna Varnell		Rep. Susan Martin
State and Local Government II	423	10:00 AM	Caroline Byars		Rep. John Bradford
			Caroline Cholette		Rep. Ted Davis, Jr.
			Lizette Duarte		Rep. Sam Watford
			Madison Gunter		Rep. Mike Clampitt
		3	7		
Health	643	11:00 AM	Chloe Worner		Rep. Harry Warren
			Austin Calhoun		Rep. William Richardson
			Joseph Pinnix	>	Rep. Chris Malone
			Mary Margaret West		Rep. George Cleveland
			7		
Pensions & Retirement	415	12:00 PM	Ashley Holland		Rep. Pat Hurley
			Carolyn McCarthy		Rep. Susan Martin
			Alex Smith		Rep. Holly Grange
Energy and Public Utilities	643	1:00 PM	Audra Cloer		Rep. Kevin Corbin
			Jared Diegelman		Rep. Dean Arp
			Samantha Lenger		Rep. Duane Hall
			Jenna Varnell		Rep. Susan Martin

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Hou Pages
Assignments
Wednesday, April 05, 2017

Committee	Room	Time	Staff	Comments	Member
Judiciary III	421	1:00 PM	Noah Ellington		Rep. Speaker Tim Moore
			Mary Margaret West		Rep. George Cleveland
			Chloe Worner		Rep. Harry Warren
State Personnel	425	1:00 PM	Caroline Byars		Rep. John Bradford
			Lizette Duarte		Rep. Sam Watford
			Madison Gunter		Rep. Mike Clampitt



Honory 8th grade of pages sitting in

House Pages
Assignments
Wednesday, April 5, 2017
Session: 2:00 PM

Students from Carteret County Schools are visiting today and observing as honorary pages. If you want to recognize them, their names are as follows:

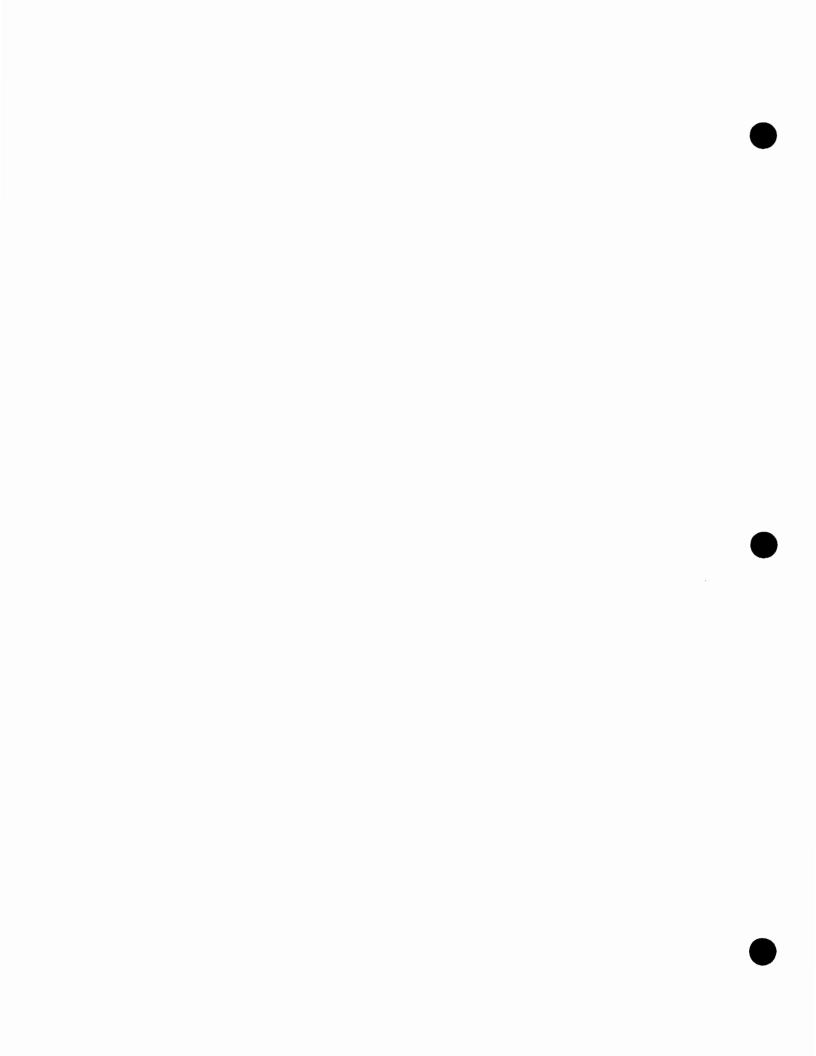
- 1. Olivia Allen
- 2. Sarah Holston
- 3. Lydia LoPiccolo
- 4. Rebecca Mills
- 5. Jackson Nowacek
- 6. Christopher Samojedny
- 7. Henry Tillett

CHAPERONES:

Rebekah Cole

Dorothy Shumate





House Comm. on Health

04/05/17

Name of Committee

Date

NAME	FIRM OR AGENCY AND ADDRESS		
Bill Croft	NC Respiratory Corne Board		
John 1452	TetrofNC		
gill Hinton	Ne Council in Down Discherition		
Ann Rodriguez	NC Council of Comm. Programs		
RICHOLLE KARIM	NAMINC .		
Thumber	NCBMH		
W. DENISE Baken	NC DAH foolsas		
Startuen Scott Robbins	NC AMHIBA SAS		
Katy Schell	NC State Crime Lab		
Juny Billings	NCSBI DECL		
Steve Marge	NC DOJ		

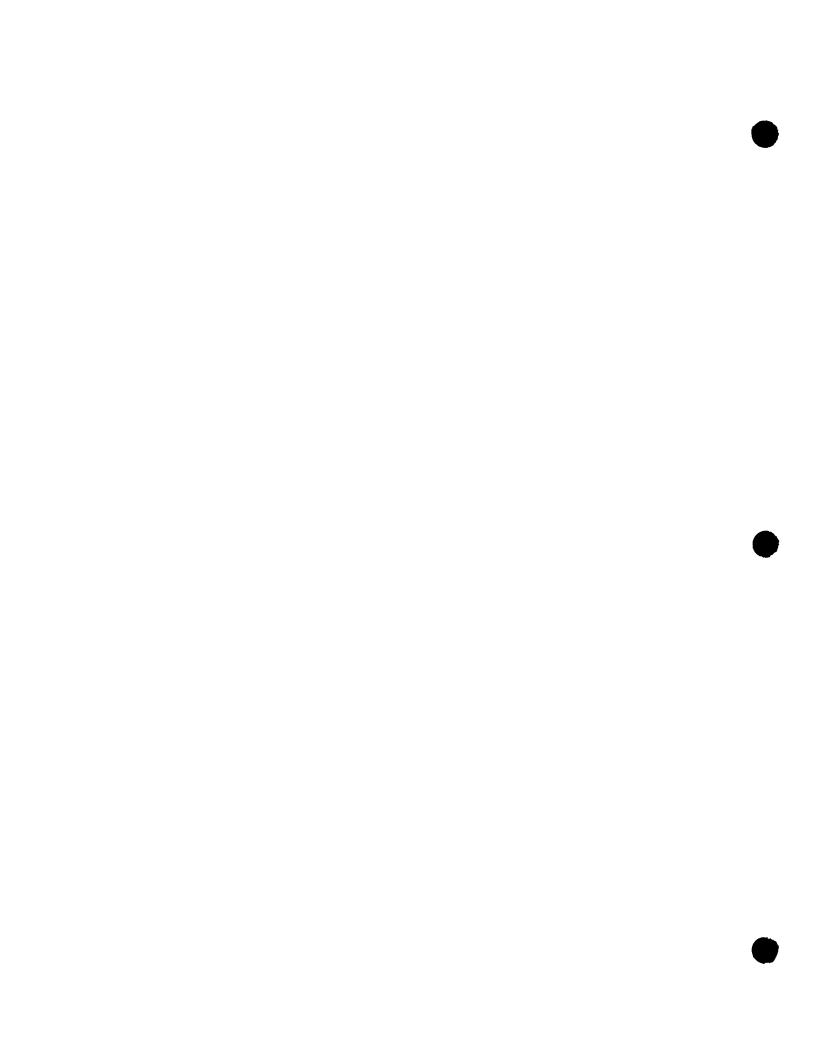
House Comm. on Health

04/05/17

Name of Committee

Date

NAME	FIRM OR AGENCY AND ADDRESS
Kelly Vogel	PLPCC
Rebecca Forbes	NC Women for Cannabis
DR. Milton ByRd	220 00000000000000000000000000000000000
Jin Rich	Enloyais
Jack Nowacek	Junio, Page
Desethy Shumate	Carrelet County Schools - Junior Page
Repetal of Core	Cartett County Schools
Caroline Miller	AMGA
Mat WI	PMB.
Rebeat milk	Carteret County Schools -> Junior page
	Junior Page



House Comm. on Health

04/05/17

Name of Committee

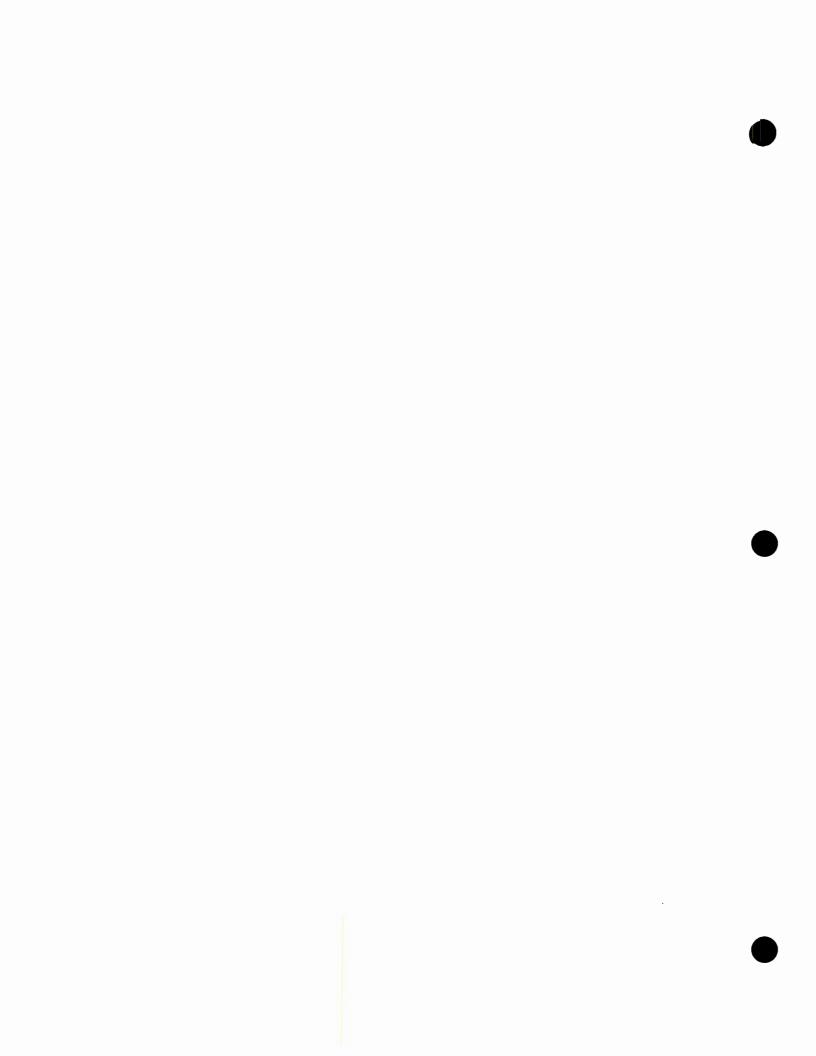
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME

FIRM OR AGENCY AND ADDRESS

Sarah Holston	Carteret County - Junior Page
Chris Somograph	
Lydia La Piccolo	Carteret County-Junior Page
Jee Forgall	NCFEC
	so John Cock Fand
Chris Mughton	MWC
Than GUBOWKA	STATE HEALTH PLAN
Lori Ann Harris	47+141
TARA FIELDS	Benchmarks
CUA MET by	SP
Silly Rukinson	Perkinson Law
1	



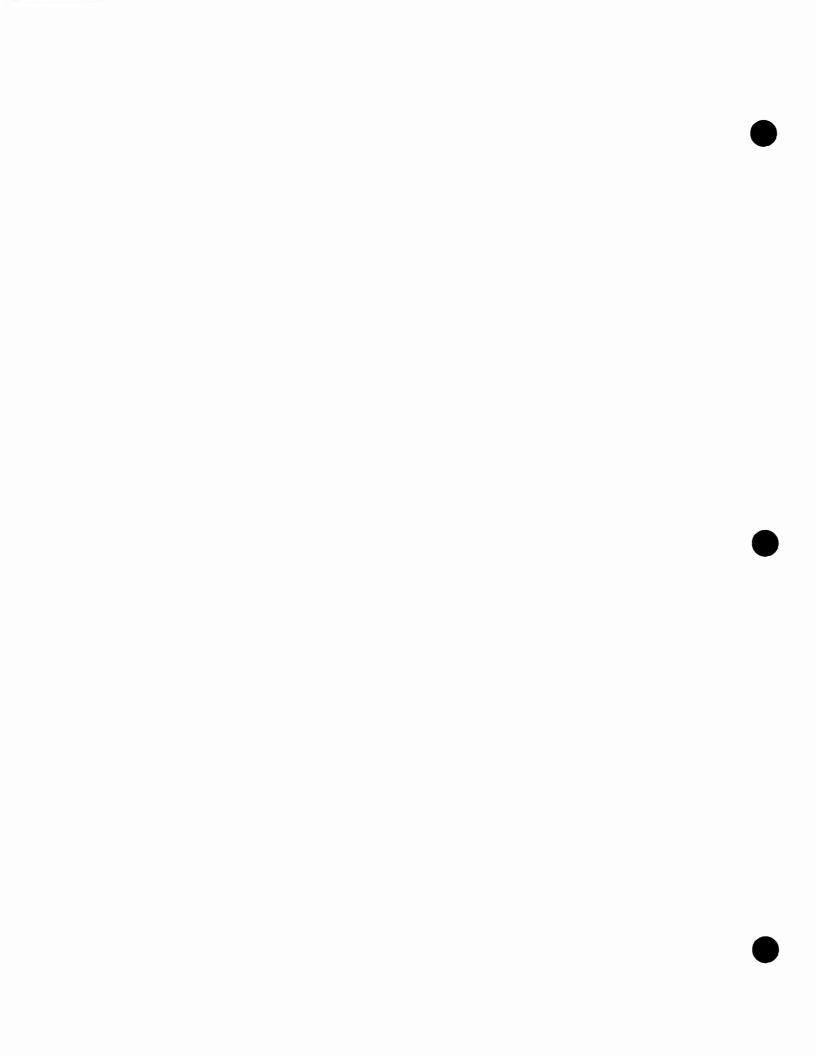
House Comm. on Health

04/05/17

Name of Committee

Date

NAME	FIRM OR AGENCY AND ADDRESS
DanielSalbackse	NC BORN & OF NUVSIND
Sarah McQuillan	KGANC
Monica Webb	NC Assoc of Woman Attorneys
Morgan Bennett	NC Assoc. Women Atty
Sarah Caraffa	NC ASSOC Woman Alty
Padel Boali	1,
Huy Jel-100	NC/I-1
Konjuga	N M RS
AndyChase	KonA.
John /BA	NCFPC
Jake Siel	NCERE



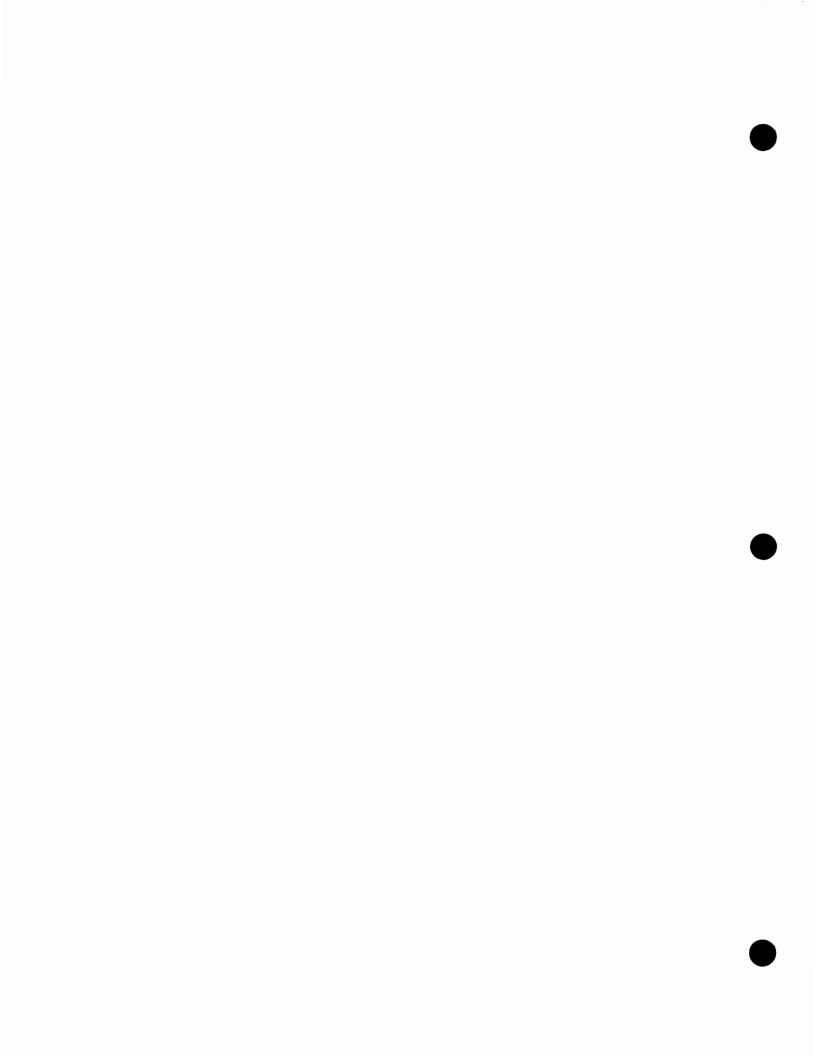
House Comm. on Health

Name of Committee

04/05/17

Date

NAME	FIRM OR AGENCY AND ADDRESS		
Rowent Imm	Mission Health		
JOHN METERIT	Policy Grup		
Molea Pm	NEGA		
Brian Cavency	BCBSNC		
A	·M		
Sve Am Forest	NCMS		
Brandon Hagrose	DEOSNE		
JASON Jakes	REBSHE		
Mark Flemx	work for Ker Lewis		
Therens	C55		
Jame Laters	C13		
Robui Huffman	NC Psychiatric Asso		



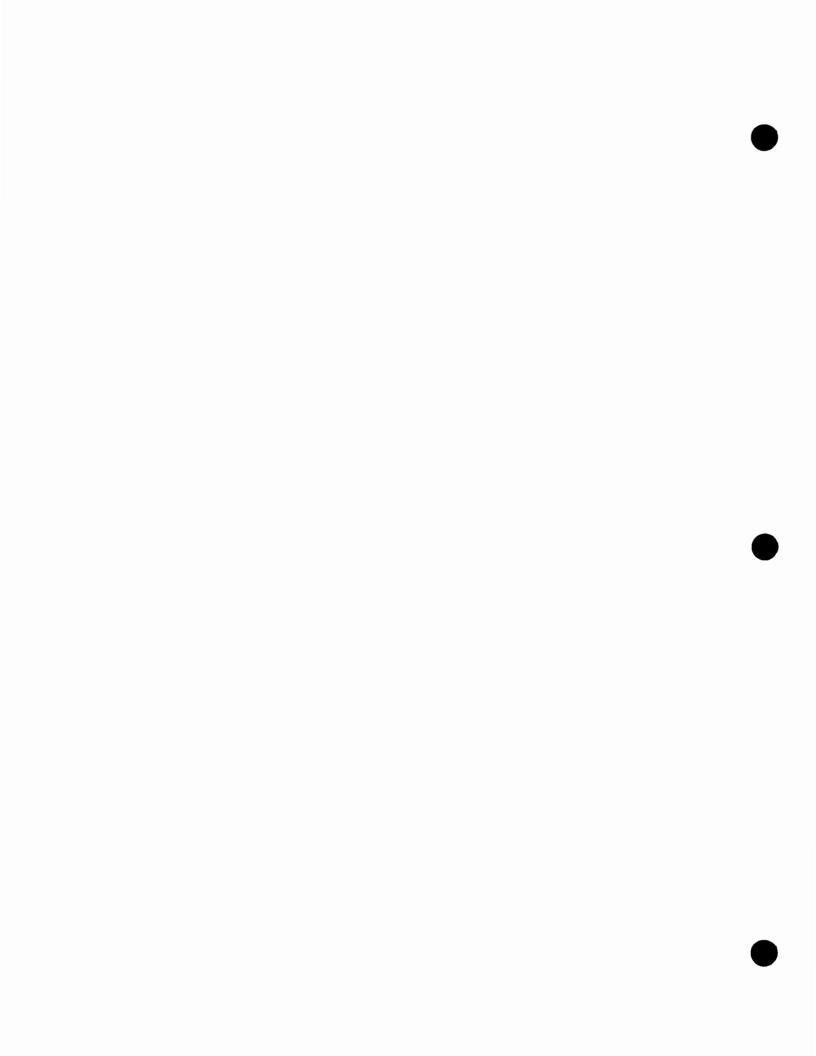
House Comm. on Health

04/05/17

Name of Committee

Date

NAME	FIRM OR AGENCY AND ADDRESS		
Ken Lewis	NCAHP		
MARTY BOCOCK	TRIME THERAPEUTICS		
Kari Barsmss	Room 60 Eway Hearty		
Nathan Bolarch	PPAB		
Cosy Jan -	public vicilia.		
Michelle Jacquis	Vertex Pharmaceuticuts, Enahossee, FL		
Savon Bales	BEA		
Paul Enderson	Youth Ollages		
Steve M. tchell	Atellas		
Ful Bone	Bone Asso.		
Queajia Holley	Association of Mexicans in North Carolina		
	(MEXCAN)		



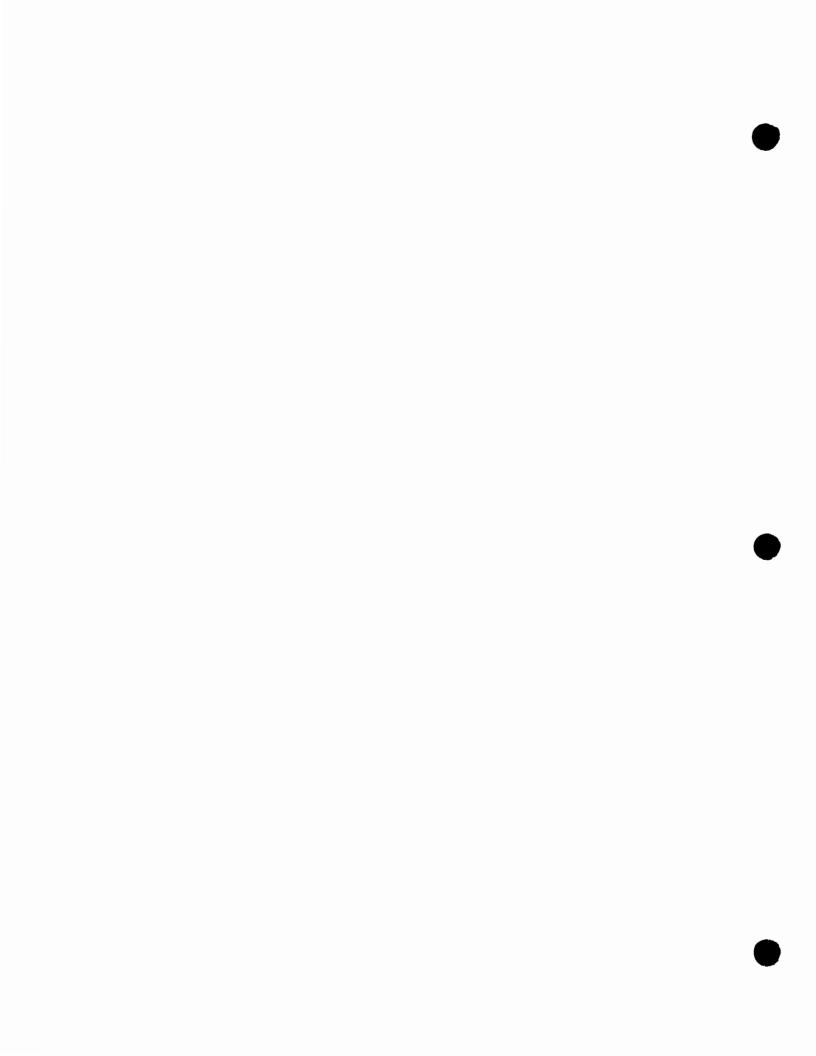
House Comm. on Health

04/05/17

Name of Committee

Date

NAME	FIRM OR AGENCY AND ADDRESS
Samantha Miller	The Association of Mexicans in North Carolina (AMEXICAN) P.O. Box 2744 Greenville MC
Juvencio Rocha-Remlta	P.O. Box 2744 Greenville, NC (AMEXCAM
Chris M'clin	Bot
Christing Wason	ACS CAN
DANNY BUDASOFF	LEGISLATIVE ANALYSIS
Ben Papker	DMMS
LTMCCrimmon	D 11H 5
Luslie Murray	NCGA - yarborongh
	•



House Committee on Health Thursday, April 6, 2017 at 11:00 AM Room 643 of the Legislative Office Building

MINUTES

The House Committee on Health met at 11:00 AM on April 6, 2017 in Room 643 of the Legislative Office Building. Representatives Adcock, Ball, Blackwell, Boswell, Brisson, Burr, Carney, Cunningham, Dobson, Dollar, Dulin, Earle, Ford, Hunter, Insko, Jackson, Bert Jones, Lambeth, Lewis, Lucas, Malone, Murphy, Potts, Rogers, Shepard, Szoka, White, Wray, and Zachary attended.

Representative Gregory F. Murphy, MD, Chair, presided.

The following bills were considered:

HB 206 NC Cancer Treatment Fairness. (Representatives Lewis, Jackson, Lambeth, McElraft)

Rep. Lewis explained the bill, which will require health benefit plans that provide coverage for prescribed orally administered cancer drugs to provide coverage for these drugs on a basis no less favorable than for IV or injectable anticancer drugs. Rep. Jackson and Rep. Lambeth further explained portions of HB 206. Committee members responded with questions and comments. Speakers included Christine Weason, American Cancer Society, Dr. Milton Byrd, and Chris Evans, BCBS. Rep. Jones motioned for a Favorable Report for the bill. The bill passed and will go to the House floor.

HB 550 Establish New Nurse Licensure Compact. (Representatives Szoka, Adcock, Boswell, White)

Rep. Szoka explained the bill. After questions and comments from the Committee members, Rep. Insko motioned for a Favorable Report. All in favor, HB 550 passed and will be sent to Finance.

The meeting adjourned at 11:40.

Represe ative Gregory F. Murphy, MD, Chair

Brenda Olls, Committee Clerk

Corrected #1: Time Change. Remove HB 512, HB 338. Add HB 550.

NORTH CAROLINA HOUSE OF REPRESENTATIVES COMMITTEE MEETING NOTICE AND BILL SPONSOR NOTIFICATION 2017-2018 SESSION

You are hereby notified that the House Committee on Health will meet as follows:

DAY & DATE: Thursday, April 6, 2017

TIME: 11:00 AM LOCATION: 643 LOB

RILL NO SHORT TITLE

The following bills will be considered:

DILL NO.	SHOKITILE	SIONSON
HB 206	NC Cancer Treatment Fairness.	Representative Lewis
		Representative Jackson
		Representative Lambeth
		Representative McElraft
HB 550	Establish New Nurse Licensure	Representative Szoka
	Compact.	Representative Adcock
		Representative Boswell
		Representative White

Respectfully,

SPONSOR

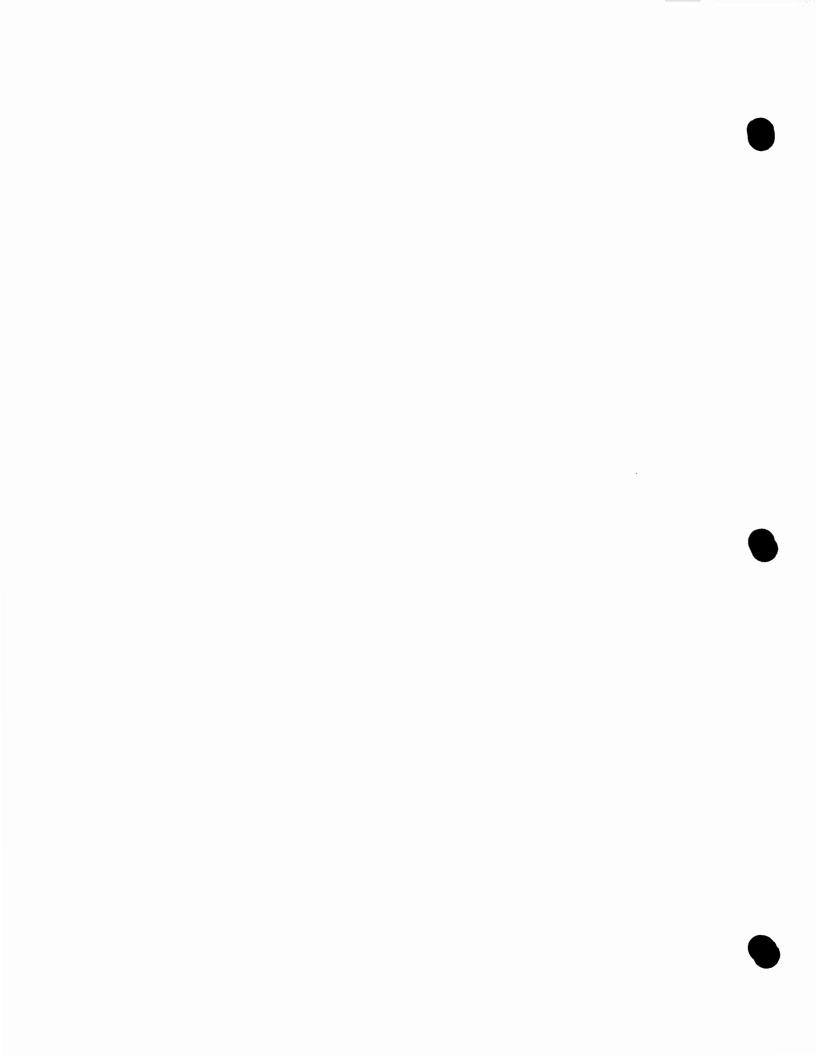
Representative Justin P. Burr, Co-Chair Representative Josh Dobson, Co-Chair Representative Bert Jones, Co-Chair Representative Donny Lambeth, Co-Chair Representative Gregory F. Murphy, MD, Co-Chair

I hereby certify this notice was filed by the committee assistant at the following offices at 4:06 PM on Wednesday, April 05, 2017.

Principal Clerk

___ Reading Clerk – House Chamber

Brenda Olls (Committee Assistant)



NORTH CAROLINA HOUSE OF REPRESENTATIVES COMMITTEE MEETING NOTICE AND BILL SPONSOR NOTIFICATION 2017-2018 SESSION

You are hereby notified that the House Committee on Health will meet as follows:

DAY & DATE:	Thursday, April 6, 2017
TIME:	15 Minutes After Session
LOCATION:	643 LOB

The following bills will be considered:

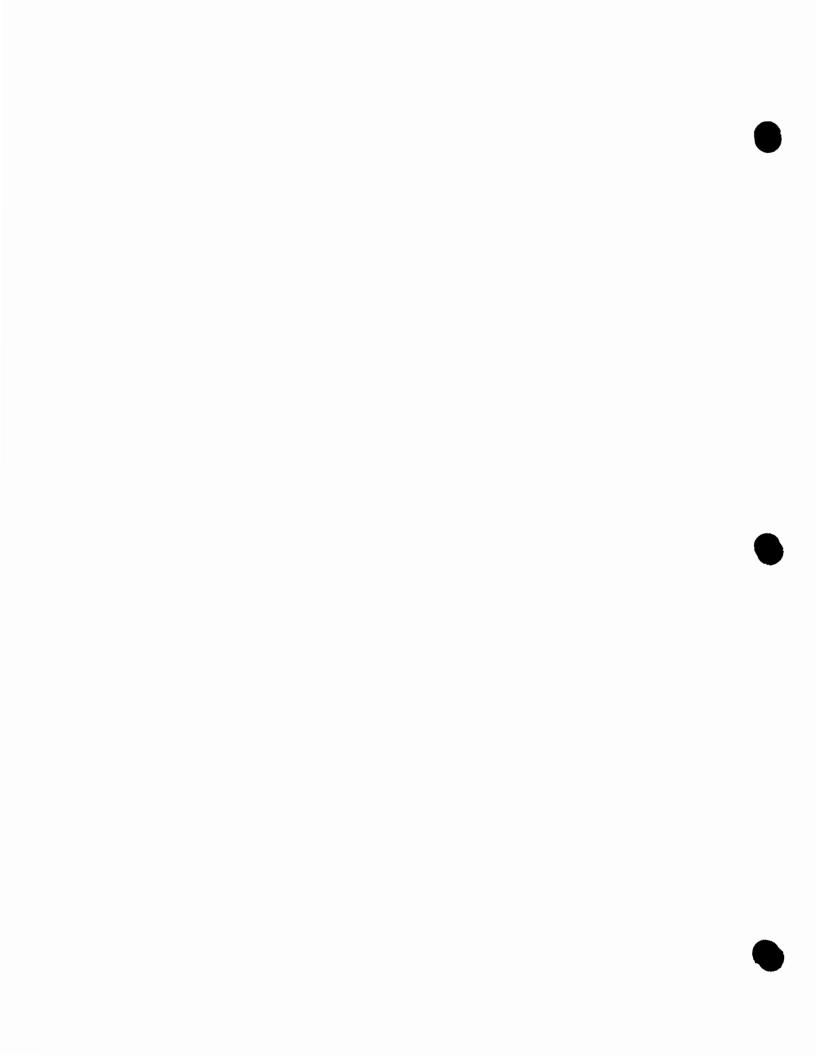
BILL NO.	SHORT TITLE	SPONSOR
HB 206	NC Cancer Treatment Fairness.	Representative Lewis
		Representative Jackson
		Representative Lambeth
		Representative McElraft
HB 338	Establish New Nurse Licensure	Representative Szoka
	Compact.	Representative Adcock
		Representative Boswell
		Representative Williams
HB 512	Monitor Implementation of TBI	Representative Torbett
•	Waiver.	

Respectfully,

Representative Justin P. Burr, Co-Chair Representative Josh Dobson, Co-Chair Representative Bert Jones, Co-Chair Representative Donny Lambeth, Co-Chair Representative Gregory F. Murphy, MD, Co-Chair

hereby certify this notice was filed by the committee assistant at the following offices at 1:26 PM (Vednesday, April 05, 2017.	on
Principal Clerk Reading Clerk – House Chamber	

Brenda Olls (Committee Assistant)



House Committee on Health Thursday, April 6, 2017, 11:00 AM 643 Legislative Office Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

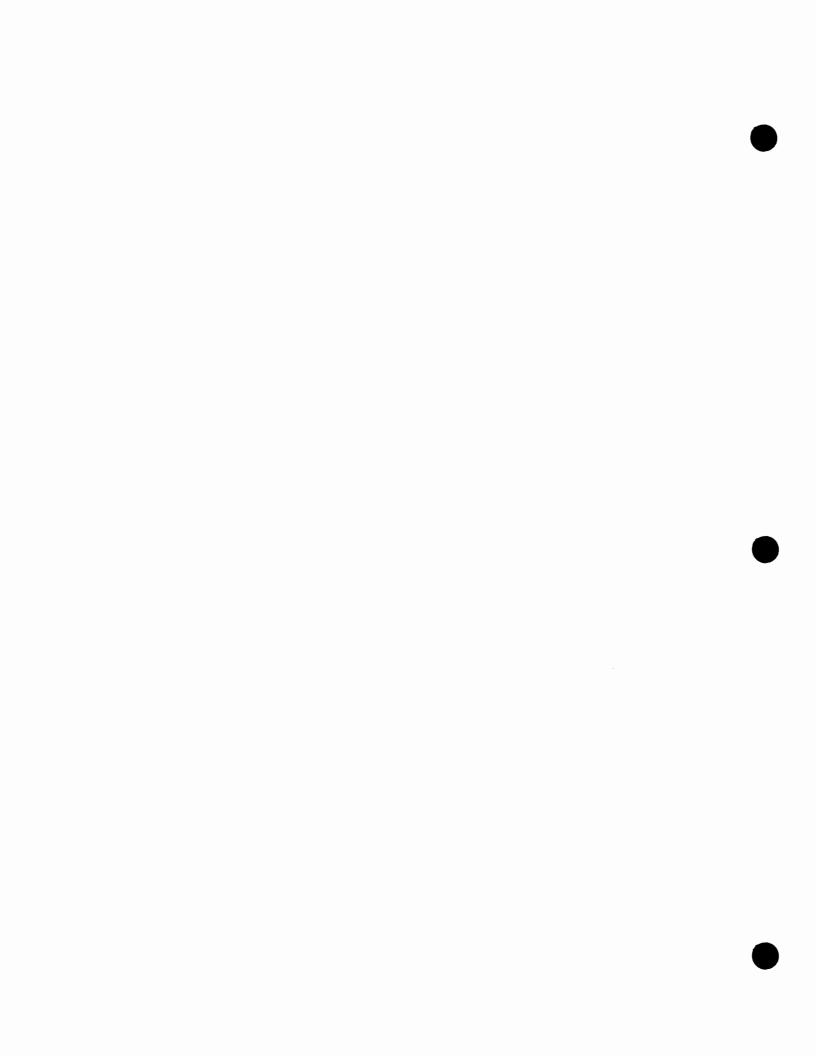
Bills

BILL NO.	SHORT TITLE	SPONSOR
HB 206	NC Cancer Treatment Fairness.	Representative Lewis
		Representative Jackson
		Representative Lambeth
		Representative McElraft
HB 550	Establish New Nurse Licensure	Representative Szoka
	Compact.	Representative Adcock
		Representative Boswell
		Representative White

Presentations

Other Business

Adjournment



NORTH CAROLINA GENERAL ASSEMBLY HOUSE OF REPRESENTATIVES

HEALTH COMMITTEE REPORT

Representative Justin P. Burr, Co-Chair Representative Josh Dobson, Co-Chair Representative Bert Jones, Co-Chair Representative Donny Lambeth, Co-Chair Representative Gregory F. Murphy, MD, Co-Chair

FAVORABLE

HB **206** NC Cancer Treatment Fairness.

Draft Number: None
Serial Referral: None
Recommended Referral: None
Long Title Amended: No
Floor Manager: Lewis

FAVORABLE AND RE-REFERRED

HB 550 Establish New Nurse Licensure Compact.

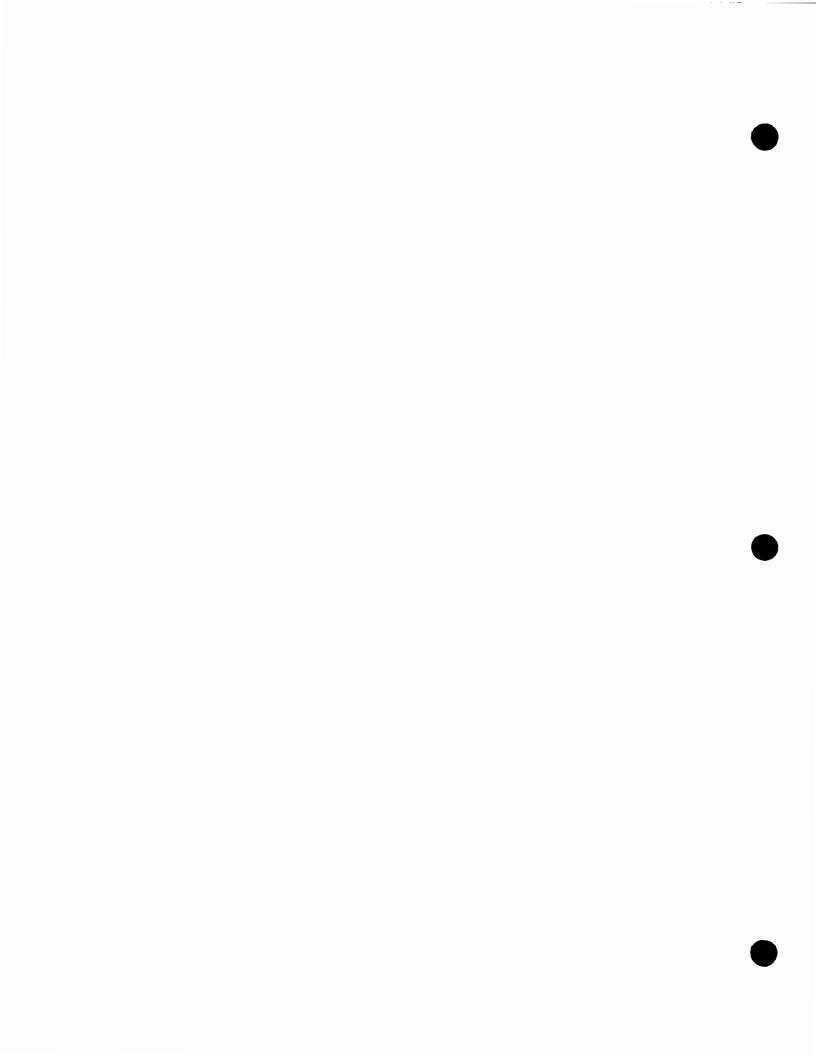
Draft Number:

Serial Referral:
Recommended Referral:
Long Title Amended:
Floor Manager:

None
No
Szoka

TOTAL REPORTED: 2







HOUSE BILL 206: NC Cancer Treatment Fairness.

2017-2018 General Assembly

Committee:

House Health

First Edition

Date:

April 6, 2017

Introduced by: **Analysis of:**

Reps. Lewis, Jackson, Lambeth, McElraft

Prepared by: Augustus D. Willis

Jason Moran-Bates

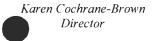
Committee Co-Counsel

OVERVIEW: House Bill 206 would require health benefit plans that provide coverage for prescribed orally administered cancer drugs to provide coverage for those drugs on a basis no less favorable than coverage the plan offers for IV or injectable anticancer drugs. Under the bill, plans would be barred from complying with the law by reclassifying anticancer drugs or by increasing patient costsharing.

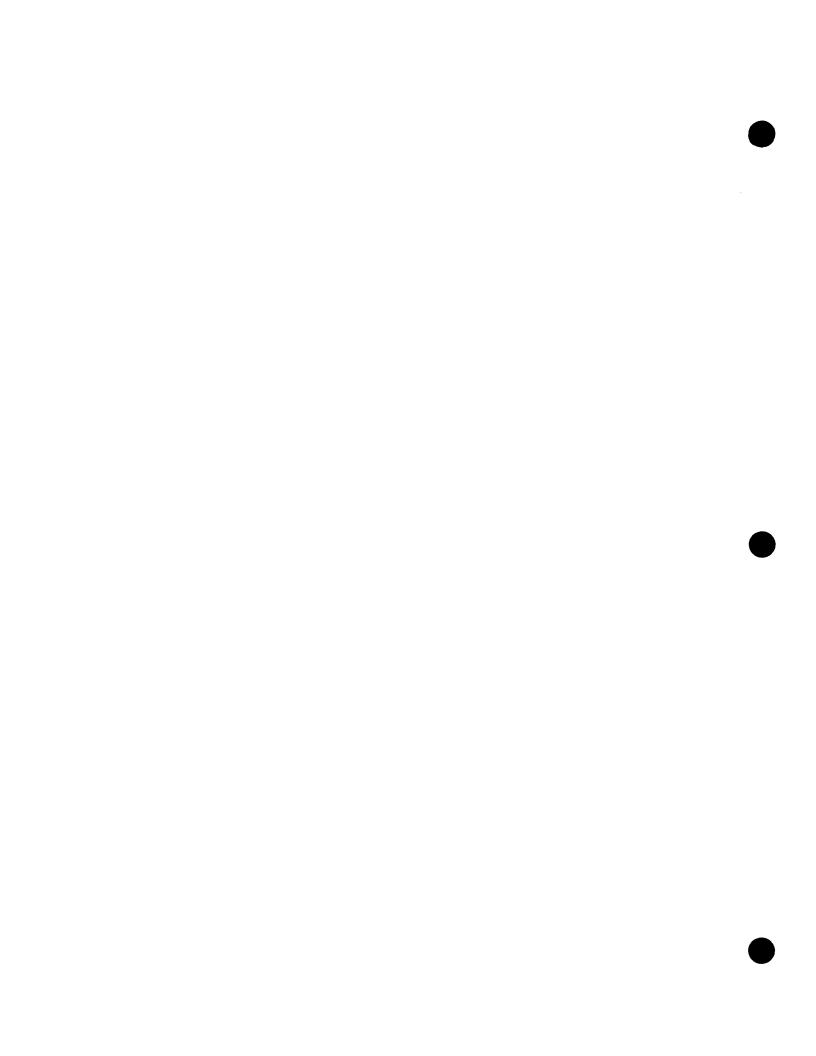
[As introduced, this bill was identical to \$152, as introduced by Sens. Hise, Tillman, Brock, which is currently in Senate Rules and Operations of the Senate.]

BILL ANALYSIS: House Bill 206 would require health benefit plans that provide coverage for prescribed, orally administered anticancer drugs and also provide coverage for intravenously administered or injected anticancer drugs, to provide coverage for those orally administered anticancer drugs on a basis no less favorable than that which is provided for intravenously administered or injected anticancer drugs. Coverage for the orally administered anticancer drugs could not be required to be subject to any prior authorization, dollar limit, co-payment, coinsurance, or deductible provision or to any other out-of-pocket expense that does not apply to intravenously administered or injected anticancer drugs. Health care plans would be prohibited from achieving compliance with this law by reclassifying anticancer drugs or increasing patient cost-sharing. Any change in a policy, contract, or plan that would increase the insured's out-of-pocket expense would also have to be applied to the majority of comparable medical or pharmaceutical benefits covered by the plan.

EFFECTIVE DATE: The bill would become effective January 1, 2018 and apply to insurance contracts or policies issued, renewed, or amended on or after that date; however the act would not become effective if it is determined by the federal government to create a state-required benefit in excess of the essential health benefits.







GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2017

H

HOUSE BILL 206

1

Short Title: NC Cancer Treatment Fairness. (Public)

Sponsors: Representatives Lewis, Jackson, Lambeth, and McElraft (Primary Sponsors).

For a complete list of sponsors, refer to the North Carolina General Assembly web site.

Referred to: Health

March 1, 2017

1 2

A BILL TO BE ENTITLED

3

AN ACT RELATING TO HEALTH BENEFIT PLAN COVERAGE FOR ORALLY ADMINISTERED ANTICANCER DRUGS.

Whereas, advances in medical research have led to significant new developments of

5 6 7

various medical treatments; and

Whereas, these treatments offer patients a wide range of new choices to combat very serious diseases; and

8

Whereas, the area of cancer treatment has been one of the fields that has seen these significant new medical advancements; and

10

Whereas, in recent years, oral chemotherapy treatments have been developed that provide viable alternatives to traditional intravenous cancer treatments for patients; and

11 12

Whereas, this oral chemotherapy treatment offers the treating physician and the patient a choice in relation to treatment options; and

13 14 15

Whereas, this choice is sometimes limited as the oral chemotherapy treatments are in most cases covered under the prescription drug benefit of an insurance plan rather than under the major medical insurance benefit of an insurance plan; and

16 17

Whereas, this discrepancy in coverage can limit a patient's ability to choose the oral chemotherapy treatment because of the cost associated with the disparate treatment; Now, therefore,

18 19 20

The General Assembly of North Carolina enacts:

21 22 **SECTION 1.** Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read as follows:

23 24

"§ 58-3-282. Coverage for orally administered anticancer drugs.

25262728

(a) Every health benefit plan offered by an insurer, as defined in G.S. 58-3-167(a), that provides coverage for prescribed, orally administered anticancer drugs that are used to kill or slow the growth of cancerous cells and that provides coverage for intravenously administered or injected anticancer drugs shall provide coverage for prescribed, orally administered anticancer drugs on a basis no less favorable than the coverage the policy, contract, or plan provides for the intravenously administered or injected anticancer drugs.

29 30 31

(b) Coverage for orally administered anticancer drugs shall not be subject to any prior authorization, dollar limit, co-payment, coinsurance, or deductible provision or to any other out-of-pocket expense that does not apply to intravenously administered or injected anticancer drugs.

32 33

(c) A policy, contract, or plan provider shall not achieve compliance with this section by reclassifying anticancer drugs or by increasing patient cost-sharing, including any coinsurance,



34 35

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co-payment, deductible, or other out-of-pocket expenses imposed on anticancer drugs. Any policy,
 contract, or plan change that otherwise increases an out-of-pocket expense applied to anticancer
 drugs must also be applied to the majority of comparable medical or pharmaceutical benefits
 covered by the policy, contract, or plan."

SECTION 2. This act becomes effective January 1, 2018, and applies to insurance contracts or policies issued, renewed, or amended on or after that date, but this act shall not become effective if this act is determined by the federal government to create a state-required benefit that is in excess of the essential health benefits pursuant to 45 C.F.R. § 155.170(a)(3).



HOUSE BILL 550: Establish New Nurse Licensure Compact.

2017-2018 General Assembly

Committee: House Health. If favorable, re-refer to Date: April 5, 2017

Finance

Introduced by: Reps. Szoka, Adcock, Boswell, White Prepared by: Jason Moran-Bates

Analysis of: Filed Edition Committee Co-Counsel

OVERVIEW: House Bill 550 would enact and make North Carolina a member state in the new nurse licensure compact. It would also repeal the current nurse licensure compact and replace it with the new version.

CURRENT LAW: The current Nurse Licensure Compact is codified as Article 9G of Chapter 90 of the General Statutes. Comparisons between the current compact (G.S. 90-171.80 through G.S. 90-171.94) and the proposed new compact will be underlined below.¹

BILL ANALYSIS: Section 1 of House Bill 550 would repeal the current nurse licensure compact, G.S. 90-171.80 through G.S. 90-171.94.

Section 2 of House Bill 550 would enact the new nurse licensure compact as described below.

G.S. 90-171.95 sets out the purpose of and findings supporting the new compact. This section is substantially similar to current G.S. 90-171.81.

G.S. 90-171.95A defines the terms to be used in the new compact. The term "adverse action" is significantly expanded in the new compact to clarify that any administrative, civil, equitable or criminal actions taken by a state licensing board qualify as adverse actions. The current compact does not define the types of actions that may be classified as adverse. The new compact also adds some procedural safeguards to the term "current significant investigative information" and adds definitions for "multistate license" and "single-state license." The remainder of this section is substantially similar to current G.S. 90-171.82.

G.S. 90-171.95B describes the general provisions and jurisdiction of the new compact.

- Subsection (a) would allow a nurse residing in North Carolina to receive a multi-state license
 which gives the nurse the privilege to practice in any other state that is a member of the new
 compact. This provision is substantially similar to G.S. 90-171.83(a) of the current compact.
- Subsection (b) would require the North Carolina Board of Nursing (Board) to consider the
 criminal history of applicants for a multi-state license by submitting fingerprints or other
 biometric data to the FBI. This provision does not appear in the current compact.
- Subsection (c) sets forth the criteria applicants must meet in order to obtain a multi-state license, which would include: 1) meeting all of North Carolina's qualifications for licensure; 2)

¹ To facilitate clarity, the nurse licensure compact that is currently in law and codified as G.S. 90-171.80 through G.S. 90-171.94 will be referred to as the "current compact" throughout this summary. The proposed nurse licensure compact that would be established by enacting this bill will be referred to as the "new compact."





Legislative Analysis Division 919-733-2578

House Bill 550

Page 2

graduating from a Board-approved nursing program; 3) demonstrating proficiency in English; 4) passing an NCLEX-RN or NCLEX-PN exam; 5) being eligible for, or currently holding, an unencumbered license; 6) submitting fingerprints or other biometric data for a criminal background check; 7) not being found guilty of a felony offense or a misdemeanor offense related to nursing; 8) being subject to self-disclosure requirements regarding current participation in an alternative program; and 9) having a valid Social Security Number. These requirements do not appear in the current compact.

- Subsection (d) would allow the Board to take adverse action against a nurse's multi-state license. This subsection is substantially similar to G.S. 90-171.83(b) of the current compact.
- Subsection (e) would require a nurse practicing in a state under a multi-state license to comply with all the laws and regulations of the state in which the nurse is practicing. This subsection is substantially similar to G.S. 90-171.83(c) of the current compact.
- Subsection (f) would prohibit nurses residing in states that are not parties to the compact from obtaining multi-state licenses allowing them the privilege to practice in states that are parties to the compact. This subsection is substantially similar to G.S. 90-171.83(e) of the current compact.
- Subsection (g) would allow nurses holding multi-state licenses under the current compact to renew those licenses under the new compact as long as no disqualifying events have taken place, and all the requirements of any new state of residency are met. These provisions do not appear in the current compact.

G.S. 90-171.95C would establish procedures for applicants seeking a multi-state license in a member state. These procedures are substantially similar to those in G.S. 90-171.84.

G.S. 90-171.95D would define the powers the Board has under the new compact to take adverse action against licensees.

- Sub-subsection (a)(1) would allow the Board to take action against the multi-state licenses of nurses residing in other states who practice in North Carolina. This provision is substantially similar to G.S. 90-171.86(c) and (d).
- Sub-subsections (a)(2)-(a)(7) would allow the Board to issue cease and desist orders or encumber a nurse's authority to practice in North Carolina, issue subpoenas for hearings and investigations, and, if permitted by law, recover the costs of investigation and disposition of adverse action taken against nurses. These three provisions are substantially similar to G.S. 90-171.87(3), (2), and (1), respectively. Sub-subsections (a)(2)-(a)(7) would also allow the Board to complete investigations of nurses who are under investigation when they relocate to North Carolina, obtain fingerprint and biometric data from applicants, and take adverse action based on factual findings of nursing boards in other states. These three provisions are not found in the current compact.
- Sub-subsection (b) would provide that if a home state takes action against a nurse's multi-state license, the nurse's privilege to practice in any remote state will be revoked until the home state license is cleared. This provision is not found in the current compact.
- Sub-subsection(c) would allow the Board to, at its discretion, place a nurse practicing in North Carolina on a multi-state license in an alternative program, rather than revoking the nurse's privilege to practice in North Carolina. This provision is not found in the current compact.

G.S. 90-171.95E would establish the rules for reporting to the coordinated licensure information system (System). The reporting provisions are substantially similar to those found in G.S. 90-171.88. This

House Bill 550

Page 3

section would also require the compact administrator in North Carolina to submit to the System a uniform data set of identifying information, licensure data, information related to participation in alternative programs, and other information that facilitates the administration of the compact, as well as provide to another member state all investigative information requested by that state. These two provisions are not found in the current compact.

G.S. 90-171.95F would establish the Interstate Commission of Nurse Licensure Compact Administrators (Commission), the governing body of the compact. None of the provisions of G.S. 90-171.95F are found in the current compact.

- Subsection (a) would require any suits filed against the Commission to be brought in the jurisdiction where the Commission's principal office is located.
- Subsection (b) would establish rules for membership in and meetings of the Commission. Each
 member state gets one administrator, with one vote, on the Commission. The Commission must
 meet at least once per year, and all meetings must be open to the public, unless a specifically
 defined exception applies.
- Subsection (c) would establish the bylaws for the Commission, including defining the fiscal year, setting forth procedures for committees, establishing rules for calling meetings and electing officers for the Commission, establishing personnel policies, and providing a mechanism to wind up the Commission's operations.
- Subsections (d), (e), and (f) would require the Commission to publish its bylaws and rules, maintain financial records in compliance with its bylaws, and take actions consistent with the new compact and the Commission's bylaws.
- Subsection (g) would grant the Commission the powers to: 1) adopt rules to administer the new compact; 2) prosecute legal actions in the Commission's name; 3) obtain insurance; 4) make personnel and hiring decisions for the Commission; 5) accept donations and gifts to the Commission; 6) dispose of Commission property as necessary; 7) establish and maintain a budget, including borrowing money if necessary; 8) appoint committees; 9) cooperate with law enforcement agencies; and 10) perform any functions necessary and appropriate to achieve the purposes of the new compact.
- Subsection (h) would allow the Commission to levy an annual assessment from each member state and require it to maintain accurate accounts and not incur any obligations prior to securing adequate funds to meet those obligations.
- Subsection (i) would grant qualified immunity to administrators, officers, executive directors, employees, and representatives of the Commission for claims arising out of their official duties and require the Commission to defend and indemnify any of these individuals for claims or judgments made against them.

G.S. 90-171.95G would establish the rule-making authority of the Commission. The rules promulgated by the Commission would be for the administration of the Commission and new compact only. They will not interfere with the Board's authority to regulate the practice of nursing in North Carolina. All rules must be adopted at a public meeting of the Commission after a notice and comment period as well as a public hearing. Emergency rules may be promulgated immediately, but they must go through the notice, comment, and hearing process within 90 days of promulgation. None of the provisions of G.S. 90-171.95G are found in the current compact.

House Bill 550

Page 4

G.S. 90-171.95H would establish the oversight, dispute resolution and enforcement standards of the new compact. Each member state would have the ability to enforce the new compact, and the Commission is required to accept service of process for any suit affecting its powers, responsibilities, or actions. This section would allow the Commission to terminate a state's membership in the new compact if the state is in default of its obligations and, after notice, refuses to cure the default. The Commission will attempt to resolve disputes related to the new compact that arise between member and non-member states, and it must promulgate a rule providing for mediation and binding dispute resolution. These provisions are not found in the current compact. If the Commission cannot resolve a dispute between member states, the member states may submit their dispute to binding arbitration. This provision is substantially similar to G.S. 90-171.92.

G.S. 90-171.95I would establish the procedures for states to amend and withdraw from the new compact. The provisions governing withdrawal are substantially similar to provisions in G.S. 90-171.91. Each member state must recognize multi-state licenses issued under the current compact until that member state has withdrawn from the current compact. If a member state withdraws from the new compact, it must still report adverse actions to the new compact. All non-member states may participate in a non-voting capacity in the activities of the Commission. None of these three provisions are found in the current compact.

G.S. 90-171.95J would allow the remainder of the new compact to remain in force and valid if one provision is struck down by a court. This section is substantially similar to G.S. 90-171.93.

EFFECTIVE DATE: This bill would become effective the earlier of December 31, 2018, or the enactment of the new compact by the 26th state. The Board must report to the Revisor of Statutes when 26 states have enacted the compact.

BACKGROUND: The current nurse licensure compact has been enacted by 25 states. As of April 1, 2017, 32 states have either enacted the new compact or filed bills to enact the new compact.

GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2017

H.B. 550 Apr 4, 2017 HOUSE PRINCIPAL CLERK

(Public)

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Short Title:

HOUSE BILL DRH50057-MGqq-57D* (02/21)

Establish New Nurse Licensure Compact.

Representatives Szoka, Adcock, Boswell, and White (Primary Sponsors). Sponsors: Referred to: A BILL TO BE ENTITLED AN ACT REPEALING AND REPLACING NORTH CAROLINA'S CURRENT NURSE LICENSURE COMPACT. The General Assembly of North Carolina enacts: **SECTION 1.** G.S. 90-171.80 through G.S. 90-171.94 are repealed. SECTION 2. Article 9G of Chapter 90 of the General Statutes is amended by adding new sections to read: "§ 90-171.95. Findings and declaration of purpose. The party states make the following findings: The health and safety of the public are affected by the degree of compliance (1)with and the effectiveness of enforcement activities related to state nurse licensure laws. Violations of nurse licensure and other laws regulating the practice of (2) nursing may result in injury or harm to the public. The expanded mobility of nurses and the use of advanced communication (3) technologies as part of our nation's health care delivery system require greater coordination and cooperation among states in the areas of nurse licensure and regulation. New practice modalities and technology make compliance with individual (4) state nurse licensure laws difficult and complex. The current system of duplicative licensure for nurses practicing in multiple (5)states is cumbersome and redundant for both nurses and states. Uniformity of nurse licensure requirements throughout the states promotes (6)public safety and public health benefits. The general purposes of this Compact are as follows: (b) (1) Facilitate the states' responsibility to protect the public's health and safety. Ensure and encourage the cooperation of party states in the areas of nurse (2)licensure and regulation. Facilitate the exchange of information between party states in the areas of (3) nurse regulation, investigation, and adverse actions. Promote compliance with the laws governing the practice of nursing in each (4) iurisdiction. <u>(5)</u> Invest all party states with the authority to hold a nurse accountable for meeting all state practice laws in the state in which the patient is located at the time care is rendered through the mutual recognition of party state



licenses.

- (6) Decrease redundancies in the consideration and issuance of nurse licenses.
- (7) Provide opportunities for interstate practice by nurses who meet uniform licensure requirements.

"§ 90-171.95A. Definitions.

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As used in this Compact:

- (a) Adverse Action. Any administrative, civil, equitable, or criminal action permitted by a state's laws which is imposed by a licensing board or other authority against a nurse, including actions against an individual's license or multistate licensure privilege such as revocation, suspension, probation, monitoring of the licensee, limitation on the licensee's practice, or any other encumbrance on licensure affecting a nurse's authorization to practice, including issuance of a cease and desist action.
- (b) Alternative Program. A nondisciplinary monitoring program approved by a licensing board.
- (c) Coordinated Licensure Information System. An integrated process for collecting, storing, and sharing information on nurse licensure and enforcement activities related to nurse licensure laws that is administered by a nonprofit organization composed of and controlled by licensing boards.
 - (d) Current Significant Investigative Information. Both of the following:
 - (1) Investigative information that a licensing board, after a preliminary inquiry that includes notification and an opportunity for the nurse to respond, if required by state law, has reason to believe is not groundless and, if proved true, would indicate more than a minor infraction.
 - (2) <u>Investigative information that indicates the nurse represents an immediate threat to public health and safety regardless of whether the nurse has been notified and had an opportunity to respond.</u>
- (e) Encumbrance. A revocation or suspension of, or any limitation on, the full and unrestricted practice of nursing imposed by a licensing board.
 - (f) Home State. The party state which is the nurse's primary state of residence.
- (g) <u>Licensing Board. A party state's regulatory body responsible for issuing nurse</u> licenses.
- (h) Multistate License. A license to practice as a registered or a licensed practical/vocational nurse (LPN/VN) issued by a home state licensing board that authorizes the licensed nurse to practice in all party states under a multistate licensure privilege.
- (i) Multistate Licensure Privilege. A legal authorization associated with a multistate license permitting the practice of nursing as either a registered nurse (RN) or LPN/VN in a remote state.
- (j) Nurse. RN or LPN/VN, as those terms are defined by each party state's practice laws.
 - (k) Party State. Any state that has adopted this Compact.
 - (1) Remote State. A party state, other than the home state.
- (m) Single-State License. A nurse license issued by a party state that authorizes practice only within the issuing state and does not include a multistate licensure privilege to practice in any other party state.
- (n) State. A state, territory, or possession of the United States and the District of Columbia.
- (o) State Practice Laws. A party state's laws, rules, and regulations that govern the practice of nursing, define the scope of nursing practice, and create the methods and grounds for imposing discipline. "State practice laws" do not include requirements necessary to obtain and retain a license, except for qualifications or requirements of the home state.
- "§ 90-171.95B. General provisions and jurisdiction.

- (a) A multistate license to practice registered or licensed practical/vocational nursing issued by a home state to a resident in that state will be recognized by each party state as authorizing a nurse to practice as a registered nurse (RN) or as a licensed practical/vocational nurse (LPN/VN), under a multistate licensure privilege, in each party state.
- (b) A state must implement procedures for considering the criminal history records of applicants for initial multistate license or licensure by endorsement. Such procedures shall include the submission of fingerprints or other biometric-based information by applicants for the purpose of obtaining an applicant's criminal history record information from the Federal Bureau of Investigation and the agency responsible for retaining that state's criminal records.
- (c) Each party state shall require all of the following for an applicant to obtain or retain a multistate license in the home state:
 - (1) Meets the home state's qualifications for licensure or renewal of licensure as well as all other applicable state laws.
 - (2) Either of the following:
 - Has graduated or is eligible to graduate from a licensing board-approved RN or LPN/VN prelicensure education program.
 - b. Has graduated from a foreign RN or LPN/VN pre-licensure education program that (a) has been approved by the authorized accrediting body in the applicable country and (b) has been verified by an independent credentials review agency to be comparable to a licensing board-approved pre-licensure education program.
 - (3) Has, if a graduate of a foreign pre-licensure education program not taught in English or if English is not the individual's native language, successfully passed an English proficiency examination that includes the components of reading, speaking, writing, and listening.
 - (4) Has successfully passed an NCLEX-RN® or NCLEX-PN® Examination or recognized predecessor, as applicable.
 - (5) Is eligible for or holds an active, unencumbered license.
 - (6) Has submitted, in connection with an application for initial licensure or licensure by endorsement, fingerprints or other biometric data for the purpose of obtaining criminal history record information from the Federal Bureau of Investigation and the agency responsible for retaining that state's criminal records.
 - (7) Has not been convicted or found guilty, or has entered into an agreed disposition, of a felony offense under applicable state or federal criminal law.
 - (8) Has not been convicted or found guilty, or has entered into an agreed disposition, of a misdemeanor offense related to the practice of nursing as determined on a case-by-case basis.
 - (9) Is not currently enrolled in an alternative program.
 - (10) Is subject to self-disclosure requirements regarding current participation in an alternative program.
 - (11) Has a valid United States Social Security number.
- (d) All party states shall be authorized, in accordance with existing state due process law, to take adverse action against a nurse's multistate licensure privilege such as revocation, suspension, probation, or any other action that affects a nurse's authorization to practice under a multistate licensure privilege, including cease and desist actions. If a party state takes such action, it shall promptly notify the administrator of the coordinated licensure information system. The administrator of the coordinated licensure information system shall promptly notify the home state of any such actions by remote states.

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limited to patient care but shall include all nursing practice as defined by the state practice laws of the party state in which the client is located. The practice of nursing in a party state under a multistate licensure privilege will subject a nurse to the jurisdiction of the licensing board, the courts, and the laws of the party state in which the client is located at the time service is provided. Individuals not residing in a party state shall continue to be able to apply for a party (f)

state in which the client is located at the time service is provided. The practice of nursing is not

- state's single-state license as provided under the laws of each party state. However, the single-state license granted to these individuals will not be recognized as granting the privilege to practice nursing in any other party state. Nothing in this Compact shall affect the requirements established by a party state for the issuance of a single-state license.
- Any nurse holding a home state multistate license, on the effective date of this Compact, may retain and renew the multistate license issued by the nurse's then-current home state, provided that:
 - (1) A nurse, who changes primary state of residence after this Compact's effective date, must meet all applicable requirements in subsection (c) of this section to obtain a multistate license from a new home state.

A nurse practicing in a party state must comply with the state practice laws of the

(2) A nurse who fails to satisfy the multistate licensure requirements in subsection (c) of this section due to a disqualifying event occurring after this Compact's effective date shall be ineligible to retain or renew a multistate license, and the nurse's multistate license shall be revoked or deactivated in accordance with applicable rules adopted by the Interstate Commission of Nurse Licensure Compact Administrators ("Commission").

"§ 90-171.95C. Applications for licensure in a party state.

- Upon application for a multistate license, the licensing board in the issuing party state shall ascertain, through the coordinated licensure information system, whether the applicant has ever held, or is the holder of, a license issued by any other state, whether there are any encumbrances on any license or multistate licensure privilege held by the applicant, whether any adverse action has been taken against any license or multistate licensure privilege held by the applicant, and whether the applicant is currently participating in an alternative program.
- (b) A nurse may hold a multistate license, issued by the home state, in only one party state at a time.
- If a nurse changes primary state of residence by moving between two party states, the nurse must apply for licensure in the new home state, and the multistate license issued by the prior home state will be deactivated in accordance with applicable rules adopted by the Commission. The following apply to nurses changing primary state of residence by moving between two party states:
 - The nurse may apply for licensure in advance of a change in primary state of (1) residence.
 - (2)A multistate license shall not be issued by the new home state until the nurse provides satisfactory evidence of a change in primary state of residence to the new home state and satisfies all applicable requirements to obtain a multistate license from the new home state.
- If a nurse changes primary state of residence by moving from a party state to a (d) nonparty state, the multistate license issued by the prior home state will convert to a single-state license, valid only in the former home state.
- "§ 90-171.95D. Additional authorities invested in party state licensing boards.
- In addition to the other powers conferred by state law, a licensing board may do all of the following:

- (7) Take adverse action based on the factual findings of the remote state, provided that the licensing board follows its own procedures for taking such adverse action.
- (b) If adverse action is taken by the home state against a nurse's multistate license, the nurse's multistate licensure privilege to practice in all other party states shall be deactivated until all encumbrances have been removed from the multistate license. All home state disciplinary orders that impose adverse action against a nurse's multistate license shall include a statement that the nurse's multistate licensure privilege is deactivated in all party states during the pendency of the order.
- (c) Nothing in this Compact shall override a party state's decision that participation in an alternative program may be used in lieu of adverse action. The home state licensing board shall deactivate the multistate licensure privilege under the multistate license of any nurse for the duration of the nurse's participation in an alternative program.
- "§ 90-171.95E. Coordinated licensure information system and exchange of information.

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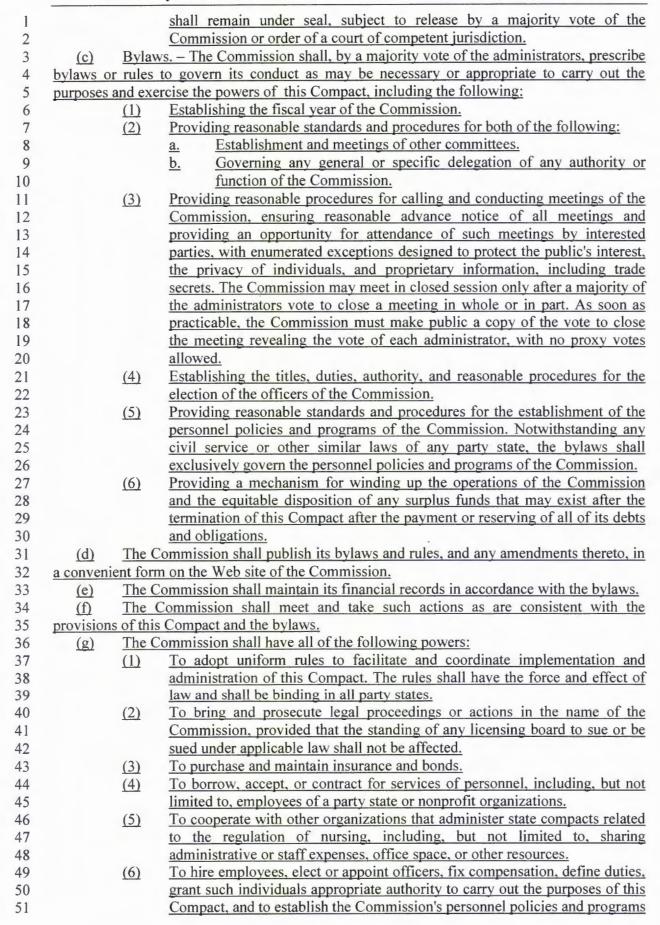
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- All party states shall participate in a coordinated licensure information system of all 1 licensed registered nurses (RNs) and licensed practical/vocational nurses (LPNs/VNs). This 2 system will include information on the licensure and disciplinary history of each nurse, as 3 4 submitted by party states, to assist in the coordination of nurse licensure and enforcement 5 efforts. 6 The Commission, in consultation with the administrator of the coordinated licensure (b) 7 information system, shall formulate necessary and proper procedures for the identification, 8 collection, and exchange of information under this Compact. All licensing boards shall promptly report to the coordinated licensure information 9 system any adverse action, any current significant investigative information, denials of 10 applications (with the reasons for such denials), and nurse participation in alternative programs 11 known to the licensing board regardless of whether such participation is deemed nonpublic or 12 13 confidential under state law. Current significant investigative information and participation in nonpublic or 14 confidential alternative programs shall be transmitted through the coordinated licensure 15 16 information system only to party state licensing boards. Notwithstanding any other provision of law, all party state licensing boards 17 contributing information to the coordinated licensure information system may designate 18 19 information that may not be shared with nonparty states or disclosed to other entities or 20 individuals without the express permission of the contributing state. 21 Any personally identifiable information obtained from the coordinated licensure 22 information system by a party state licensing board shall not be shared with nonparty states or disclosed to other entities or individuals except to the extent permitted by the laws of the party 23 24 state contributing the information. 25 Any information contributed to the coordinated licensure information system that is 26 subsequently required to be expunged by the laws of the party state contributing that information shall also be expunged from the coordinated licensure information system. 27 The Compact administrator of each party state shall furnish a uniform data set to the 28 Compact administrator of each other party state, which shall include, at a minimum, all of the 29 30 following: 31 (1)Identifying information. 32 Licensure data. (2)33 Information related to alternative program participation. (3) Other information that may facilitate the administration of this Compact, as 34 (4) 35 determined by Commission rules. The Compact administrator of a party state shall provide all investigative documents 36 and information requested by another party state. 37 "§ 90-171.95F. Establishment of the Interstate Commission of Nurse Licensure Compact 38 Administrators. 39 40 Creation. – The party states hereby create and establish a joint public entity known as the Interstate Commission of Nurse Licensure Compact Administrators. 41 The Commission is an instrumentality of the party states. 42 (1)Venue is proper, and judicial proceedings by or against the Commission 43 (2)shall be brought solely and exclusively in a court of competent jurisdiction 44 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.
 - Nothing in this Compact shall be construed to be a waiver of sovereign (3) immunity.
 - Membership, Voting and Meetings. -(b)

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- To accept any and all appropriate donations, grants and gifts of money, equipment, supplies, materials, and services, and to receive, utilize, and dispose of the same; provided that at all times the Commission shall avoid any appearance of impropriety or conflict of interest.
- To lease, purchase, accept appropriate gifts or donations of, or otherwise to own, hold, improve, or use any property, whether real, personal, or mixed; provided that at all times the Commission shall avoid any appearance of impropriety.
- To sell, convey, mortgage, pledge, lease, exchange, abandon, or otherwise (9)dispose of any property, whether real, personal, or mixed.
- To establish a budget and make expenditures. (10)
- To borrow money. (11)
- To appoint committees, including advisory committees comprised of (12)administrators, state nursing regulators, state legislators or their representatives, and consumer representatives, and other such interested
- To provide and receive information from, and to cooperate with, law (13)enforcement agencies.
- To adopt and use an official seal. (14)
- To perform such other functions as may be necessary or appropriate to (15)achieve the purposes of this Compact consistent with the state regulation of nurse licensure and practice.
- Financing of the Commission. -(h)
 - The Commission shall pay, or provide for the payment of, the reasonable (1) expenses of its establishment, organization, and ongoing activities.
 - (2) The Commission may also levy on and collect an annual assessment from each party state to cover the cost of its operations, activities, and staff in its annual budget as approved each year. The aggregate annual assessment amount, if any, shall be allocated based upon a formula to be determined by the Commission, which shall promulgate a rule that is binding upon all party states.
 - <u>(3)</u> 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 party states, except by, and with the authority of, such party
 - <u>(4)</u> 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.
- Qualified Immunity, Defense, and Indemnification. -(i)
 - The administrators, officers, executive director, employees, and (1)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 1 responsibilities; provided that nothing in this paragraph shall be construed to 2 protect any such person from suit or liability for any damage, loss, injury, or 3 liability caused by the intentional, willful, or wanton misconduct of that 4 5 person. 6 (2)The Commission shall defend any administrator, officer, executive director, 7 employee, or representative of the Commission in any civil action seeking to 8 impose liability arising out of any actual or alleged act, error, or omission that occurred within the scope of Commission employment, duties, or 9 responsibilities, or that the person against whom the claim is made had a 10 reasonable basis for believing occurred within the scope of Commission 11 employment, duties, or responsibilities; provided that nothing herein shall be 12 construed to prohibit that person from retaining his or her own counsel; and 13 provided further that the actual or alleged act, error, or omission did not 14 result from that person's intentional, willful, or wanton misconduct. 15 The Commission shall indemnify and hold harmless any administrator, 16 (3)officer, executive director, employee, or representative of the Commission 17 for the amount of any settlement or judgment obtained against that person 18 arising out of any actual or alleged act, error, or omission that occurred 19 within the scope of Commission employment, duties, or responsibilities, or 20 that such person had a reasonable basis for believing occurred within the 21 scope of Commission employment, duties, or responsibilities; provided that 22 the actual or alleged act, error, or omission did not result from the 23 24 intentional, willful, or wanton misconduct of that person. 25 "§ 90-171.95G. Rule making. The Commission shall exercise its rule-making powers pursuant to the criteria set 26 forth in this Article and the rules adopted thereunder. Rules and amendments shall become 27 binding as of the date specified in each rule or amendment and shall have the same force and 28 29 effect as provisions of this Compact. Rules or amendments to the rules shall be adopted at a regular or special meeting of 30 (b) 31 the Commission. Prior to promulgation and adoption of a final rule or rules by the Commission, and 32 at least 60 days in advance of the meeting at which the rule will be considered and voted upon, 33 the Commission shall file a notice of proposed rule making in both of the following locations: 34 On the Web site of the Commission. 35 (1)On the Web site of each licensing board or the publication in which each 36 (2) state would otherwise publish proposed rules. 37 The notice of proposed rule making shall include all of the following: 38 (d) 39 The proposed time, date, and location of the meeting in which the rule will (1) be considered and voted upon. 40 The text of the proposed rule or amendment and the reason for the proposed 41 (2)42 rule. A request for comments on the proposed rule from any interested person. 43 (3) The manner in which interested persons may submit notice to the 44 (4) Commission of their intention to attend the public hearing and any written 45 46 comments. Prior to adoption of a proposed rule, the Commission shall allow persons to submit 47 written data, facts, opinions, and arguments, which shall be made available to the public. 48

The Commission shall grant an opportunity for a public hearing before it adopts a

rule or amendment.

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- The Commission shall publish the place, time, and date of the scheduled public (g) hearing.
 - (1) 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. All hearings will be recorded, and a copy will be made available upon request.
 - Nothing in this section shall be construed as requiring a separate hearing on <u>(2)</u> each rule. Rules may be grouped for the convenience of the Commission at hearings required by this section.
- (h) If no one appears at the public hearing, the Commission may proceed with promulgation of the proposed rule.
- 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.
- The Commission shall, by majority vote of all administrators, take final action on the proposed rule and shall determine the effective date of the rule, if any, based on the rulemaking record and the full text of the rule.
- 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 this 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 do one or more of the following:
 - Meet an imminent threat to public health, safety, or welfare.
 - (2) Prevent a loss of Commission or party state funds.
 - Meet a deadline for the promulgation of an administrative rule that is (3) required by federal law or rule.
- 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 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.

"§ 90-171.95H. Oversight, dispute resolution, and enforcement.

- Oversight. -(a)
 - Each party state shall enforce this Compact and take all actions necessary (1)and appropriate to effectuate this Compact's purposes and intent.
 - The Commission shall be entitled to receive service of process in any (2) proceeding that may affect the powers, responsibilities, or actions of the Commission and shall have standing to intervene in such a proceeding for all purposes. Failure to provide service of process in such proceeding to the Commission shall render a judgment or order void as to the Commission, this Compact, or promulgated rules.
- Default, Technical Assistance, and Termination. -(b)
 - If the Commission determines that a party state has defaulted in the (1) performance of its obligations or responsibilities under this Compact or the promulgated rules, the Commission shall do both of the following:

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.

"§ 90-171.95I. Effective date, withdrawal, and amendment.

- (a) This Compact shall become effective and binding on the earlier of the date of legislative enactment of this Compact into law by no less than 26 states or December 31, 2018. All party states to this Compact, that also were parties to the prior Nurse Licensure Compact superseded by this Compact ("Prior Compact"), shall be deemed to have withdrawn from said Prior Compact within six months after the effective date of this Compact.
- (b) Each party state to this Compact shall continue to recognize a nurse's multistate licensure privilege to practice in that party state issued under the Prior Compact until such party state has withdrawn from the Prior Compact.
- (c) Any party state may withdraw from this Compact by enacting a statute repealing the same. A party state's withdrawal shall not take effect until six months after enactment of the repealing statute.
- (d) A party state's withdrawal or termination shall not affect the continuing requirement of the withdrawing or terminated state's licensing board to report adverse actions and significant investigations occurring prior to the effective date of such withdrawal or termination.
- (e) Nothing contained in this Compact shall be construed to invalidate or prevent any nurse licensure agreement or other cooperative arrangement between a party state and a nonparty state that is made in accordance with the other provisions of this Compact.
- (f) This Compact may be amended by the party states. No amendment to this Compact shall become effective and binding upon the party states unless and until it is enacted into the laws of all party states.
- (g) Representatives of nonparty states to this Compact shall be invited to participate in the activities of the Commission, on a nonvoting basis, prior to the adoption of this Compact by all states.

"§ 90-171.95J. Construction and severability.

This Compact shall be liberally construed so as to effectuate the purposes thereof. The provisions of this Compact shall be severable, and if any phrase, clause, sentence, or provision of this Compact is declared to be contrary to the constitution of any party state or of the United States, or if the applicability thereof to any government, agency, person, or circumstance is held invalid, the validity of the remainder of this Compact and the applicability thereof to any government, agency, person, or circumstance shall not be affected thereby. If this Compact shall be held to be contrary to the constitution of any party state, this Compact shall remain in full force and effect as to the remaining party states and to all severable matters."

SECTION 3. This act becomes effective when at least 26 states have enacted the Nurse Licensure Compact set forth in Section 2 of this act or December 31, 2018, whichever is earlier. The North Carolina Board of Nursing shall report to the Revisor of Statutes when the Nurse Licensure Compact set forth in Section 2 of this act has been enacted by the 26 member states.



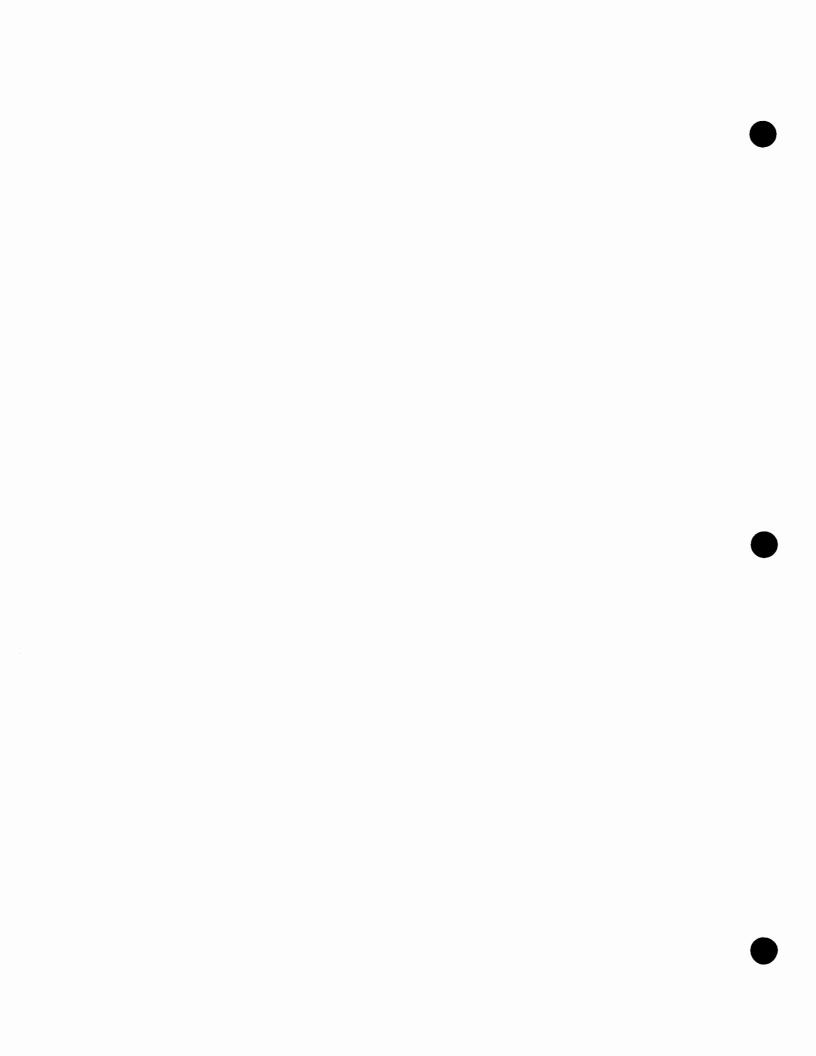
Cost-Sharing Financial Disparity for Oral Chemotherapy in North Carolina

Indication	Oral Chemotherapy 1 Mor	nthly Payment	Intravenous (IV) Chemotherapy ² Monthly Payment			Disparity In Cost Straving	
indication	Cash Price (Uninsured)	Co-Pay with Insurance ³	Cash Price (Uninsured)	Co-Pay with Insurance ⁴	(O)rall	IN.	
A STANDARD STAND	Imatinib (Gleevec®): \$6912.35	\$1728.09					
Chronic Myeloid	Nilotinib (Tasigna®): \$9274.45	\$2318.61	No clinically equivalent therapy available 5	N/A	,	I/A	
Leukemia	Dasatinib (Sprycel®): \$8841.35	\$ 2210.34					
100000000000000000000000000000000000000	Sunitinib (Sutent®): \$1535.85	cases of					
Metastatic Renal	Sorafenib (Nexavar®): \$8576.15	\$2383.96	No clinically equivalent therapy available	N/A	- N/A		
Cell Carcinoma	Pazopanib (Votrient®): \$6179.1	\$1544.78					
Melanoma (V600E Mutation)	Vemurafenib (Zelboraf®): \$8464.20	\$2116.05	Ipilimumab (Yervoy®): \$58,944.10	\$250	25%	ől 4%	
Medullary thyroid cancer	Vandetanib (Caprelsa®): \$11,880	\$2970	No clinically equivalent therapy available ⁵	N/A	,	I/A	
Non-Small Cell Lung Cancer	Crizotinib ⁶ (Xalkori®) ⁶ : \$12,424.16		(2 nd line options) ⁷	The state of the s	25%		
		\$3106.04	Cispaltin + Pemetrexed: \$10,683.80	\$250		2.3%	
	Erlotinib ⁶ (Tarceva®) ⁶ : \$6218.15	\$1554.54	Carboplatin + Paclitaxel + Bevacizumab (Avastin®): \$15,640.20	\$250	25%	1.6%	
Metastatic Breast	Lapatinib (Tykerb®): \$5632.31	\$1408.078		4050		1.	
Cancer	Control School S		Trastuzumab (Herceptin®): \$10,624.40	\$250	25%	2.4%	
1 1 10 10 1	Thalidomide (Thalomid®): \$8762.70	\$2190.68	Bortezomib (Velcade®): \$7,326	\$250	25%	31.4%	
Multiple Myeloma	Lenalidomide (Revlimid®): \$11,854	\$2963.50	Carfilzomib (Kyprolis®): \$20,036.00	\$250	25%	1.2%	
Average Annual Cost Per Regimen ⁹	\$96,306.72	\$29,707.68	\$141,592.90°	\$3000	25%	2.1%	

- 1. Cost for oral chemotherapy is based on a 30-day supply. This would be out-of-pocket cost of uninsured patient
- 2. IV chemotherapy cost estimate is cost of drug for a one-month treatment (this may include 1-4 treatments based on length of cycle of therapy). Also dosing estimated based on average weight of 70 kg, and average body surface area of 1.73 m²
- 3. Insurance co-payment and co-insurance based on the In-Network benefits of BlueCross BlueShield (BCBS) of North Carolina (Blue Advantage Plan B) and United Healthcare (UHC) Choice Balanced (Plan S1E) in North Carolina. Oral agents are classified as 'specialty tier' so the member is responsible for 25% of cost.
- 4. For IV agents, patients have a \$1000 deductible, 80% co-insurance, and \$3000 annual out-of-pocket maximum with the plans selected. Assuming the patient meets the out-of-pocket maximum because of the high drug cost, the patient would be responsible for \$3000 annually (\$250 when divided monthly)
- 5. When there is no clinically equivalent therapy available, patient is forced to: 1. Pay the large co-pay, 2. Apply for assistance from co-pay assistance foundation or manufacturer, 3. Hospitalization (since drug will be treated under the 'medical' plan if the patient is in the hospital)
- 6. Crizotinib is specifically indicated in patients that are positive for the ALK fusion gene and erlotinib is indicated in patients who have mutated epidermal growth factor receptor (EGFR).
- 7. IV agents listed are 2nd line options. The National Cancer Comprehensive Network lists the oral agents first line for the mutations listed above.
- 8. Disparity calculation: (% insurance pays for oral chemotherapy % insurance pays for IV chemotherapy)
- 9. Annual drug estimate for IV agent takes into account average number of total cycles given

Committee Sergeants at Arms

NAME O	F COMMITTEE H	<u>ouse Comm.</u>	on Health
DATE: _	04/06/17	Room:	643
		House Sgt-At Arms:	
1. Name:	Young Bae		
2. Name:	Jim Moran		
3. Name:	Warren Haw	kins	
	Doug Harris		
5. Name: _			
		Senate Sgt-At Arms:	
l. Name:			
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. Name: _			
Name:			·
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Hou Pages Assignments Thursday, April 06, 2017 Session: 2:00 PM

Committee	Room	Time	Staff	Comments	Member
Homeland Security,	421	9:00 AM	Caroline Byars		Rep. John Bradford
Military, and Veterans					
Affairs					
			Jared Diegelman		Rep. Dean Arp
			Madison Gunter		Rep. Mike Clampitt
			Chloe Worner		Rep. Harry Warren
Judiciary III	1228/1327	9:00 AM	Noah Ellington		Rep. Speaker Tim
					Moore
			Caroline Cholette		Rep. Mike Clampitt
			Jenna Varnell		Rep. Susan Martin
			Mary Margaret West		Rep. George Cleveland
Environment	1228/1327	11:00 AM	Caroline Cholette		Rep. Ted Davis, Jr.
			Zina Hockaday		Rep. Yvonne Holley
			Samantha Lenger		Rep. Duane Hall
			Alex Smith		Rep. Holly Grange
Health	643	11:00 AM	Audra Cloer		Rep. Kevin Corbin
			Carolyn McCarthy		Rep. Susan Martin
			Joseph Pinnix		Rep. Chris Malone
Banking	1228/1327	12:00 PM	Caroline Byars		Rep. John Bradford
			Austin Calhoun		Rep. William Richardson
			Jared Diegelman		Rep. Dean Arp
			Chloe Worner		Rep. Harry Warren



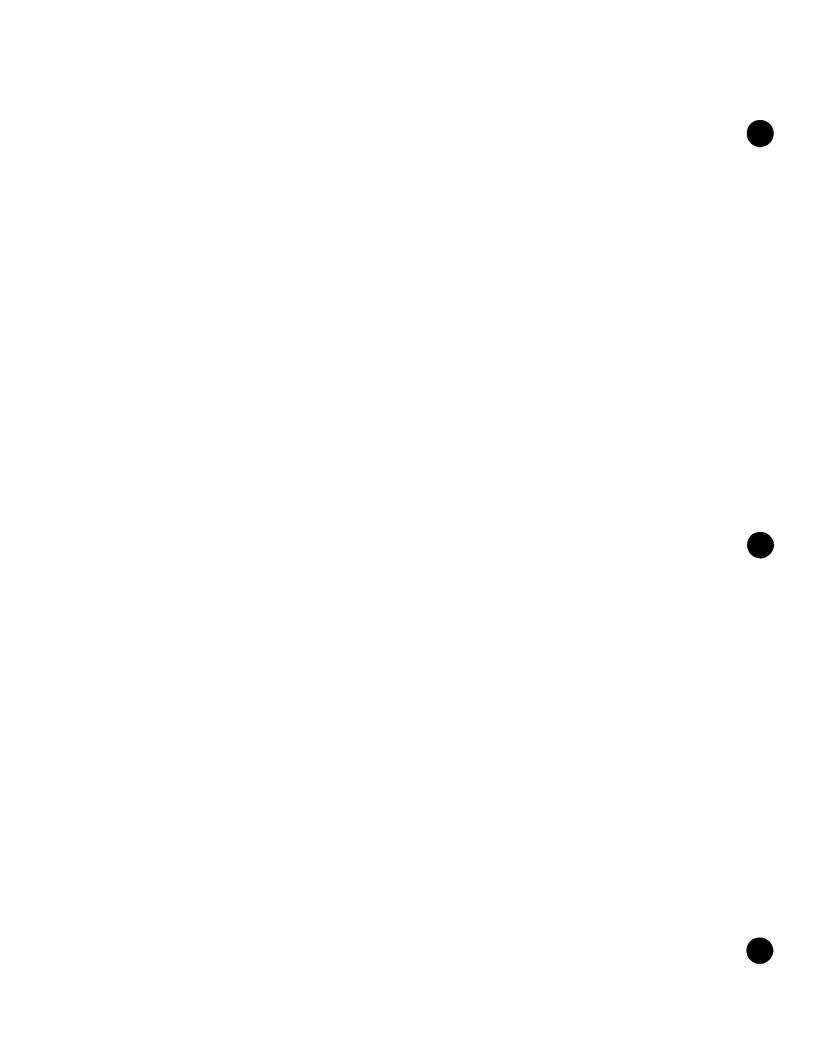
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1	, , SPEAKER REGISTRATION SHEET
//	// ///
House	Health

Name of Committee

NAME	FIRM OR AGENCY AND ADDRESS			
DR. Mitton ByRd.	Asheville K			
DR. Mitton Byrd. Chris Evans	BCBSNC			
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HB 206

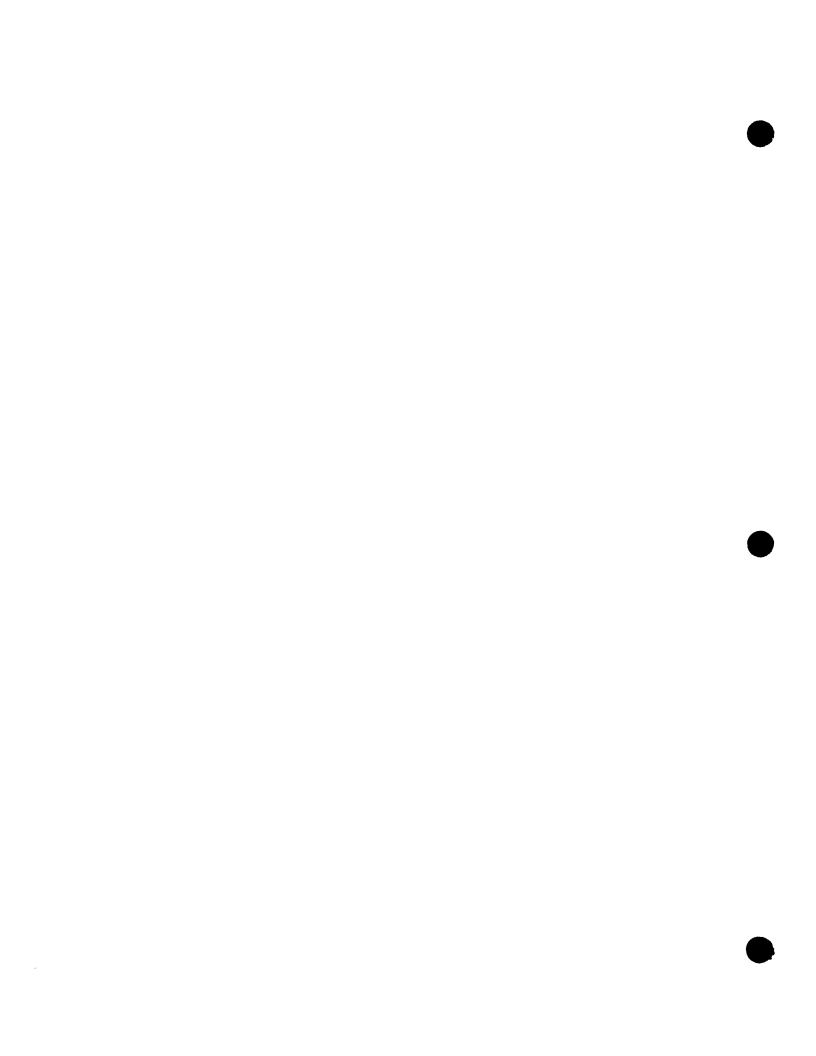
SPEAKER REGISTRATION SHEET

House Health

Date

Name of Committee

NAME	FIRM OR AGENCY AND ADDRESS		
Cheistine Weason	ACS CAN		



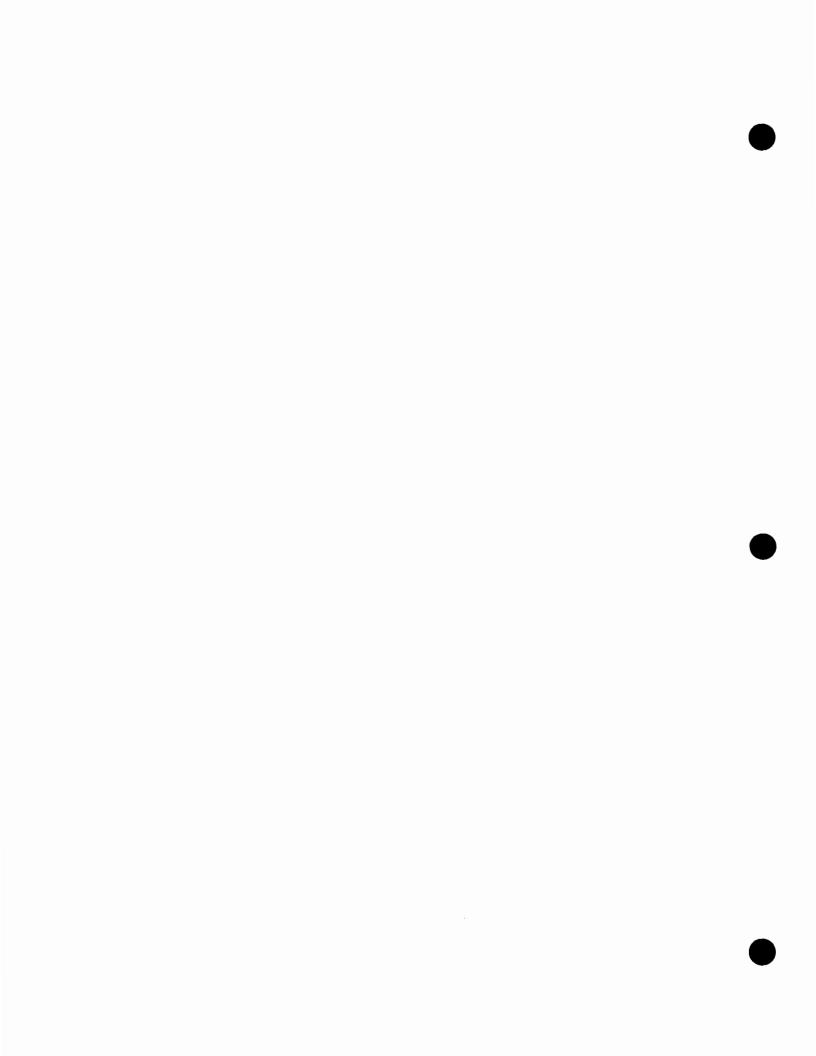
House Comm. on Health

04/06/17

Name of Committee

Date

NAME	FIRM OR AGENCY AND ADDRESS
y C Remain	C35
Sarah Zales	BCA
Lindsy Powling	FSP
Mark Fleming	BCBSnC
Chris Evans	BCBSNC
TJ Buybee	NP
Adam Sholar	NCHCFA
JOE LANIER	T55
DOUL HERON	DUKEZ.
DANIEL VANLIERE	VINENT PERCEN
Chp Byst	wicms
Day ou May MARID	74



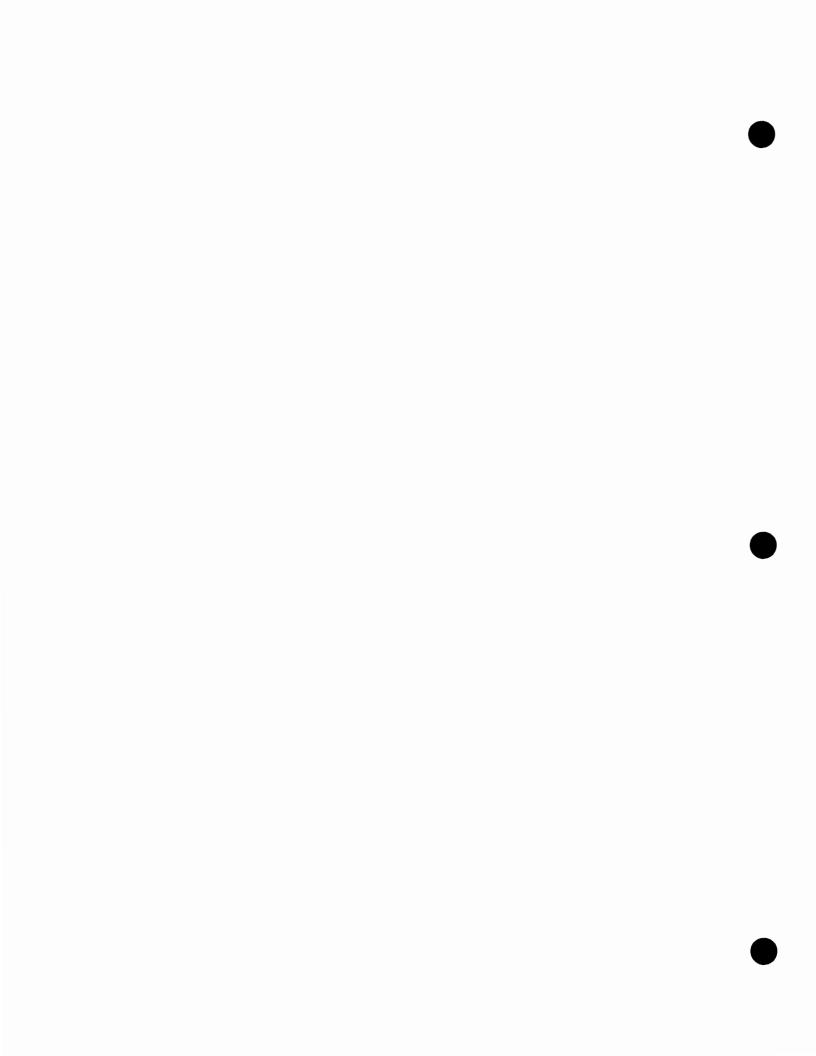
House Comm. on Health

04/06/17

Name of Committee

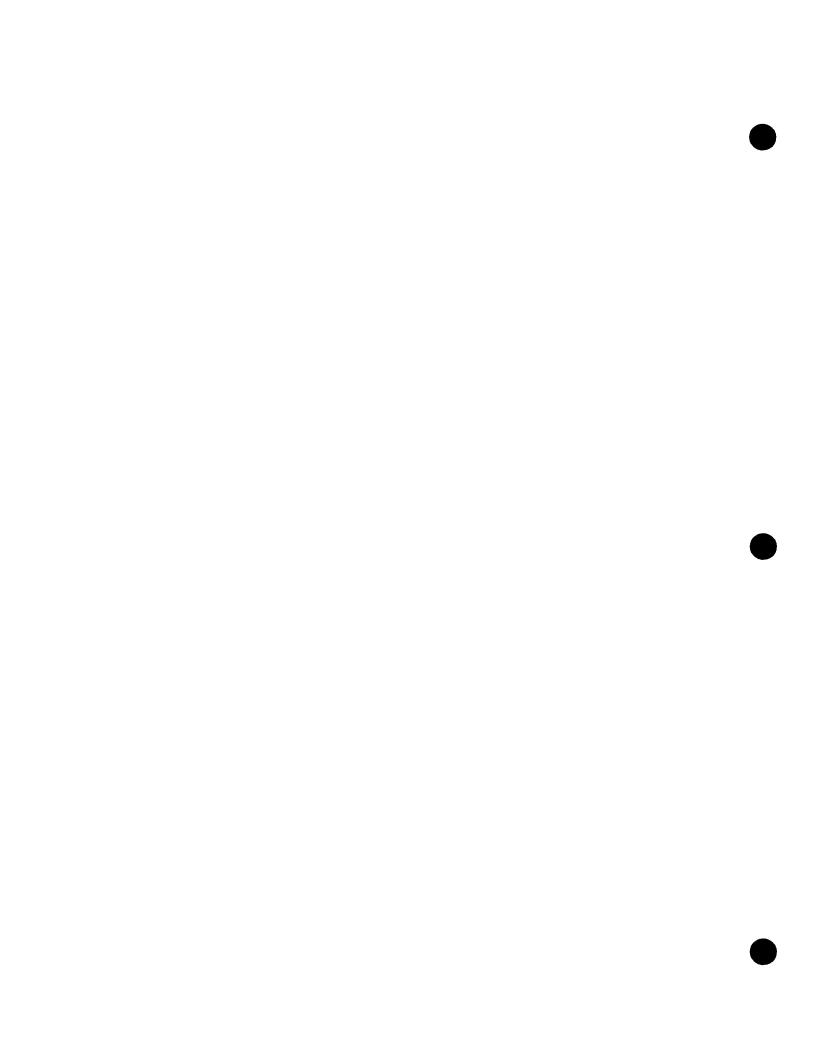
Date

NAME	FIRM OR AGENCY AND ADDRESS
Sue Am Forrest	Nems
ROBLAMANT	PLA
And Da	MAPHA
There an Jackson	Tucus Conoling
MatasBalan	. PPAB
Dana Singen	SIA
Tim By LER	Nivers
Jun 1fm	73r/
Andy Man	MVA.
Jillian Diman	Mwcllc
amanda Donovon	KTS



House Comm. on Health 04/06/17 Name of Committee Date

NAME	FIRM OR AGENCY AND ADDRESS
John Mich Dla	Mifet S
Lou Ann Hayres	4941
MARN BROCK	TEME THIERDEUTICS
Abigal Stodard	Prime Therapeutics
John Sipe	. NCERC
	•



House Comm. on Health

04/06/17

NAME	FIRM OR AGENCY AND ADDRESS
Coryl Denner	DRNC
MARK HARVEY	
Isaac Ridgeway	Visiting
Kay Cashlo	NASW-NC
Caroline Miller	· AM5A
Kari Barsness	Gateman Health
BILL SCOGGIN	13
LT McCrimmon	DHHS
De Millon Byel	Askeville NC
Michelle Frazia	SML
Josh Laria	SnL

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VISITOR REGISTRATION SHEET

House Comm. on Health

04/06/17

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

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FIRM OR AGENCY AND ADDRESS

Draw balladige	PC BOARD OF NOWSING
Isidare Graham	Ne Board of Nursing
Ang Sitchugh	NC Board of Nursing
Been Langdon	NC Board of NUVSING
MAM GRAZOWSKI	. STATE HEART PLAN
Alex Zizzi	VNC
Scaloin Seara	UNCCH
Michael Zicker	unc
Pan Silberna	UNC
	UNC
Karthok Adaga Scriquinia Peacock	NCNA

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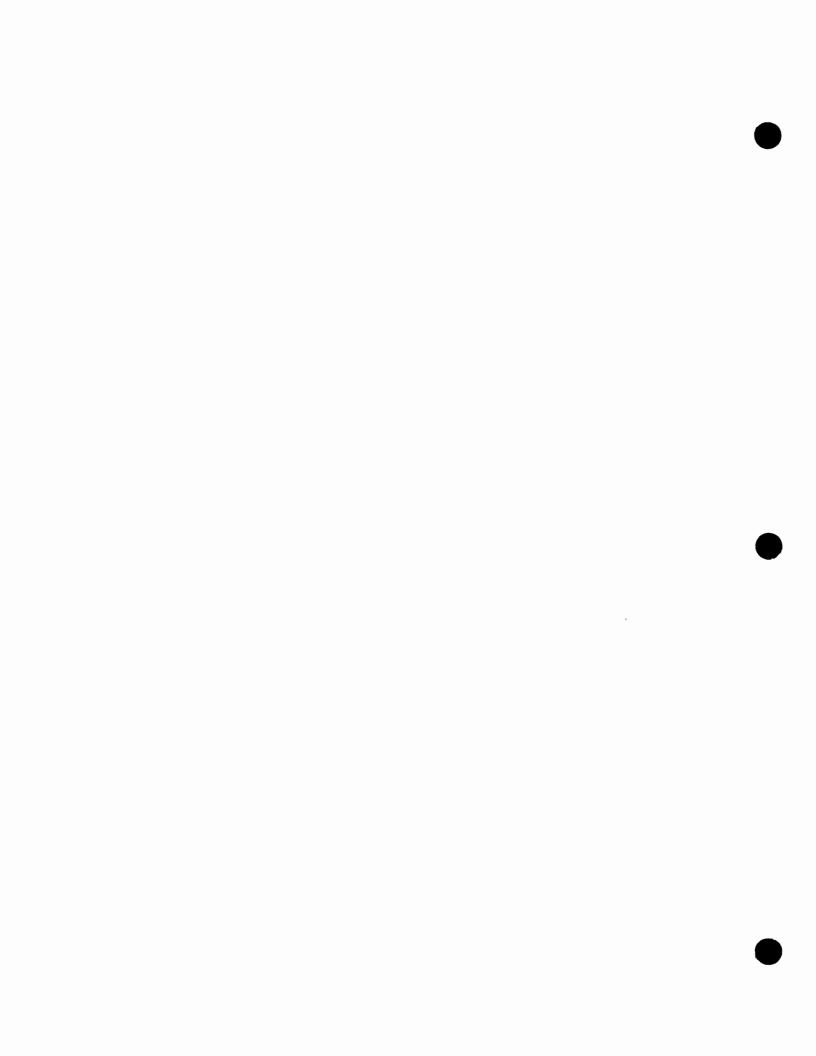
VISITOR REGISTRATION SHEET

House Comm. on Health

04/06/17

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Sarah	20pré
DAVIEL BAUM	TROUTHIAN SAUSES
Bo Heath	McGuire Wood
Christin Weaso	on ACS CAN
Jon Cupp	. 12 2
John Framonte	a or



House Committee on Health Wednesday, April 19, 2017 at 2:00 PM Room 544 of the Legislative Office Building

MINUTES

The House Committee on Health met at 2:00 PM on April 19, 2017 in Room 544 of the Legislative Office Building. Representatives Ball, Boswell, Brisson, Carney, Cunningham, Dobson, Dollar, Dulin, Earle, Farmer-Butterfield, Ford, Hunter, Insko, Jackson, Lambeth, Lucas, Murphy, Rogers, Shepard, Wray, and Yarborough attended.

Representative Josh Dobson, Chair, presided.

The following bills were considered:

HB 10 DHHS Eating Disorder Study. (Representatives McGrady, Lewis, Malone, Goodman)

Representative McGrady presented the bill. Representative Lucas motioned for a favorable report, unfavorable to the original, favorable to the PCS.

HB 248 Sunset CABHAs/OmbudsmanChanges/DHHS Study. (Representatives Dobson, Presnell, White, Carney)

Representatives Dobson, White and Murphy explained the bill. Representative Murphy motioned for a favorable report, unfavorable to the original, favorable to the PCS.

HB 631 Reduce Admin. Duplication MH/DD/SAS Providers. (Representatives Stone, Dobson, Murphy)

Representative Stone explained the bill. Representative Lambeth motioned for Amendment H631-CSTY-8(v.1) to be before the committee. Motioned carried. Representative Farmer-Butterfield motioned for a favorable report, unfavorable to the original bill, as amended and rolled into a new PCS.

HB 690 SUDEP Awareness Week. (Representatives Riddell, Malone, Beasley, Murphy) Representative Ridell explained the bill. Representative Dulin motioned for a favorable report.

HB 741 DHHS Study/Maternal and Neonatal Care. (Representatives Murphy, Boswell, Adcock, Cunningham)

Representative Murphy explained the bill. Representative Carney motioned for a favorable report.

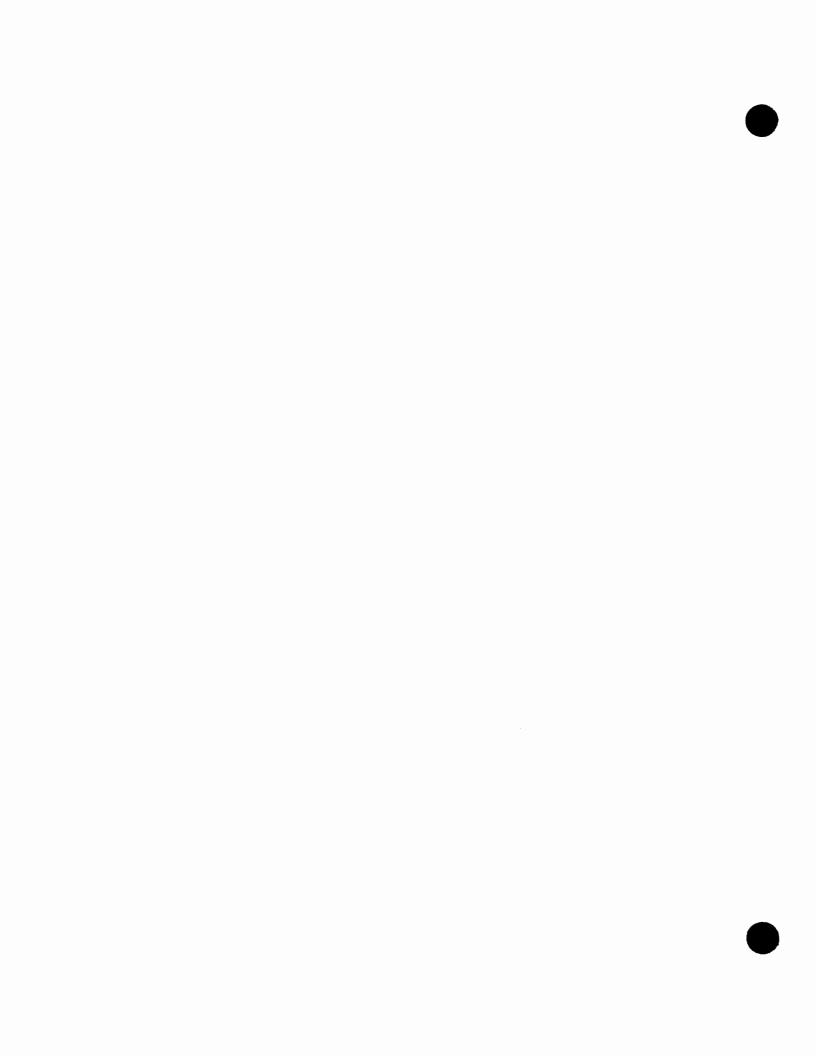
HB 725 Mental Health Support Funding/Study. (Representatives B. Turner, Dobson, Dollar, Cunningham)

Representative Turner explained the bill. Representative Lambeth motioned for a favorable report with a serial referral to Education K-12.



The meeting adjourned at 2:58 pm.

Representative Josh Dobson, Chair Presiding



Corrected #2: Add H 725

NORTH CAROLINA HOUSE OF REPRESENTATIVES COMMITTEE MEETING NOTICE AND BILL SPONSOR NOTIFICATION 2017-2018 SESSION

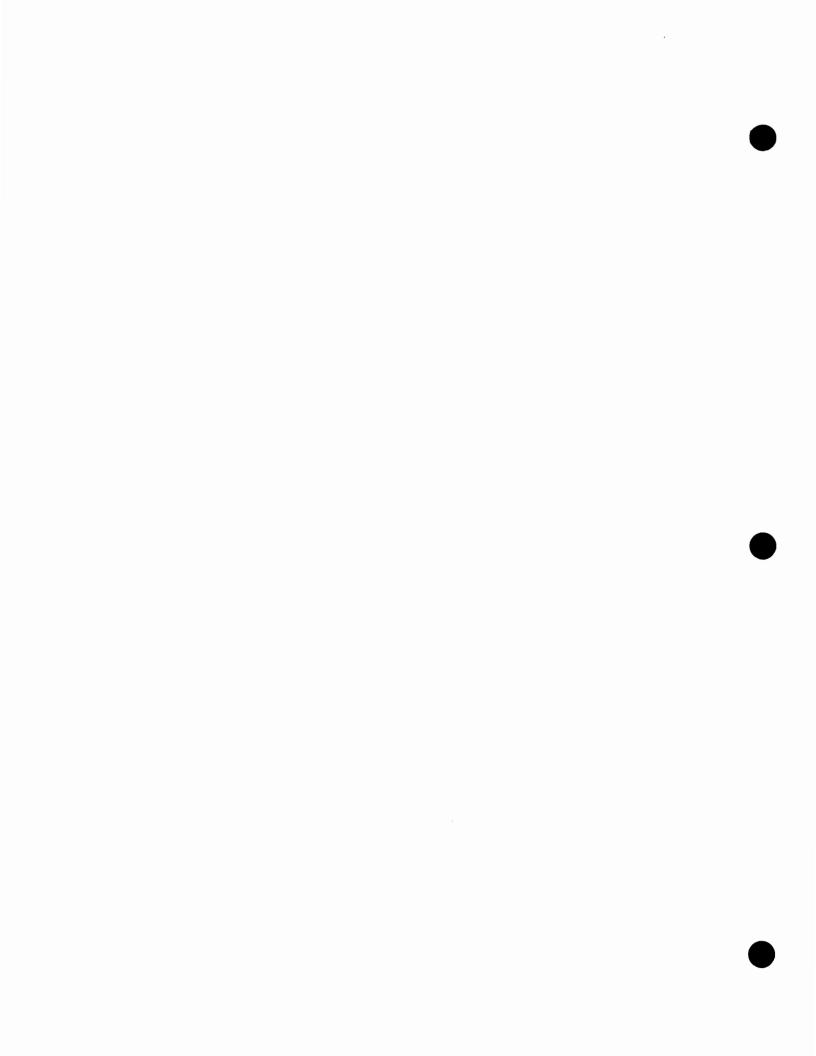
You are hereby notified that the House Committee on Health will meet as follows:

DAY & DATE: Wednesday, April 19, 2017

TIME: 2:00 PM LOCATION: 544 LOB

The following bills will be considered:

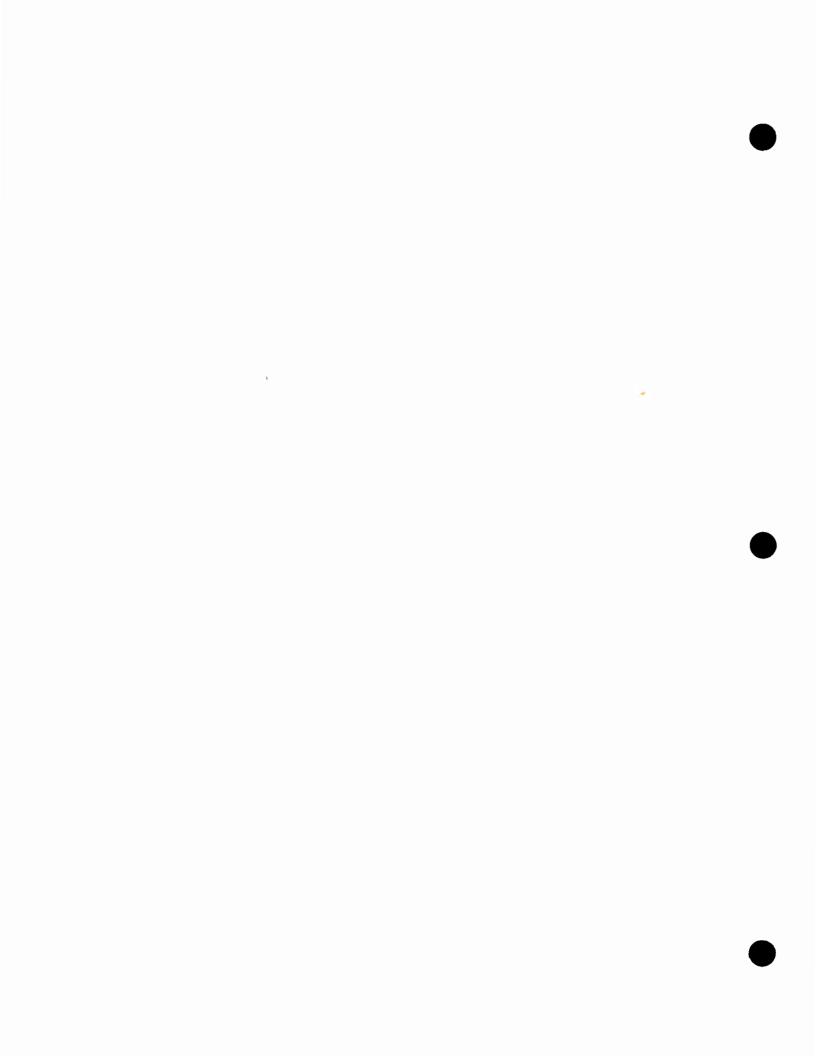
BILL NO.	SHORT TITLE	SPONSOR
<u>HB 10</u>	Eminent Domain Statutory Revisions.	Representative McGrady
		Representative Lewis
		Representative Malone
		Representative Goodman
HB 248	Establish Aging Subcommittee of	Representative Dobson
	JLOC HHS.	Representative Presnell
		Representative White
		Representative Carney
<u>HB 631</u>	Reduce Admin. Duplication/BH	Representative Stone
	Providers.	Representative Dobson
		Representative Murphy
HB 690	SUDEP Awareness Week.	Representative Riddell
		Representative Malone
		Representative Beasley
		Representative Murphy
HB 741	DHHS Study/Maternal and Neonatal	Representative Murphy
	Care.	Representative Boswell
		Representative Adcock
		Representative Cunningham
HB 725	Mental Health Support Funding/Study.	Representative B. Turner
		Representative Dobson
		Representative Dollar
		Representative Cunningham



Respectfully,

Representative Josh Dobson, Co-Chair Representative Nelson Dollar, Co-Chair Representative Bert Jones, Co-Chair Representative Donny Lambeth, Co-Chair Representative Gregory F. Murphy, MD, Co-Chair

I hereby certify this notice was filed by the committee assistant at the following offices at 11:44 AM on Wednesday, April 19, 2017.
Principal Clerk Reading Clerk – House Chamber
Brenda Olls (Committee Assistant)



Corrected #1: Add HB 690 and HB 741

NORTH CAROLINA HOUSE OF REPRESENTATIVES **COMMITTEE MEETING NOTICE** AND **BILL SPONSOR NOTIFICATION** 2017-2018 SESSION

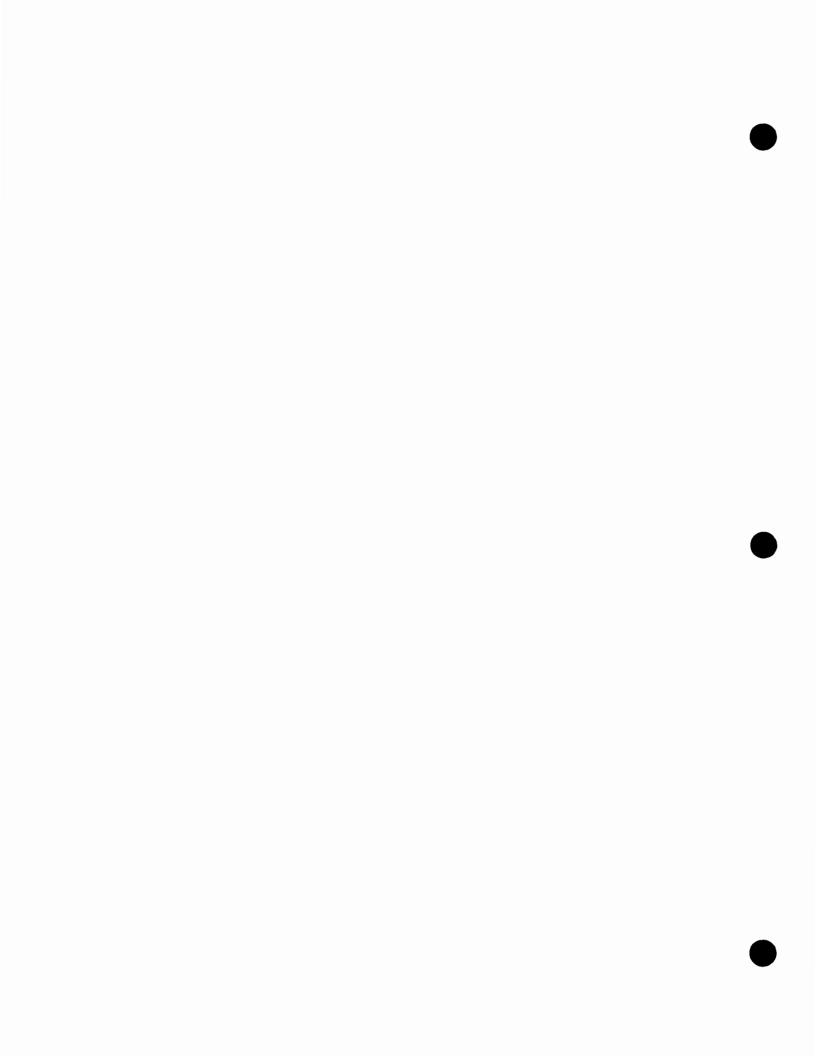
You are hereby notified that the House Committee on Health will meet as follows:

DAY & DATE: Wednesday, April 19, 2017

2:00 PM TIME: **LOCATION: 544 LOB**

The following bills will be considered:

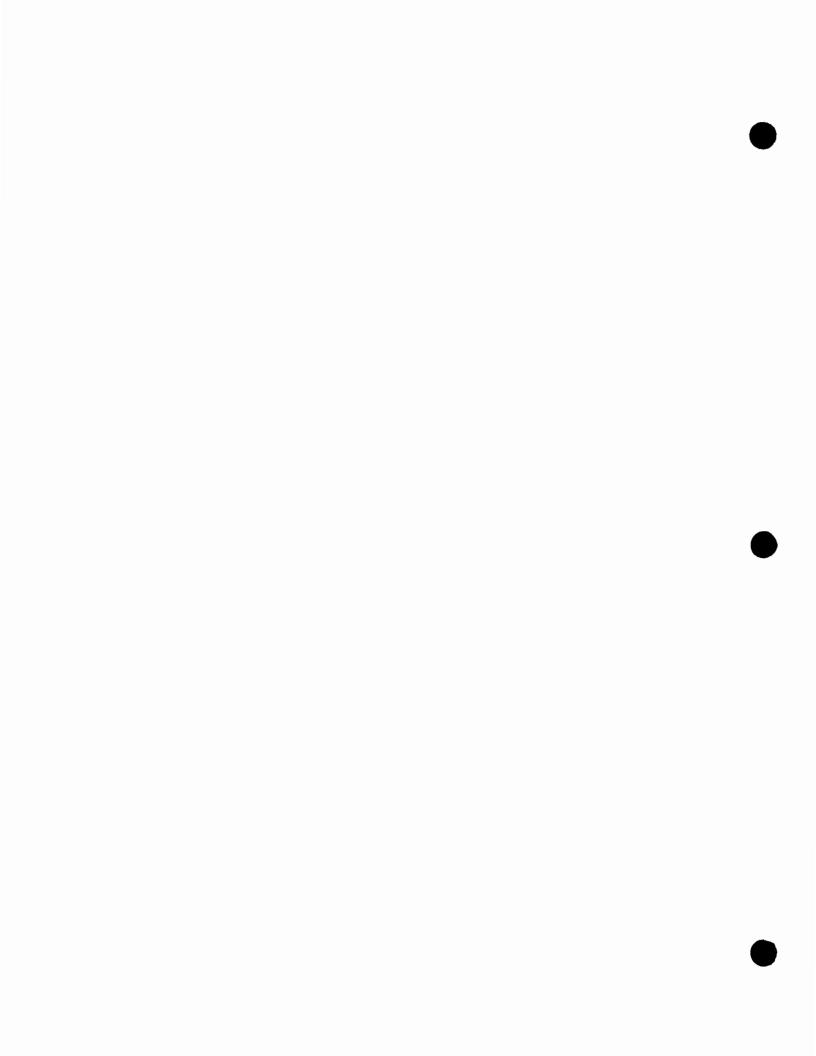
BILL NO.	SHORT TITLE	SPONSOR
<u>HB 10</u>	Eminent Domain Statutory Revisions.	Representative McGrady
		Representative Lewis
		Representative Malone
		Representative Goodman
HB 248	Establish Aging Subcommittee of	Representative Dobson
	JLOC HHS.	Representative Presnell
		Representative White
		Representative Carney
HB 631	Reduce Admin. Duplication/BH	Representative Stone
	Providers.	Representative Dobson
		Representative Murphy
HB 690	SUDEP Awareness Week.	Representative Riddell
		Representative Malone
		Representative Beasley
		Representative Murphy
HB 741	DHHS Study/Maternal and Neonatal	Representative Murphy
	Care.	Representative Boswell
		Representative Adcock
		Representative Cunningham
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Respectfully,

Representative Josh Dobson, Co-Chair Representative Nelson Dollar, Co-Chair Representative Bert Jones, Co-Chair Representative Donny Lambeth, Co-Chair Representative Gregory F. Murphy, MD, Co-Chair

I hereby certify this notice was filed by the committee assistant at the following offices at $6:19PM$ on Tuesday, April 18, 2017 .
Principal Clerk Reading Clerk — House Chamber
Brenda Olls (Committee Assistant)



NORTH CAROLINA HOUSE OF REPRESENTATIVES COMMITTEE MEETING NOTICE AND BILL SPONSOR NOTIFICATION 2017-2018 SESSION

You are hereby notified that the House Committee on Health will meet as follows:

DAY & DATE: Wednesday, April 19, 2017

TIME: 2:00 PM LOCATION: 544 LOB

The following bills will be considered:

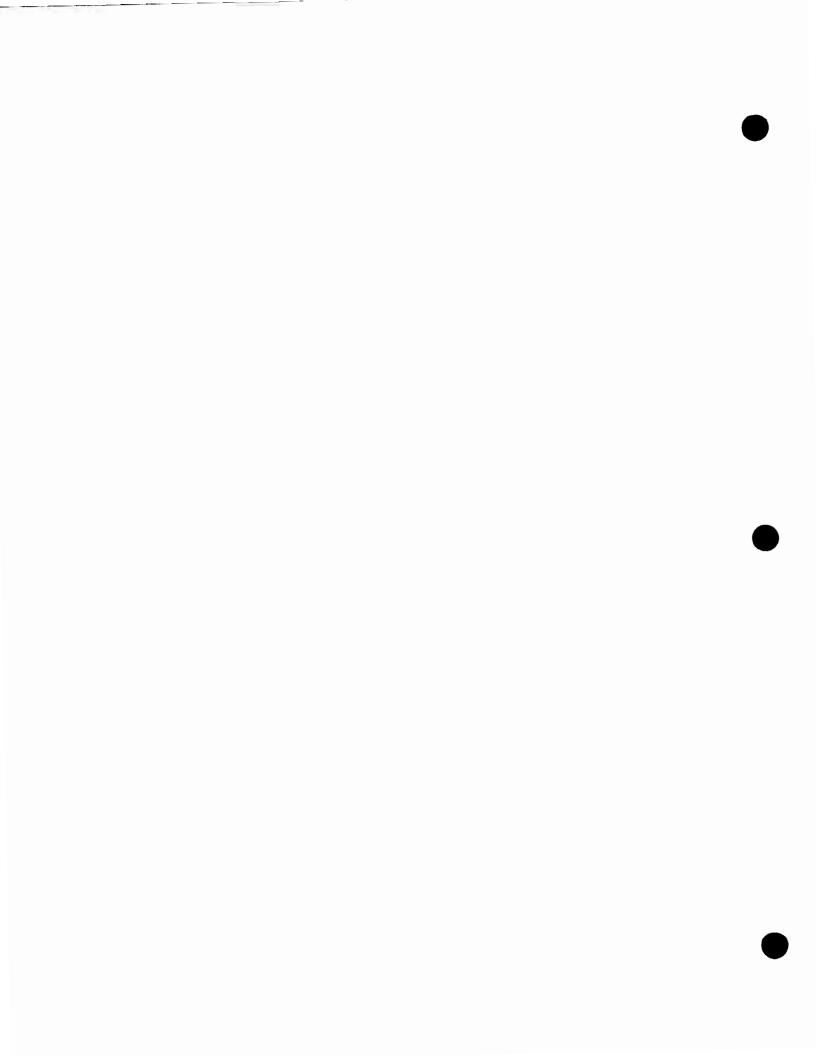
BILL NO.	SHORT TITLE	SPONSOR
<u>HB 10</u>	Eminent Domain Statutory Revisions.	Representative McGrady
		Representative Lewis
		Representative Malone
		Representative Goodman
HB 248	Establish Aging Subcommittee of	Representative Dobson
	JLOC HHS.	Representative Presnell
		Representative White
		Representative Carney
HB 631	Reduce Admin. Duplication/BH	Representative Stone
	Providers.	Representative Dobson
		Representative Murphy

Respectfully,

Representative Justin P. Burr, Co-Chair Representative Josh Dobson, Co-Chair Representative Bert Jones, Co-Chair Representative Donny Lambeth, Co-Chair Representative Gregory F. Murphy, MD, Co-Chair

I hereby certify this notice was filed by the con	nmittee assistant at the following offices at 2:07 PM on
Thursday, April 13, 2017.	
Principal Clerk	
Reading Clerk – House Chan	nber

Brenda Olls (Committee Assistant)



NORTH CAROLINA GENERAL ASSEMBLY HOUSE OF REPRESENTATIVES

HEALTH COMMITTEE REPORT

Representative Josh Dobson, Co-Chair Representative Nelson Dollar, Co-Chair Representative Bert Jones, Co-Chair Representative Donny Lambeth, Co-Chair Representative Gregory F. Murphy, MD, Co-Chair

FAVORABLE

HB **690** SUDEP Awareness Week.

Draft Number: None
Serial Referral: None
Recommended Referral: None
Long Title Amended: No
Floor Manager: Riddell

HB 741 DHHS Study/Maternal and Neonatal Care.

Draft Number: None
Serial Referral: None
Recommended Referral: None
Long Title Amended: No
Floor Manager: Murphy

FAVORABLE AND RE-REFERRED

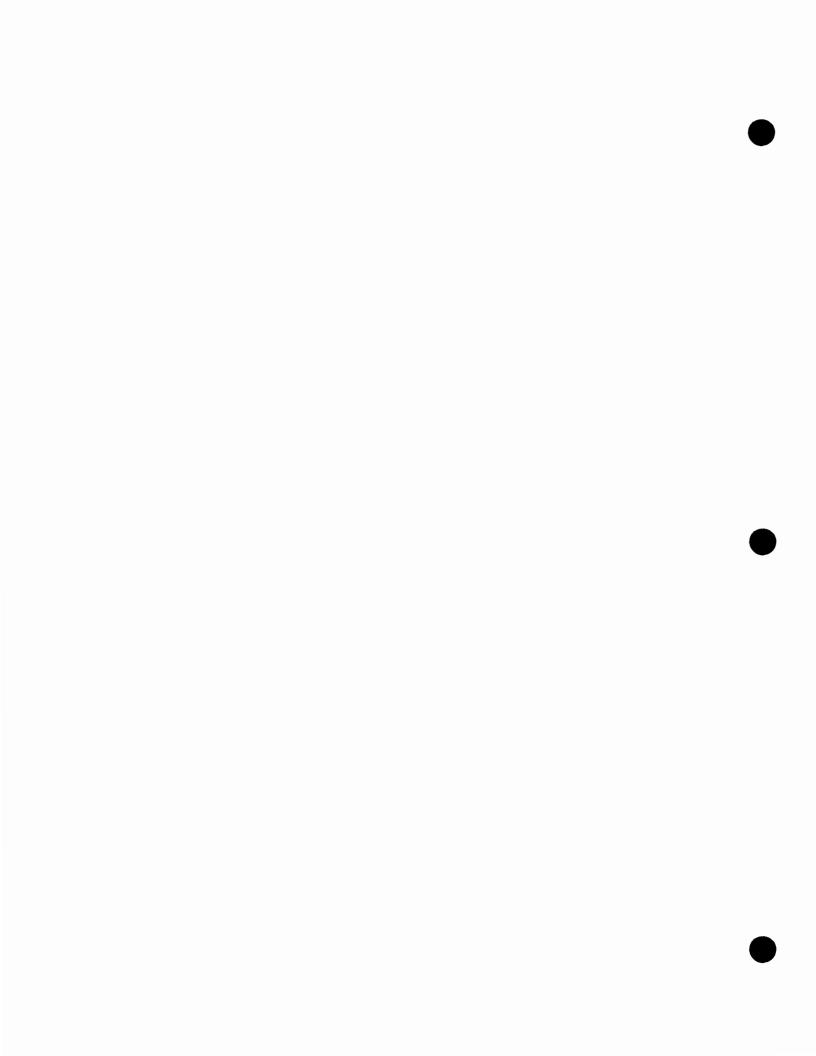
HB 725 Mental Health Support Funding/Study.

Draft Number: None

Serial Referral: EDUCATION - K-12

Recommended Referral: None Long Title Amended: No Floor Manager: B. Turner





NORTH CAROLINA GENERAL ASSEMBLY HOUSE OF REPRESENTATIVES

HEALTH COMMITTEE REPORT

Representative Josh Dobson, Co-Chair Representative Nelson Dollar, Co-Chair Representative Bert Jones, Co-Chair Representative Donny Lambeth, Co-Chair Representative Gregory F. Murphy, MD, Co-Chair

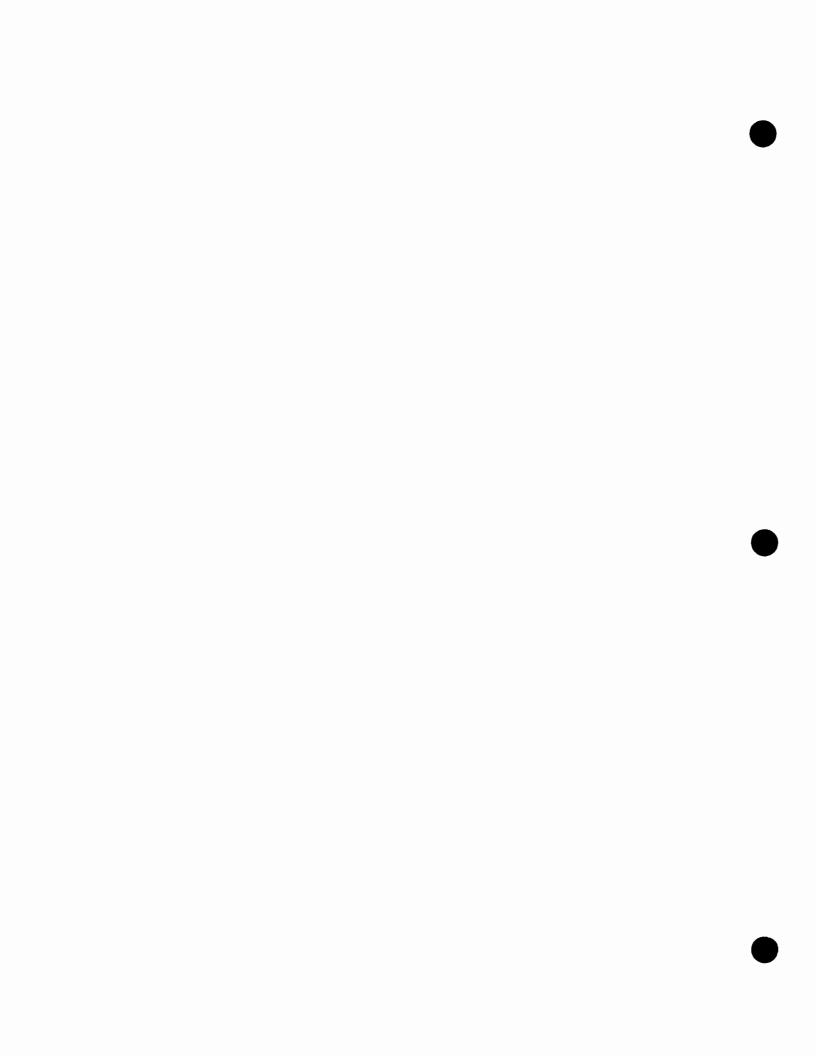
FAVORABLE COM SUB, UNFAVORABLE ORIGINAL BILL

HB 631 Reduce Admin. Duplication/BH Providers.

Draft Number: H631-PCS30355-TY-8

Serial Referral: None Recommended Referral: None Long Title Amended: Yes Floor Manager: Stone





NORTH CAROLINA GENERAL ASSEMBLY HOUSE OF REPRESENTATIVES

HEALTH COMMITTEE REPORT

Representative Josh Dobson, Co-Chair Representative Nelson Dollar, Co-Chair Representative Bert Jones, Co-Chair Representative Donny Lambeth, Co-Chair Representative Gregory F. Murphy, MD, Co-Chair

FAVORABLE COM SUB, UNFAVORABLE ORIGINAL BILL

HB 10 Eminent Domain Statutory Revisions.

Draft Number:

H10-PCS40500-BC-12

Serial Referral:

None

Recommended Referral: None Long Title Amended:

Yes

Floor Manager:

McGrady



NORTH CAROLINA GENERAL ASSEMBLY HOUSE OF REPRESENTATIVES

HEALTH COMMITTEE REPORT

Representative Josh Dobson, Co-Chair Representative Nelson Dollar, Co-Chair Representative Bert Jones, Co-Chair Representative Donny Lambeth, Co-Chair Representative Gregory F. Murphy, MD, Co-Chair

FAVORABLE COM SUB, UNFAVORABLE ORIGINAL BILL

HB 248 Establish Aging Subcommittee of JLOC HHS.

Draft Number:

H248-PCS30357-SH-14

Serial Referral: Recommended Referral: None Long Title Amended: Floor Manager:

Yes Dobson

None





House Committee on Health Wednesday, April 19, 2017, 2:00 PM 544 Legislative Office Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

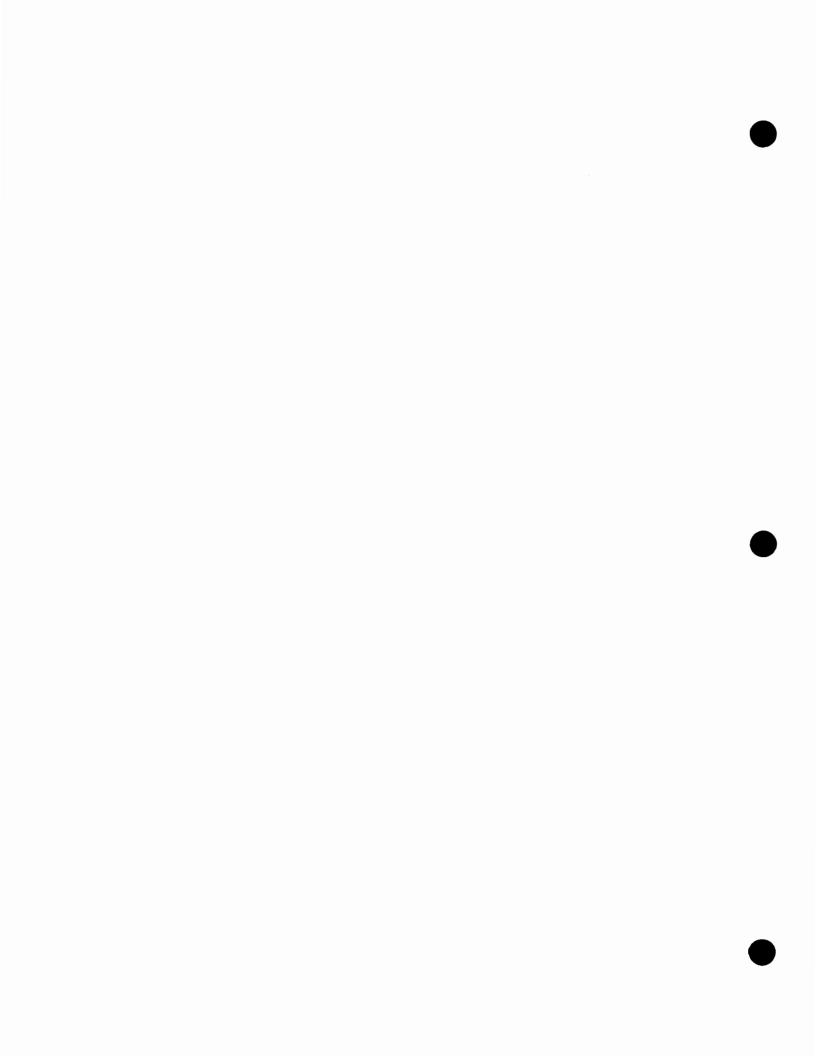
Bills

BILL NO.	SHORT TITLE	SPONSOR
HB 10	Eminent Domain Statutory Revisions.	Representative McGrady
		Representative Lewis
		Representative Malone
		Representative Goodman
HB 248	Establish Aging Subcommittee of	Representative Dobson
	JLOC HHS.	Representative Presnell
		Representative White
		Representative Carney
HB 631	Reduce Admin. Duplication/BH	Representative Stone
	Providers.	Representative Dobson
		Representative Murphy
HB 690	SUDEP Awareness Week.	Representative Riddell
		Representative Malone
		Representative Beasley
		Representative Murphy
HB 741	DHHS Study/Maternal and Neonatal	Representative Murphy
	Care.	Representative Boswell
		Representative Adcock
		Representative Cunningham
HB 725	Mental Health Support Funding/Study.	Representative B. Turner
		Representative Dobson
		Representative Dollar
		Representative Cunningham

Presentations

Other Business

Adjournment





HOUSE BILL 10: DHHS Eating Disorder Study.

2017-2018 General Assembly

Committee: House Health

Introduced by: Reps. McGrady, Lewis, Malone, Goodman Prepared by: Jason Moran-Bates

Analysis of: PCS to First Edition

PCS to First Edition Committee Co-Counsel

Date:

April 12, 2017

H10-CSBC-12

OVERVIEW: The Proposed Committee Substitute to House Bill 10 would require the Department of Health and Human Services, Division of Public health to study eating disorders in North Carolina and issue a report on its findings to the Joint Legislative Oversight Committee on Health and Human Services by November 1, 2017.

BILL ANALYSIS:

Section 1 of the bill would direct the Department of Health and Human Services, Division of Public Health to study eating disorders in North Carolina. The study must do the following:

- Identify the number of diagnosed incidences of eating disorders in North Carolina.
- Provide an estimate of the number of individuals who have an eating disorder but have not been diagnosed.
- Identify the number of individuals being treated for an eating disorder.
- Identify ways the state can increase awareness of eating disorders.
- Examine the adequacy of training provided to public school educators in identifying the symptoms of eating disorders and in providing support to those affected by eating disorders.
- Make recommendations for improving education, prevention, early detection, and treatment of eating disorders.
- Identify the availability of treatment consistent with the current best practices described by the American Psychiatric Association.
- Consider any other issue the Division deems relevant.

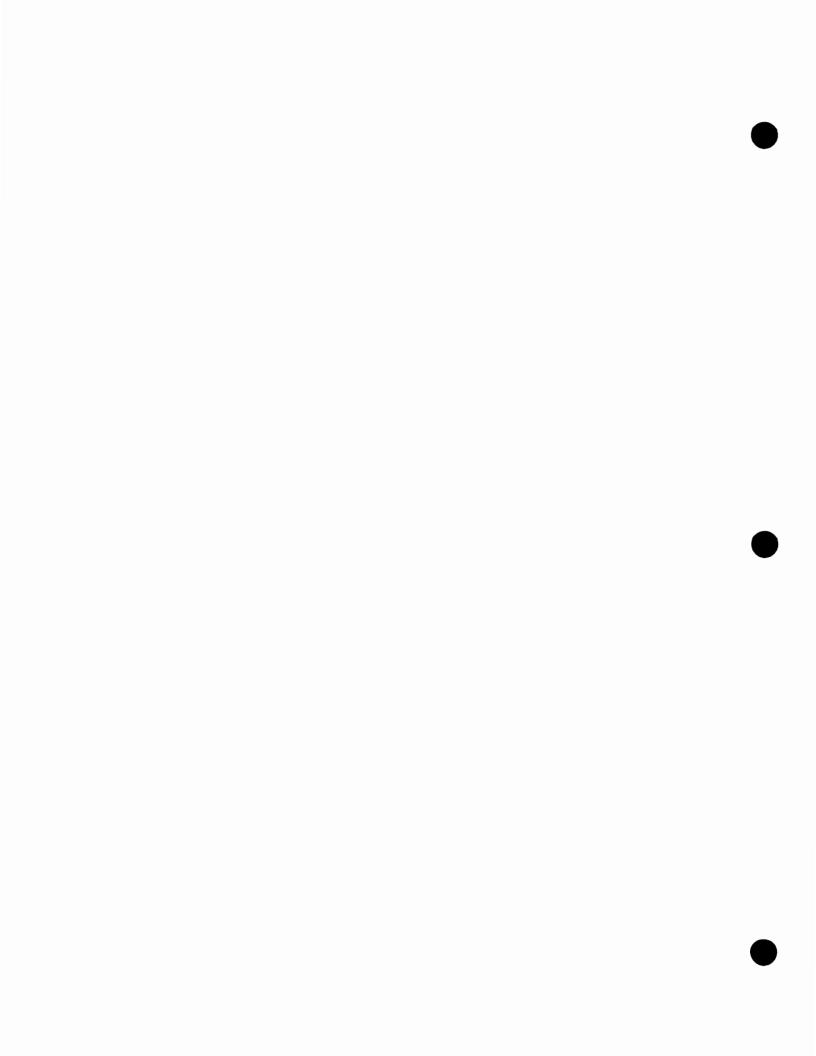
Section 2 of the bill would require the Division to submit a report containing its findings and recommendations to the Joint Legislative Oversight Committee on Health and Human Services on or before November 1, 2017. Based on the Division's report, the Committee must consider making a recommendation to the 2018 General Assembly.

EFFECTIVE DATE: This bill would be effective when it becomes law.





Legislative Analysis Division 919-733-2578



GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2017

H D

HOUSE BILL 10 PROPOSED COMMITTEE SUBSTITUTE H10-CSBC-12 [v.5] 04/18/2017 05:26:39 PM

Short Title: DHHS Eating Disorder Study. (Public)

Sponsors:

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Referred to:

January 26, 2017

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF PUBLIC HEALTH TO STUDY AND REPORT ON EATING DISORDERS IN NORTH CAROLINA.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services, Division of Public Health is directed to study eating disorders in the State of North Carolina. At a minimum, the Division shall:

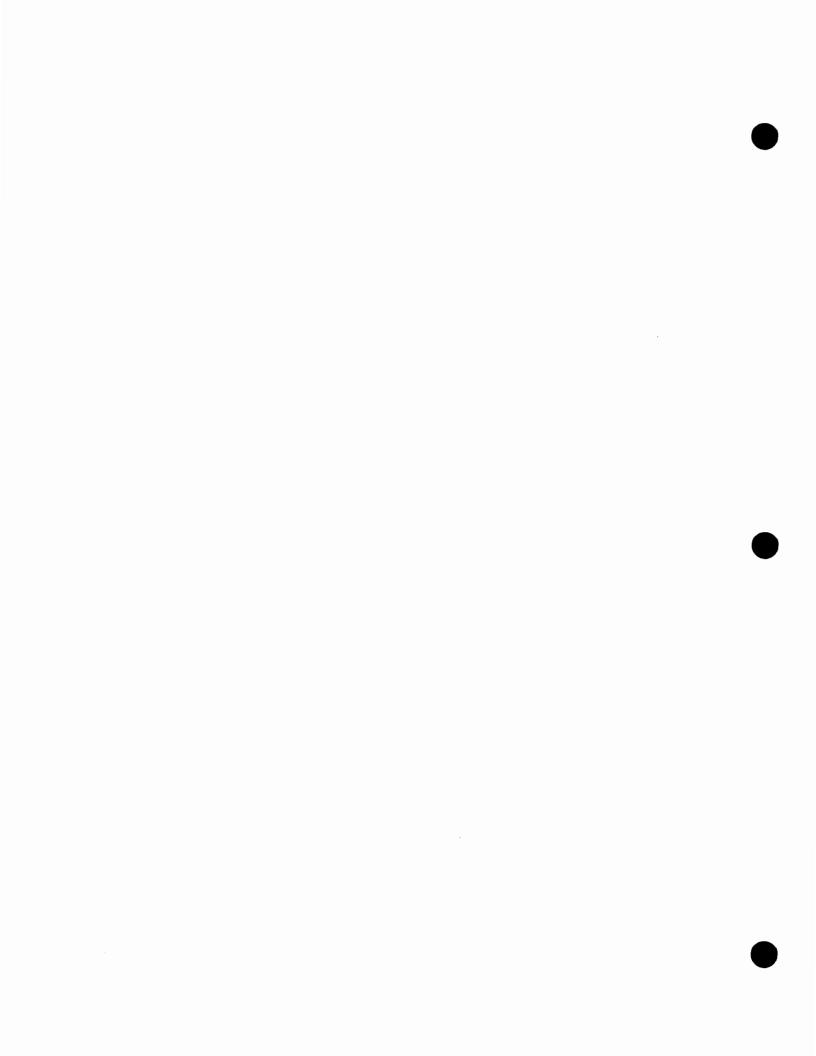
- (1) Identify the number of diagnosed incidences of eating disorders in North Carolina.
- (2) Provide an estimate of the number of individuals in North Carolina who are suffering from an eating disorder but who have not been formally diagnosed.
- (3) Identify the number of individuals who are being treated for an eating disorder.
- (4) Identify strategies by which the State can increase awareness of, and disseminate information about, eating disorders, including their symptoms, effects, and preventative interventions.
- (5) Examine the adequacy of training provided to public school officials in identifying the symptoms of eating disorders and in providing support to the individuals and families affected by eating disorders
- (6) Make recommendations for improving education, prevention, early detection, and treatment of eating disorders.
- (7) Identify the availability of treatment consistent with the best practices described by the American Psychiatric Association and other published materials to individuals and families affected by eating disorders.
- (8) Consider any other issues the Division identifies that are related to the objectives of this study.

The Division shall solicit input from relevant organizations and entities, including the UNC Center for Excellence for Eating Disorders at the University of North Carolina at Chapel Hill, the North Carolina Chapter of the American Academy of Pediatrics, the North Carolina Academy of Family Physicians, and national organizations specializing in eating disorders.

SECTION 2. On or before November 1, 2017, the Division shall submit a report containing findings and recommendations to the Joint Legislative Oversight Committee on Health and Human Services. Based on the Division's report, the Committee shall consider making a recommendation to the 2018 General Assembly.

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





GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2017

H

HOUSE BILL 10

Short Title: Eminent Domain Statutory Revisions. (Public)

Sponsors: Representatives McGrady, Lewis, Malone, and Goodman (Primary Sponsors).

Referred to: Energy and Public Utilities, if favorable, Judiciary I

January 26, 2017

A BILL TO BE ENTITLED

AN ACT TO PROVIDE THAT CONDEMNATION OF PRIVATE PROPERTY SHALL ONLY BE FOR A PUBLIC USE AND TO EXPAND THE PURPOSES FOR WHICH CONDEMNORS MAY EXERCISE THEIR CONDEMNATION POWERS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 40A-3(a) reads as rewritten:

- "(a) Private Condemnors. For the public use or benefit, use, the persons or organizations listed below shall have the power of eminent domain and may acquire by purchase or condemnation property for the stated purposes and other works which are authorized by law.law:
 - (1) Corporations, bodies politic or persons have the power of eminent domain for the construction of railroads, power generating facilities, substations, switching stations, microwave towers, roads, alleys, access railroads, turnpikes, street railroads, plank roads, tramroads, canals, telegraphs, telephones, communication facilities, electric power lines, electric lights, public water supplies, public sewerage systems, flumes, bridges, facilities related to the distribution of natural gas, and pipelines or mains originating in North Carolina for the transportation of petroleum products, coal, natural gas, limestone or minerals. Land condemned for any liquid pipelines shall:shall meet both of the following requirements:
 - a. Not be less than 50 feet nor more than 100 feet in width; and width.
 - b. Comply with the provisions of G.S. 62-190(b).

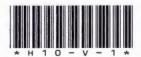
The width of land condemned for any natural gas pipelines shall not be more than 100 feet.

SECTION 2. G.S. 40A-3(b) reads as rewritten:

"(b) Local Public Condemnors – Standard Provision. – For the public use or benefit, use, the governing body of each municipality or county shall possess the power of eminent domain and may acquire by purchase, gift or condemnation any property, either inside or outside its boundaries, for the following purposes:

SECTION 3. G.S. 40A-3(b1) reads as rewritten:

"(b1) Local Public Condemnors – Modified Provision for Certain Localities. – For the public use or benefit, use, the governing body of each municipality or county shall possess the power of eminent domain and may acquire by purchase, gift or condemnation any property or interest therein, either inside or outside its boundaries, for the following purposes:



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SECTION 4. G.S. 40A-3(c) reads as rewritten:

"(c) Other Public Condemnors. – For the public use or benefit, use, the following political entities shall possess the power of eminent domain and may acquire property by purchase, gift, or condemnation for the stated purposes:
...."

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SECTION 5. G.S. 40A-3 is amended by adding a new subsection to read:

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"(d) Connection of Customers. – For the public use, private condemnors, local public condemnors, and other public condemnors in subsections (a), (b), (b1), and (c) of this section shall possess the power of eminent domain and may acquire by purchase, gift, or condemnation any property for the connection of any customer or customers."

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SECTION 6. This act is effective when it becomes law and applies to takings occurring on or after that date.



HOUSE BILL 248: Support for Older Adults & DHHS Study.

2017-2018 General Assembly

Committee: House Health

Introduced by: Reps. Dobson, Presnell, White, Carney

Analysis of: PCS to First Edition H248-CSSH-14

Date: April 17, 2017

Prepared by: Theresa Matula

Committee Staff

OVERVIEW: The Proposed Committee Substitute (PCS) for HB 248 does the following three things:

1) encourages the cochairs of the Joint Legislative Oversight Committee on Health and Human Services (Oversight Committee) to consider appointing a Subcommittee on Aging to ensure that the State is meeting the current and anticipated needs of older adults; 2) makes changes to the adult care home and nursing home community advisory committees and the duties of the Office of the State Long-Term Care ombudsman Program that conform to federal changes; and 3) requires the Department of Health and Human Services to study Public Law 113-51, HIV Organ Policy Equity (HOPE) Act and the Final Safeguards and Research Criteria publication by the US Department of Health and Human Services and the National Institutes of Health to determine any necessary public health safeguards, regulations, and statutory changes and to submit findings and recommendations to the Oversight Committee on or before January 1, 2018. The bill would become effective when it becomes law.

BILL ANALYSIS:

Section 1: Subcommittee on Aging — Under current law, ¹ the cochairs of the Joint Legislative Oversight Committee on Health and Human Services (Oversight Committee) have authority to establish subcommittees for the purpose of examining issues relating to services provided by particular Divisions within the Department of Health and Human Services (DHHS). Currently North Carolina has a significant older adult population and the percentage of older adults is anticipated to increase in the coming years. Section 1(a) of the PCS for HB 248 encourages the cochairs of the Oversight Committee to consider appointing a Subcommittee on Aging to determine the service needs of older adults and to make recommendations on how to address those needs. While conducting the study, the Subcommittee is urged to seek input from a variety of stakeholders and interest groups, specifically including: the Divisions of Aging and Adult Services and Social Services, DHHS; the NC Coalition on Aging; the Senior Tarheel Legislature; and the Governor's Advisory Council on Aging. Section 1(b) provides that if the Subcommittee is appointed, it shall submit to the Oversight Committee an interim report on or before March 1, 2018, and a final report on or before November 1, 2018.

Section 2: Office of State Long-Term Care Ombudsman Changes – The federal Older Americans Act authorized Long-Term Care Ombudsman Programs. North Carolina's Long-Term Care Ombudsman Program consists of an Office of the State Long-Term Care Ombudsman and Offices of the Regional Long-Term Care Ombudsman housed in Area Agencies on Aging. Ombudsmen assist

1 G.S. 120-208.2(d)

Karen Cochrane-Brown Director



Legislative Analysis Division 919-733-2578

House PCS 248

Page 2

residents of long term care facilities in exercising their rights and attempt to resolve grievances between residents, families and facilities, in addition to other services for older adults and their families. S.L. 2015-220, Section 2, made changes to the Long-Term Care Ombudsman Program to conform to federal changes. Section 2 of the PCS for HB 248 makes additional amendments to conform to the federal changes. Section 2(a) of the PCS amends the adult care home community advisory committee to provide that the committee members function as representatives of, and are accountable to, the Office of the State Long-Term Care Ombudsman. Section 2(b) amends the nursing home advisory committees in a similar manner. Both Section 2(a) and (b) provide that the training, certification, and designation is in accordance with 45 C.F.R. 1324.13(c)(2). Consistent with 45 C.F.R. 1324.11(e) and other similar provisions, Section 2(c) amends the duties of the Office of the State Long-Term Care Ombudsman Program to add the responsibility to designate, suspend, and remove the designation of volunteer representatives of the Office of the State Long-Term Care Ombudsman, including any community advisory committee appointees.

Section 3: DHHS Study HOPE Act Safeguard and Research Criteria — Section 3 of the PCS requires DHHS to examine P.L. 113-51 HIV Organ Policy Equity (HOPE) Act, and the Final Safeguards and Research Criteria for transplantation of HIV-positive donor organs in HIV-positive recipients, published by the US Department of Health and Human Services and National Institutes of Health. The DHHS is required to determine public health safeguards, regulations and statutory changes necessary for consideration by the General Assembly. On or before January 1, 2018, the DHHS is required to submit a report of findings and recommendations. including any necessary statutory changes to the Oversight Committee.

EFFECTIVE DATE: The bill would become effective when it becomes law.

² 2015 NC State Long-Term Care Ombudsman Program 2015 Report

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HOUSE BILL 248 PROPOSED COMMITTEE SUBSTITUTE H248-CSSH-14 [v.4]

04/17/2017 05:11:39 PM

Short Title:	Support for Older Adults & DHHS S	Study.
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(Public)

Sponsors:

Referred to:

March 6, 2017

A BILL TO BE ENTITLED

AN ACT TO RECOMMEND THAT THE COCHAIRS FOR THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON HEALTH AND HUMAN SERVICES CONSIDER A SUBCOMMITTEE ON AGING; TO MAKE CHANGES TO THE ADULT CARE HOME AND NURSING HOME ADVISORY COMMITTEES TO CONFORM TO THE ADMINISTRATION FOR COMMUNITY LIVING RULES AND RECENT CHANGES TO THE STATE LONG-TERM CARE OMBUDSMAN PROGRAM; AND TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES STUDY THE HOPE ACT AND RELATED **FEDERAL** REGULATIONS AND TO MAKE RECOMMENDATIONS TO THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON HEALTH AND HUMAN SERVICES.

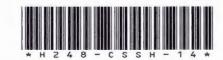
The General Assembly of North Carolina enacts:

SECTION 1.(a) Pursuant to the authority in G.S. 120-208.2(d), the cochairs for the Joint Legislative Oversight Committee on Health and Human Services may consider appointing a Subcommittee on Aging 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. North Carolina currently ranks ninth in the nation for the size of the age 60 and older population and tenth in the nation for the age 85 and older population. From 2015 to 2035, the age 65 and older population is projected to increase 67% and the age 85 and older population is projected to increase 102%. By 2019, North Carolina will have more people that are 60 years of age and older than children age 0-17. It is recommended that the Subcommittee examine the range of programs and services for older adults throughout the continuum of care. The Subcommittee is encouraged 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 Tarheel Legislature, and the Governor's Advisory Council on Aging.

SECTION 1.(b) If a Subcommittee on Aging is appointed, the Subcommittee shall 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 shall 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).

SECTION 2. (a) G.S. 131D-31 reads as written:

"§ 131D-31. Adult care home community advisory committees.



D

- (a) Statement of Purpose. It is the intention of the General Assembly that community advisory committees committee members function as representatives of the Office of the State Long-Term Care Ombudsman and through their designation work to maintain the intent of the Adult Care Home Residents' Bill of Rights within the licensed adult care homes in this State. It is the further intent of the General Assembly that the committees promote community involvement and cooperation with adult care homes to ensure quality care for the elderly and disabled adults.
 - (b) Establishment and Appointment of Committees.
 - (1) A community advisory committee shall be established in each county that has at least one licensed adult care home, shall serve all the homes in the county, and shall work with each of these homes for the best interests of the residents. In a county that has one, two, or three adult care homes with 10 or more beds, the committee shall have five members.
 - (2) In a county with four or more adult care homes with 10 or more beds, the committee shall have one additional member for each adult care home with 10 or more beds in excess of three, and may have up to five additional members at the discretion of the county commissioners, not to exceed a maximum of 25 members. In each county with four or more adult care homes with 10 or more beds, the committee shall establish a subcommittee of no more than five members and no fewer than three members from the committee for each adult care home in the county. Each member must serve on at least one subcommittee.
 - (3) In counties with no adult care homes with 10 or more beds, the committee shall have five members. Regardless of how many members a particular community advisory committee is required to have, at least one member of each committee shall be a person involved in the area of mental retardation.
 - The boards of county commissioners are encouraged to appoint the Adult (4) Care Home Community Advisory Committees. Of the members, a minority (not less than one-third, but as close to one-third as possible) shall be chosen from among persons nominated by a majority of the chief administrators of adult care homes in the county. If the adult care home administrators fail to make a nomination within 45 days after written notification has been sent to them requesting a nomination, these appointments may be made without nominations. If the county commissioners fail to appoint members to a committee by July 1, 1983, the appointments shall be made by the Assistant Secretary for Aging, Department of Health and Human Services, Office of the State Long-Term Care Ombudsman, no sooner than 45 days after nominations have been requested from the adult care home-administrators, but no later than October 1, 1983, administrators. In making appointments, the Assistant Secretary for Aging Office of the State Long-Term Care Ombudsman shall follow the same appointment process as that specified for the County Commissioners.
 - Notwithstanding any other provision of this Article, appointment to an Adult Care Home Community Advisory Committee is contingent upon designation of the appointee by the Office of the State Long-Term Care Ombudsman in accordance with G.S. 143B-181.18. A designated appointee is directly accountable to the State Long-Term Care Ombudsman Program in order to perform the duties as a representative of the Office of the State Long-Term Care Ombudsman. Removal of the appointee's designation by the Office of the State Long-Term Care Ombudsman automatically rescinds the appointment to the Adult Care Home Community Advisory Committee.

- Any individual who serves as a community advisory committee member must go through the Office of the State Long-Term Care Ombudsman's certification and designation process and meet the certification and designation requirements in accordance with the State Long-Term Care Ombudsman Program Policies and Procedures.
- Joint Nursing and Adult Care Home Community Advisory Committees. -Appointment to the Nursing Home Community Advisory Committees shall preclude appointment to the Adult Care Home Community Advisory Committees except where written approval to combine these committees is obtained from the Assistant Secretary for Aging, Department of Health and Human Services. Office of the State Long-Term Care Ombudsman. Where this approval is obtained, the Joint Nursing and Adult Care Home Community Advisory Committee shall have the membership required of Nursing Home Community Advisory Committees and one additional member for each adult care home with 10 or more beds licensed in the county. In counties with no adult care homes with 10 or more beds, there shall be one additional member for every four other types of adult care homes in the county. In no case shall the number of members on the Joint Nursing and Adult Care Home Community Advisory Committee exceed 25. Each member shall exercise the statutory rights and responsibilities of both Nursing Home Committees and Adult Care Home Committees. In making appointments to this joint committee, the county commissioners shall solicit nominations from both nursing and adult care home administrators for the appointment of approximately (but no more than) one-third of the members.
- (d) Terms of Office. Each committee member shall serve an initial term of one year. Any person reappointed to a second or subsequent term in the same county shall serve a two-or three-year term at the county commissioners' discretion to ensure staggered terms of office.
- (e) Vacancies. Any vacancy shall be filled by appointment of a person for a one-year term. If this vacancy is in a position filled by an appointee nominated by the chief administrators of adult care homes within the county, then the county commissioners shall fill the vacancy from persons nominated by a majority of the chief administrators. If the adult care home administrators fail to make a nomination by registered mail within 45 days after written notification has been sent to them requesting a nomination, this appointment may be made without nominations. If the county commissioners fail to fill a vacancy, the vacancy shall may be filled by the Office of the State Long-Term Care Ombudsman Assistant Secretary for Aging, Department of Health and Human Services no sooner than 45 days after the commissioners have been notified of the appointment or vacancy.
- (f) Officers. The committee shall elect from its members a chair, to serve a one-year term.
- (g) Minimum Qualifications for Appointment. Each member must be a resident of the county which the committee serves. No person or immediate family member of a person with a financial interest in a home served by the committee, or employee or governing board member of a home served by the committee, or immediate family member of a resident in a home served by the committee may be a member of that committee. Any county commissioner who is appointed to the committee shall be deemed to be serving on the committee in an ex officio capacity. Members of the committee shall serve without compensation, but may be reimbursed for actual expenses incurred by them in the performance of their duties. The names of the committee members and the date of expiration of their terms shall be filed with the Office of the State Long-Term Care Ombudsman. Division of Aging, Department of Health and Human Services.
- (h) <u>Training</u>, <u>Certification and Designation</u>. <u>Training</u>. The <u>Office of the State Long-Term Care Ombudsman</u> <u>Division of Aging</u>, <u>Department of Health and Human Services</u>, shall develop <u>training materials</u>, <u>which shall be distributed to each committee member:training requirements for certification and designation in accordance with 45 C.F.R. 1324.13(c)(2).</u>

Each committee member must receive <u>certification</u> training as specified by the <u>State Long-Term Care Ombudsman Program Policies and Procedures and be designated as representatives of the State Long-Term Care Ombudsman Program <u>Division of Aging prior</u> to exercising any power under G.S. 131D-32. The <u>State Long-Term Care Ombudsman Program Division of Aging, Department of Health and Human Services, shall provide the committees with information, guidelines, training, and consultation to direct them in the performance of their duties.</u></u>

(i) Any written communication made by a member of adult care home advisory committee within the course and scope of the member's duties, as specified in G.S. 131D-32, shall be privileged to the extent provided in this subsection. All communication shall be considered the property of the Office of the State Long-Term Care Ombudsman and subject to the Office's disclosure policies. This privilege shall be a defense in a cause of action for libel if the member was acting in good faith and the statements and communications do not amount to intentional wrongdoing.

To the extent that any adult care home advisory committee or any member is covered by liability insurance, that committee or member shall be deemed to have waived the qualified immunity herein to the extent of indemnification by insurance."

SECTION 2. (b) G.S. 131E-128 reads as rewritten:

""§ 131E-128. Nursing home advisory committees.

- (a) It is the purpose of the General Assembly that community advisory eommittees committee members function as representatives of the Office of the State Long-Term Care Ombudsman and through their designation, work to maintain the intent of the Nursing Home Resident's Bill of Rights this Part within the nursing homes in this State, including nursing homes operated by hospitals licensed under Article 5 of G.S. Chapter 131E. It is the further purpose of the General Assembly that the committees promote community involvement and cooperation with nursing homes and an integration of these homes into a system of care for the elderly.
 - (b) (1) A community advisory committee shall be established in each county which has a nursing home, including a nursing home operated by a hospital licensed under Article 5 of G.S. Chapter 131E, shall serve all the homes in the county, and shall work with each home in the best interest of the persons residing in each home. In a county which has one, two, or three nursing homes, the committee shall have five members. In a county with four or more nursing homes, the committee shall have one additional member for each nursing home in excess of three, and may have up to five additional members per committee at the discretion of the county commissioners.
 - (2) In each county with four or more nursing homes, the committee shall establish a subcommittee of no more than five members and no fewer than three members from the committee for each nursing home in the county. Each member must serve on at least one subcommittee.
 - Boards of county commissioners are encouraged to appoint the Nursing Home Community Advisory Committees. Each committee shall be appointed by the board of county commissioners. Of the members, a minority (not less than one-third, but as close to one-third as possible) must be chosen from among persons nominated by a majority of the chief administrators of nursing homes in the county and of the governing bodies of the hospitals licensed under Article 5 of G.S. Chapter 131E, which operate nursing homes. If the nursing home administrators and the governing bodies of the hospitals licensed under Article 5 of G.S. Chapter 131E, which operate nursing homes fail to make a nomination within 45 days after written notification has been sent to them by the board of county commissioners

- requesting a nomination, these appointments may be made by the board of county commissioners without nominations.
- (4) Notwithstanding any other provision of this Article, appointment to a nursing home community advisory committee is contingent upon designation of the appointee by the Office of the State Long-Term Care Ombudsman in accordance with G.S. 143B-181.18. A designated appointee is directly accountable to the State Long-Term Care Ombudsman Program in order to perform the duties as a representative of the Office of the State Long-Term Care Ombudsman. Removal of the appointee's designation by the Office of the State Long-Term Care Ombudsman automatically rescinds the appointment to the nursing home community advisory committee.
- Any individual who serves as a community advisory committee member must go through the Office of the State Long-Term Care Ombudsman's certification and designation process and meet the certification and designation requirements in accordance with the State Long-Term Care Ombudsman Program Policies and Procedures.
- (c) Each committee member shall serve an initial term of one year. Any person reappointed to a second or subsequent term in the same county shall serve a three-year term. Persons who were originally nominees of nursing home chief administrators and the governing bodies of the hospitals licensed under Article 5 of G.S. Chapter 131E, which operate nursing homes, or who were appointed by the board of county commissioners when the nursing home administrators and the governing bodies of the hospitals licensed under Article 5 of G.S. Chapter 131E, which operate nursing homes failed to make nominations, may not be reappointed without the consent of a majority of the nursing home chief administrators and the governing bodies of the hospitals licensed under Article 5 of G.S. Chapter 131E, which operate nursing homes within the county. If the nursing home chief administrators and the governing bodies of the hospitals licensed under Article 5 of G.S. Chapter 131E, which operate nursing homes fail to approve or reject the reappointment within 45 days of being requested by the board of county commissioners, the commissioners may reappoint the member if they so choose.
- Any vacancy shall be filled by appointment of a person for a one-year term. Any person replacing a member nominated by the chief administrators and the governing bodies of the hospitals licensed under Article 5 of G.S. Chapter 131E, which operate nursing homes or a person appointed when the chief administrators and the governing bodies of the hospitals licensed under Article 5 of G.S. Chapter 131E, which operate nursing homes failed to make a nomination shall be selected from among persons nominated by the administrators and the governing bodies of the hospitals licensed under Article 5 of G.S. Chapter 131E, which operate nursing homes, as provided in subsection (b). If the county commissioners fail to appoint members to a committee, or fail to fill a vacancy, the appointment shall may be made or vacancy filled by the Office of the State Long-Term Care Ombudsman Secretary or the Secretary's designee-no sooner than 45 days after the commissioners have been notified of the appointment or vacancy if nomination or approval of the nursing home administrators and the governing bodies of the hospitals licensed under Article 5 of G.S. Chapter 131E, which operate nursing homes is not required. If nominations or approval of the nursing home administrators and the governing bodies of the hospitals licensed under Article 5 of G.S. Chapter 131E, which operate nursing homes is required, the appointment shall may be made or vacancy filled by the Office of the State Long-Term Care Ombudsman Secretary or the Secretary's designee no sooner than 45 days after the commissioners have received the nomination or approval, or no sooner than 45 days after the 45-day period for action by the nursing home administrators and the governing bodies of the hospitals licensed under Article 5 of G.S. Chapter 131E, which operate nursing homes.

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- (e) The committee shall elect from its members a chair, to serve a one-year term.
- (f) Each member must be a resident of the county which the committee serves. No person or immediate family member of a person with a financial interest in a home served by a committee, or employee or governing board member or immediate family member of an employee or governing board member of a home served by a committee, or immediate family member of a patient in a home served by a committee may be a member of a committee. Membership on a committee shall not be considered an office as defined in G.S. 128-1 or G.S. 128-1.1. Any county commissioner who is appointed to the committee shall be deemed to be serving on the committee in an ex officio capacity. Members of the committee shall serve without compensation, but may be reimbursed for the amount of actual expenses incurred by them in the performance of their duties. The names of the committee members and the date of expiration of their terms shall be filed with the Office of the State Long-Term Care Ombudsman, Division of Aging, which shall supply a copy to the Division of Health Service Regulation.
- (g) The Office of the State Long-Term Care Ombudsman Division of Aging, Department of Health and Human Services, shall develop training materials which shall be distributed to each committee member and nursing home. requirements for certification and designation in accordance with 45 C.F.R. 1324.13(c)(2). Each committee member must receive certification training as specified by the State Long-Term Care Ombudsman Program Policies and Procedures and be designated as representatives of the State Long-Term Care Ombudsman Program Division of Aging-prior to exercising any power under subsection (h) of this section. The State Long-Term Care Ombudsman Program Division of Aging, Department of Health and Human Services, shall provide the committees with information, guidelines, training, and consultation to direct them in the performance of their duties.
 - (h) (1) Each committee shall apprise itself of the general conditions under which the persons are residing in the homes, and shall work for the best interests of the persons in the homes. This may include assisting persons who have grievances with the home and facilitating the resolution of grievances at the local level.
 - (2) Each committee shall quarterly visit the nursing home it serves. For each official quarterly visit, a majority of the committee members shall be present. In addition, each committee may visit the nursing home it serves whenever it deems it necessary to carry out its duties. In counties with four or more nursing homes, the subcommittee assigned to a home shall perform the duties of the committee under this subdivision, and a majority of the subcommittee members must be present for any visit.
 - (3) Each member of a committee shall have the right between 10:00 A.M. and 8:00 P.M. to enter into the facility the committee serves in order to carry out the members' responsibilities. In a county where subcommittees have been established, this right of access shall be limited to homes served by those subcommittees to which the member has been appointed.
 - (4) The committee or subcommittee may communicate through its chair with the Department or any other agency in relation to the interest of any patient. The identity of any complainant or resident involved in a complaint shall not be disclosed except as permitted under the Older Americans Act of 1965, as amended, 42 U.S.C. § 3001 et seq.
 - (5) Each home shall cooperate with the committee as it carries out its duties.
 - (6) Before entering into any nursing home, the committee, subcommittee, or member shall identify itself to the person present at the facility who is in charge of the facility at that time.

 (i) Any written communication made by a member of a nursing home advisory committee within the course and scope of the member's duties, as specified in G.S. 131E-128, shall be privileged to the extent provided in this subsection. All communication shall be considered the property of the Office of the State Long-Term Care Ombudsman and subject to the Office's disclosure policies. This privilege shall be a defense in a cause of action for libel if the member was acting in good faith and the statements or communications do not amount to intentional wrongdoing.

To the extent that any nursing home advisory committee or any member thereof is covered by liability insurance, that committee or member shall be deemed to have waived the qualified immunity herein to the extent of indemnification by insurance."

SECTION 2. (c) G.S. 143B-181.18 reads as rewritten:

"§ 143B-181.18. Office of State Long-Term Care Ombudsman Program/State Ombudsman duties.

The State Ombudsman shall perform the duties provided below:

- (1) Promote community involvement with long-term care providers and residents of long-term care facilities and serve as liaison between residents, residents' families, facility personnel, and facility administration.
- (2) Supervise the <u>State Long-Term Care Ombudsman Program pursuant to rules</u> adopted by the Secretary of the Department of Health and Human Services pursuant to G.S. 143B-10.
- (3) Certify regional ombudsmen. Certification requirements shall include an internship, training in the aging process, complaint resolution, long-term care issues, mediation techniques, recruitment and training of volunteers, and relevant federal, State, and local laws, policies, and standards.
- (3a) Designate certified Regional Ombudsmen as representatives of the Office of the State Long-Term Care Ombudsman Office as well as refuse, suspend, or remove designation as a representative of the Office of the State Long-Term Care Ombudsman in accordance with the Office of the State Long-Term Care Ombudsman Program Policies and Procedures.
- (3b) Designate and refuse, suspend or remove designation of volunteer representatives of the Office of the State Long-Term Care Ombudsman, including any community advisory committee appointees, in accordance with the State Long-Term Care Ombudsman Program Policies and Procedures.
- (4) Attempt to resolve complaints made by or on behalf of individuals who are residents of long-term care facilities, which complaints relate to administrative action that may adversely affect the health, safety, or welfare of residents.
- (5) Provide training and technical assistance to regional ombudsmen.
- (6) Establish procedures for appropriate access by regional ombudsmen to long-term care facilities and residents' files, records, and other information, including procedures to protect the confidentiality of these files, records, and other information and to ensure that the identity of any complainant or resident will not be disclosed except as permitted under the Older Americans Act of 1965, as amended, 42 U.S.C. § 3001 et seq. and regulations promulgated thereunder.
- (7) Analyze data relating to complaints and conditions in long-term care facilities to identify significant problems and recommend solutions.
- (8) Prepare an annual report containing data and findings regarding the types of problems experienced and complaints reported by residents as well as recommendations for resolutions of identified long-term care issues.

SECTION 3. The Department of Health and Human Services shall examine Public Law 113-51, HIV Organ Policy Equity (HOPE) Act, and the Final Safeguards and Research Criteria publication by the U.S. Department of Health and Human Services and National Institutes of Health to determine public health safeguards, regulations, and statutory changes necessary for consideration by the General Assembly. The Department shall submit a report of

findings and recommendations, including any necessary statutory changes, to the Joint Legislative Oversight Committee on Health and Human Services on or before January 1, 2018.

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

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Page 8 House Bill 248 H248-CSSH-14 [v.4]

HOUSE BILL 248

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Short Title:	Establish Aging Subcommittee of JLOC HHS.	(Public)
Sponsors:	Representatives Dobson, Presnell, White, and Carney (Primary Sponsor For a complete list of sponsors, refer to the North Carolina General Assembly we	
Referred to:	Health	

March 6, 2017 A BILL TO BE ENTITLED 1 AN ACT ESTABLISHING A SUBCOMMITTEE ON AGING OF THE JOINT LEGISLATIVE 2 OVERSIGHT COMMITTEE ON HEALTH AND HUMAN SERVICES. 3 4 The General Assembly of North Carolina enacts: 5 SECTION 1.(a) The Joint Legislative Oversight Committee on Health and Human Services (HHS Oversight Committee) shall appoint a Subcommittee on Aging to examine the 6 State's delivery of services for older persons in order to (i) determine their service needs and (ii) 7 make recommendations to the HHS Oversight Committee on how to address their service needs. 8 SECTION 1.(b) The Subcommittee on Aging shall consist of 21 members, appointed 9 10 as follows: (1) Two cochairs appointed as follows: 11 One member of the House of Representatives who is currently serving 12 on the HHS Oversight Committee, appointed by the House of 13 Representatives cochair of the HHS Oversight Committee. 14 One member of the Senate who is currently serving on the HHS 15 b. Oversight Committee, appointed by the Senate cochair of the HHS 16 Oversight Committee. 17 Eight members appointed by the House of Representatives cochair of the 18 (2) Subcommittee with the following qualifications: 19 Three members of the House of Representatives designated by the 20 Speaker of the House of Representatives. 21 One licensed physician who is board certified in geriatric medicine. 22 b. One representative of AARP North Carolina. 23 c. One licensed provider of home care services, as defined in 24 d. 25 G.S. 131E-136. One consumer of services for older persons. 26 e. One licensed provider of home- and community-based services. 27 Eight members appointed by the Senate cochair of the Subcommittee with the 28 (3) following qualifications: 29 Three members of the Senate designated by the President Pro Tempore 30 a. 31 32

- One licensed long-term care facility operator.
- b.
- One representative of a North Carolina chapter of the Alzheimer's c.
- d. One licensed provider of hospice care services.



One consumer of services for older persons. 1 e. One representative of the North Carolina Health Care Facilities 2 f. Association. 3 4 The Director of the Division on Aging and Adult Services of the Department of (4) 5 Health and Human Services (DHHS) or the Director's designee. The Director of the Division of Social Services of DHHS or the Director's 6 (5) 7 designee. 8 The Director of the Division of Medical Assistance of DHHS or the Director's (6) 9 designee. 10 SECTION 1.(c) Vacancies on the Subcommittee shall be filled by the original appointing authority. The Subcommittee may meet at any time upon the joint call of the cochairs. 11 A quorum of the Subcommittee is nine members. No action may be taken except by a majority 12 vote at a meeting at which a quorum is present. 13 The Subcommittee, while in the discharge of its official duties, may exercise all powers 14 provided for under G.S. 120-19 and G.S. 120-19.1 through G.S. 120-19.4. The Subcommittee may 15 meet in the Legislative Building or the Legislative Office Building. The Subcommittee may 16 contract for professional, clerical, or consultant services as provided by G.S. 120-32.02. 17 The Legislative Services Commission, through the Legislative Services Officer, shall 18 assign professional staff to assist the Subcommittee in its work. The Senate and House of 19 20 Representatives' Directors of Legislative Assistants shall assign clerical staff to the Subcommittee, and the expenses relating to the clerical employees shall be borne by the Subcommittee. Members 21 22 of the Subcommittee shall receive subsistence and travel expenses at the rates set forth in 23 G.S. 120-3.1, 138-5, or 138-6, as appropriate. 24 SECTION 1.(d) As part of its examination, the Subcommittee shall study all of the 25 following issues: 26 (1) Existing services for older persons and any deficiencies in service array, quality 27 of services, accessibility, and availability of services. Current and future service needs of older persons, including supports for older 28 (2) 29 persons residing in institutional and in-home settings. The feasibility of developing mechanisms for allowing older persons to express 30 (3) 31 the setting in which they prefer to receive services and honoring these preferences. 32 33 (4) Existing service definitions for older persons who receive services through federally funded programs, including Medicaid; through federal block grants; 34 through State-funded programs; through county-funded programs; and through 35 other funding sources, as well as the need for additional or revised service 36 definitions to meet the specific needs of older persons. 37 38 (5) The adequacy of existing Special Assistance programs in meeting the needs of older persons residing in institutional, in-home, and community settings. 39 Current accessibility of information, educational materials, and family 40 (6)resources for older persons, as well as any deficiencies and needed 41 improvements. 42. Issues pertaining to working caregivers for older persons, including at least all 43 (7) 44 of the following: 45 The percentage of working caregivers in the workforce. a. 46 The needs of working caregivers. b. The consequences of working and caregiving. 47 C.

Family responsibility discrimination encountered by

Employment opportunity for caregivers.

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caregivers.

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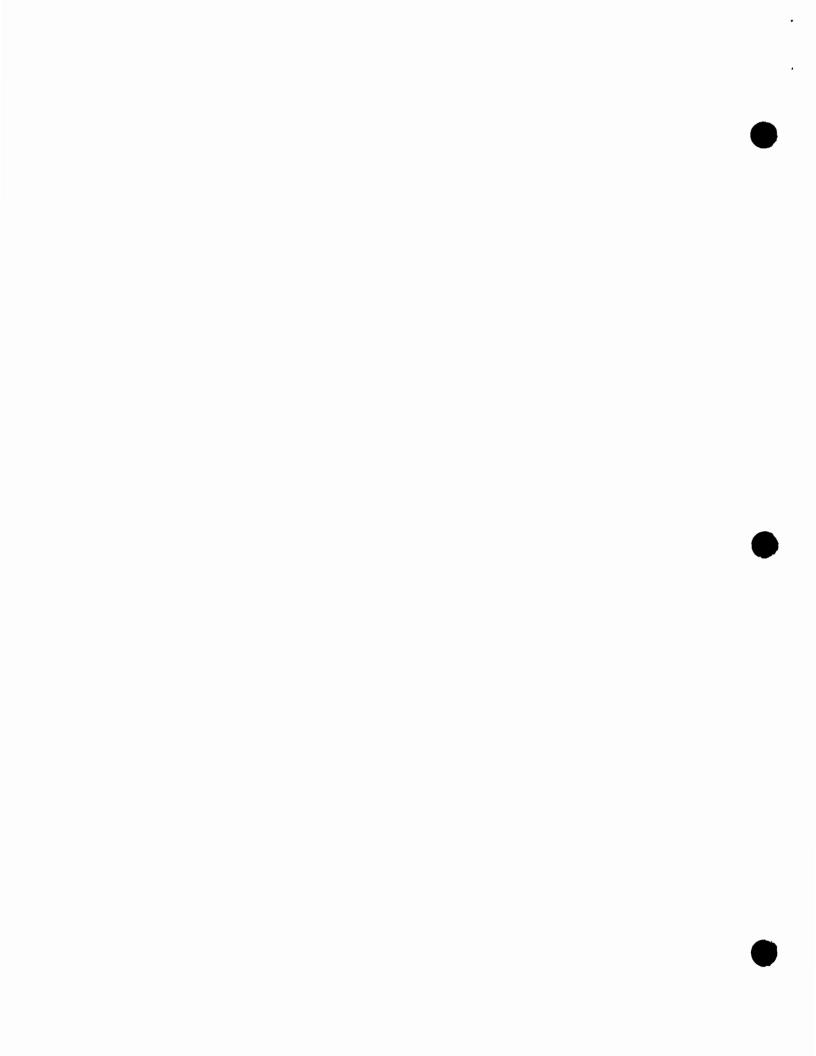
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working

General Assembly Of North Carolina Session 2017 1 Costs associated with caregiving, including costs to the employer, the g. 2 working caregiver, and the public health care system. 3 Leave policies for working caregivers. h. 4 Employer responses to the needs of working caregivers. i. 5 Government responses to the needs of working caregivers. j. 6 Strategies for addressing the needs of working caregivers. k. 7 Any other matter related to services for older persons and their families. (8) 8 SECTION 1.(e) The Subcommittee on Aging shall submit an interim report of its findings and recommendations, including any proposed legislation, to the HHS Oversight 9 10 Committee on or before May 8, 2018, and shall submit a final report of its findings and recommendations, including any proposed legislation, to the HHS Oversight Committee on or 11 12 before January 15, 2019, at which time it shall terminate.





HOUSE BILL 631: Reduce Admin. Duplication MH/DD/SAS Providers.

2017-2018 General Assembly

Committee: House Health

Introduced by: Reps. Stone, Dobson, Murphy

Analysis of: PCS to First Edition

H631-CSTY-8

Date: April 19, 2017

Prepared by: Augustus D. Willis

Committee Counsel

OVERVIEW: The PCS to House Bill 631 would create a workgroup to examine the requirements of physical health providers and mental health, intellectual/developmental disability, and substance abuse disorder providers. The PCS would require a report to the General Assembly with recommendations on how to avoid duplication and enhance efficiency in the provision of health care services.

BILL ANALYSIS: The PCS to House Bill 631 would require the Secretary of the Department of Health and Human Services to establish a workgroup to examine the current administrative requirements for mental health, intellectual/developmental disability, and substance use disorder providers and how best to integrate those requirements with similar administrative requirements for physical health providers in order to avoid duplication and enhance efficiency.

The workgroup would have to consist of representatives from the following:

- Division of Mental Health, Developmental Disabilities, and Substance Abuse Services;
- Division of Medical Assistance:
- Division of Health Benefits:
- Local management entity/managed care organizations;
- Providers:
- Stakeholders.

The following categories of requirements imposed on mental health, intellectual/developmental disability, and substance use disorder providers and physical health providers would be required to be reviewed:

- Training
- Service delivery
- Documentation
- Claims processing
- Reporting

- Monitoring
- Oversight
- Facility licensure
- Medicaid enrollment
- Credentialing

- Accreditation
- Contracts
- Investigations
- Audits

In conducting the examination, the workgroup would be required to identify the federal or State entity that created each requirement examined by the workgroup, and recommend whether that requirement should remain, be eliminated, or be redesigned. The work group would have to consider any





Legislative Analysis
Division
919-733-2578

House PCS 631

Page 2

requirement imposed on mental health, intellectual/developmental disability, and substance use providers that:

- Is not federally mandated;
- Exceeds what is required for physical health;
- Does not add value to the delivery of behavioral health services;
- Is unable to be incorporated into standard electronic health records or does not align with meaningful use of electronic health records.

DHHS would be required to report the findings and recommendations of the workgroup to the Joint Legislative Oversight Committee on Health and Human Services, the Joint Legislative Oversight Committee on Medicaid and NC Health Choice, and the Fiscal Research Division by March 31, 2018.

EFFECTIVE DATE: This act would be effective when it becomes law.

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HOUSE BILL 631 PROPOSED COMMITTEE SUBSTITUTE H631-CSTY-8 [v.1] 4/18/2017 7:14:17 PM

Reduce Admin. Duplication MH/DD/SAS Providers.	(Public)
	Reduce Admin. Duplication MH/DD/SAS Providers.

April 10, 2017

A BILL TO BE ENTITLED

AN ACT REQUIRING THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO ESTABLISH A WORKGROUP TO EXAMINE AND MAKE RECOMMENDATIONS ABOUT HOW TO ELIMINATE ADMINISTRATIVE DUPLICATION FOR MENTAL HEALTH, INTELLECTUAL/DEVELOPMENTAL DISABILITY, AND SUBSTANCE USE DISORDER PROVIDERS.

The General Assembly of North Carolina enacts:

Referred to:

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SECTION 1.(a) The Secretary of the Department of Health and Human Services shall establish a workgroup to examine current administrative requirements for mental health, intellectual/developmental disability, and substance use disorder providers and how best to integrate these requirements with similar administrative requirements for physical health providers in order to avoid duplication and enhance efficiency. The workgroup shall consist of representatives from the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, the Division of Medical Assistance, the Division of Health Benefits, local management entity/managed care organizations, providers, and stakeholders. The examination shall include a review of at least all of the following categories of requirements imposed on mental health, intellectual/developmental disability, and substance use disorder providers and physical health providers:

- (1) Training.
- (2) Service delivery.
- (3) Documentation.
- (4) Claims processing.
- (5) Reporting.
- (6) Monitoring.
- (7) Oversight.
 - (8) Facility licensure.
- (9) Medicaid enrollment.
 - (10) Credentialing.
 - (11) Accreditation.
 - (12) Contracts.
 - (13) Investigations.
- (14) Audits.

SECTION 1.(b) In conducting the examination required under subsection (a) of this section, the workgroup shall identify the federal or State entity that created each requirement examined by the workgroup to include state legislation, statutes, contractual requirements, federal Medicaid and managed care law and provide a recommendation about



	General Assembly Of North Carolina Session 2017
1	whether that requirement should remain, be eliminated or redesigned. The workgroup shall
2	consider any requirement imposed on mental health, intellectual/developmental disability, and
3	substance use disorder providers that:
4	(1) Is not federally mandated.
5	(2) Exceeds what is required for physical health.
6	(3) Does not add value to the delivery of behavioral health services.
7	(4) Is unable to be incorporated into standard electronic health records or does
8	not align with meaningful use of electronic health records.
9	SECTION 1.(c) By March 31, 2018, the Department of Health and Human and
10	Human Services shall report the findings and recommendations of the workgroup to the Joint
11	Legislative Oversight Committee on Health and Human Services, the Joint Legislative
12	Oversight Committee on Medicaid and NC Health Choice, and the Fiscal Research Division.

SECTION 2. This act is effective when it becomes law.

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Page 2 House Bill 631 H631-CSTY-8 [v.1]

1

H HOUSE BILL 631

Short Title:	Reduce Admin. Duplication/BH Providers.	(Public)
Sponsors:	Representatives Stone, Dobson, and Murphy (Primary Sponsors).	
	For a complete list of sponsors, refer to the North Carolina General Assembly	web site.
Referred to:	Health	

April 10, 2017

A BILL TO BE ENTITLED
AN ACT REQUIRING THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO ESTABLISH A WORKGROUP TO EXAMINE AND MAKE RECOMMENDATIONS ABOUT HOW TO ELIMINATE ADMINISTRATIVE DUPLICATION FOR BEHAVIORAL HEALTH PROVIDERS.

The General Assembly of North Carolina enacts:

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SECTION 1.(a) The Secretary of the Department of Health and Human Services shall establish a workgroup to examine current administrative requirements for behavioral health providers and how best to integrate these requirements with similar administrative requirements for physical health providers in order to avoid duplication and enhance efficiency. The workgroup shall consist of representatives from the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, the Division of Medical Assistance, the Division of Health Benefits, local management entity/managed care organizations, providers, and stakeholders. The examination shall include a review of at least all of the following categories of requirements imposed on behavioral health providers and physical health providers:

- (I) Training.
- (2) Service delivery.
- (3) Documentation.
- (4) Claims processing.
- (5) Reporting.
- (6) Monitoring.
- (7) Oversight.
- (8) Facility licensure.
- (9) Medicaid enrollment.
 - (10) Credentialing.
 - (11) Accreditation.
 - (12) Contracts.
 - (13) Investigations.
- (14) Audits.

SECTION 1.(b) In conducting the examination required under subsection (a) of this section, the workgroup shall identify the federal or State entity that created each requirement examined by the workgroup and provide a recommendation about whether that requirement should be eliminated or redesigned. The workgroup shall consider for elimination



	General Assembly Of North Carolina Session 2017
1	any requirement imposed on behavioral health providers that meets one or more of the
2	following criteria:
3	(1) Is not federally mandated.
4	(2) Exceeds what is required for physical health.
5	(3) Does not add value to the delivery of behavioral health services.
6	(4) Is unable to be incorporated into standard electronic health records or does
7	not align with meaningful use of electronic health records.
8	SECTION 1.(c) By March 31, 2018, the Department of Health and Human and
9	Human Services shall report the findings and recommendations of the workgroup to the Joint
10	Legislative Oversight Committee on Health and Human Services, the Joint Legislative
11	Oversight Committee on Medicaid and NC Health Choice, and the Fiscal Research Division.

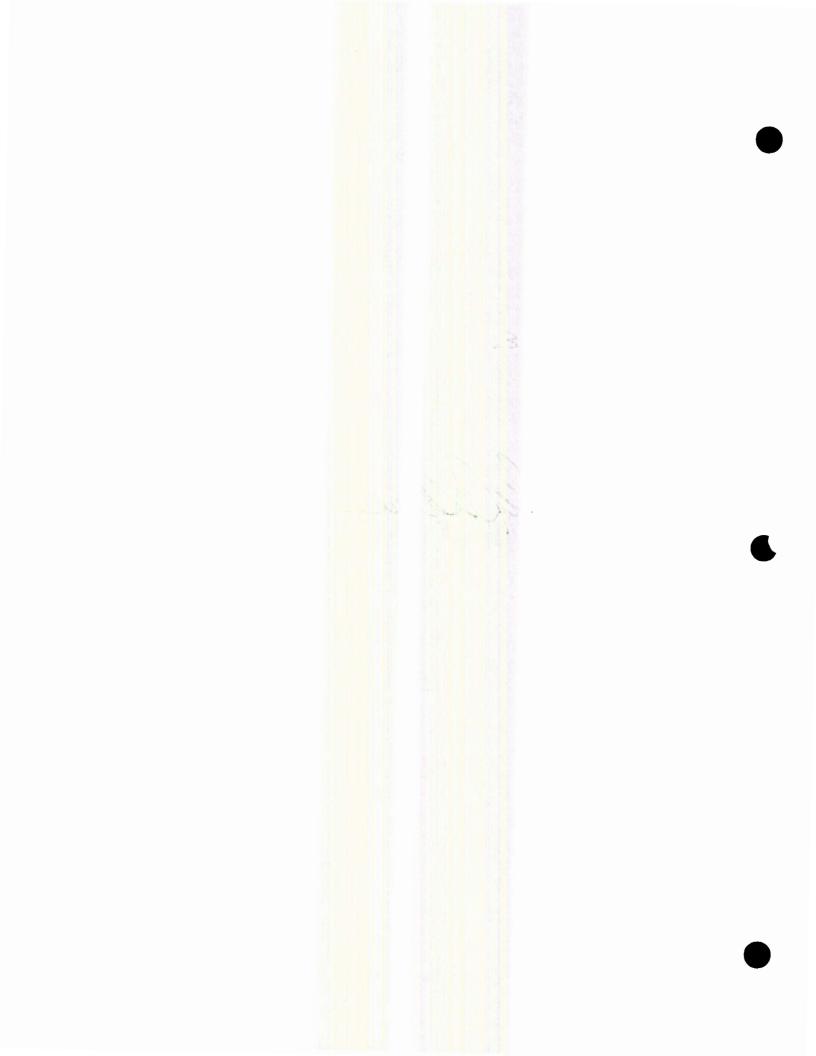
SECTION 2. This act is effective when it becomes law.



NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT House Bill 631

AMENDMENT NO.___ (to be filled in by Principal Clerk) H631-ATY-21 [v.1] Page 1 of 1 Amends Title [NO] H631-CSTY-8 [v.1] Representative STONE moves to amend the bill on page 1, line 14 by inserting between the words "Benefits," and 1 "local" the phrase "the Division of Health Service Regulation,". 2 3 4 **SIGNED** Committee Chair if Senate Committee Amendment FAILED ____ ADOPTED TABLED







HOUSE BILL 690: SUDEP Awareness Week.

2017-2018 General Assembly

Committee: House Health Date: April 18, 2017
Introduced by: Reps. Riddell, Malone, Beasley, Murphy
Analysis of: First Edition Committee Staff

OVERVIEW: House Bill 690 would designate the week beginning on the second Sunday in November as Sudden Unexpected Death in Epilepsy (SUDEP) Awareness Week.

CURRENT LAW:

S.L. 2015-211 required county medical examiners to complete continuing education training as directed by the Office of the Chief Medical Examiner and based upon established and published guidelines for conducting death investigations. The continuing education training is required to include training regarding sudden unexpected death in epilepsy.

BILL ANALYSIS:

House Bill 690 amends Chapter 103 to add a new section on SUDEP Awareness Week. Chapter 103 of the General Statutes pertains to Sundays, Holidays, and Special Days. The new law [G.S. 103-15] would designate the week beginning on the second Sunday in November as Sudden Unexpected Death in Epilepsy (SUDEP) Awareness Week in North Carolina.

The long title designates the act as the Shannon Leigh Adcock and Steven Anthony Christos Memorial Act.

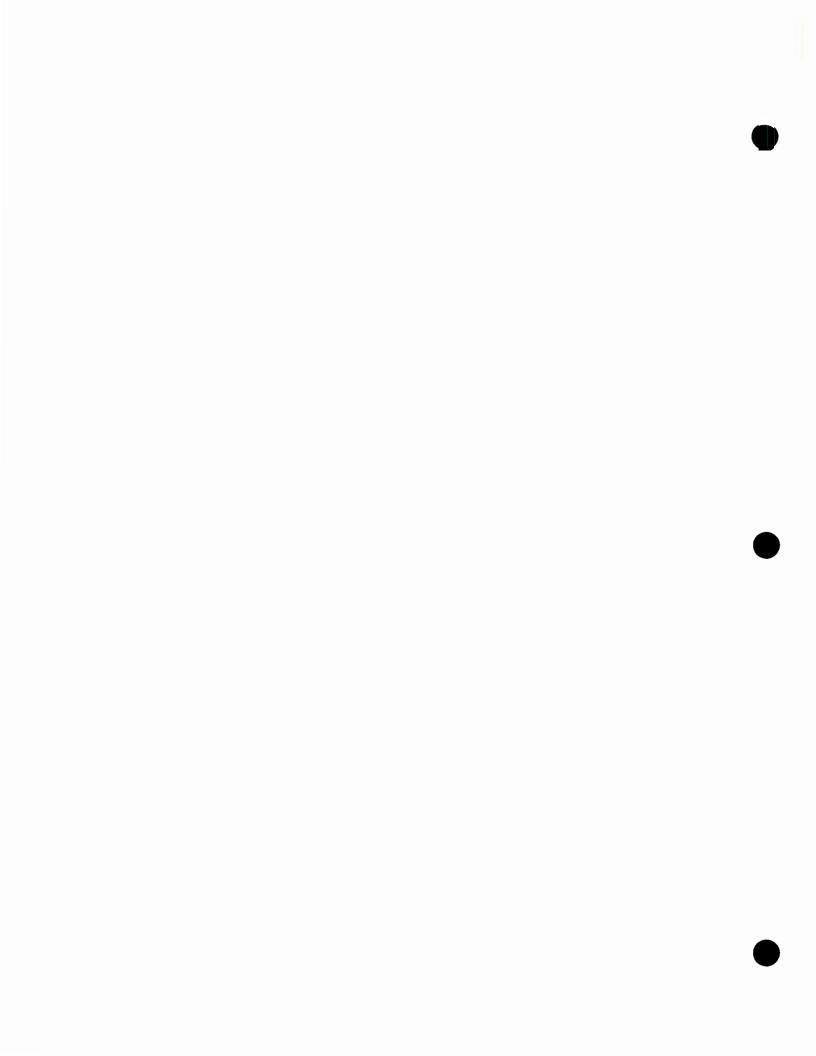
EFFECTIVE DATE: House Bill 690 would become effective when it becomes law.

BACKGROUND: According to the Epilepsy Foundation, SUDEP "is said to occur when a person with epilepsy dies unexpectedly and was previously in their usual state of health. The death is not known to be related to an accident or seizure emergency such as status epilepticus. When an autopsy is done, no other of cause of death can be found. Each year, more than 1 out of 1,000 people with epilepsy die from SUDEP." ¹

http://www.epilepsy.com/sudep-institute







Н **HOUSE BILL 690**

SUDEP Awareness Week.

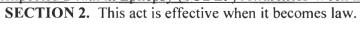
Short Title:

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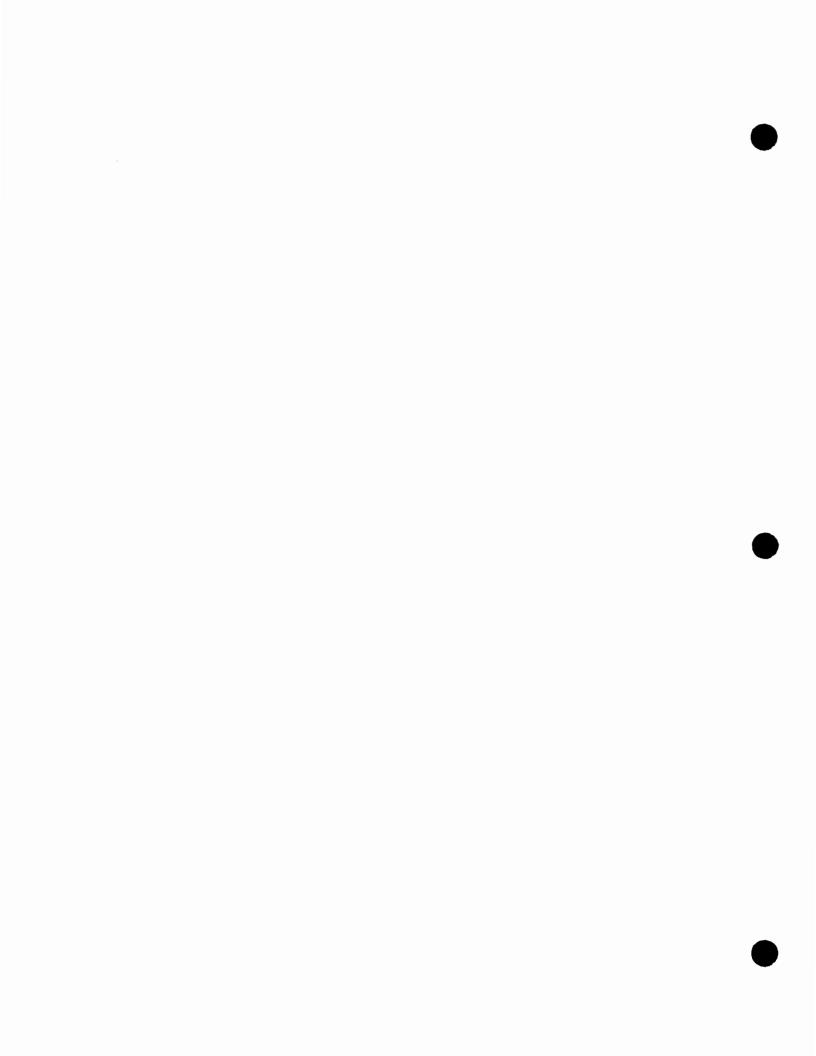
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(Public) Representatives Riddell, Malone, Beasley, and Murphy (Primary Sponsors). For a complete list of sponsors, refer to the North Carolina General Assembly web site.

	Referred to: Health
	April 11, 2017
1	A BILL TO BE ENTITLED
2	AN ACT CREATING THE SHANNON LEIGH ADCOCK AND STEVEN ANTHONY
3	CHRISTOS MEMORIAL ACT TO ESTABLISH THE SECOND WEEK IN NOVEMBER
4	AS SUDEP AWARENESS WEEK IN THE STATE OF NORTH CAROLINA.
5	Whereas, "SUDEP" is the sudden, unexpected death of a person with epilepsy, who
6	was otherwise considered healthy; and
7	Whereas, each year, more than 1 out of 1,000 people with epilepsy die from
8	SUDEP; and
9	Whereas, uncontrolled seizures increases the risk of SUDEP to more than 1 out of
10	150; and
11	Whereas, November is observed as National Epilepsy Awareness Month throughout
12	the nation; and
13	Whereas, during National Epilepsy Awareness Month, it is important to also bring
14	awareness of SUDEP; Now, therefore,
15	The General Assembly of North Carolina enacts:
16	SECTION 1. Chapter 103 of the General Statutes is amended by adding a new
17	section to read:
18	"§ 103-15. SUDEP Awareness Week.
19	The week beginning on the second Sunday in November of each year is designated as
20	Sudden Unexpected Death in Epilepsy (SUDEP) Awareness Week in North Carolina."









HOUSE BILL 741: DHHS Study/Maternal and Neonatal Care.

2017-2018 General Assembly

April 19, 2017 Committee: House Health Date: Introduced by: Reps. Murphy, Boswell, Adcock, **Prepared by:**

Cunningham

Jason Moran-Bates

Committee Co-Counsel

First Edition Analysis of:

OVERVIEW: House Bill 741 would direct the Department of Health and Human Services (DHHS) to study and report on North Carolina's ability to provide access to high-quality, risk-appropriate maternal and neonatal care.

[As introduced, this bill was identical to S311, as introduced by Sens. D. Davis and Krawiec, which is currently in Senate Rules and Operations of the Senate.]

BILL ANALYSIS:

Section 1.(a) of the bill would direct DHHS to study North Carolina's ability to provide timely and equitable access to high-quality, risk-appropriate maternal and neonatal care. The study must examine the following:

- The complexity levels of care by all delivering hospitals in caring for birth mothers and newborns.
- The current management of referral and transportation to different facilities and specialty providers.
- Disparities in access to risk-appropriate maternal and hospital care.
- Service gaps.
- Issues impacting the ability to match patient need with provider skill.
- Recommendations to ensure women in North Carolina receive quality prenatal care and to ensure that mothers and newborns are cared for in a facility that can meet their needs.
- Any other issues DHHS deems relevant to the study.

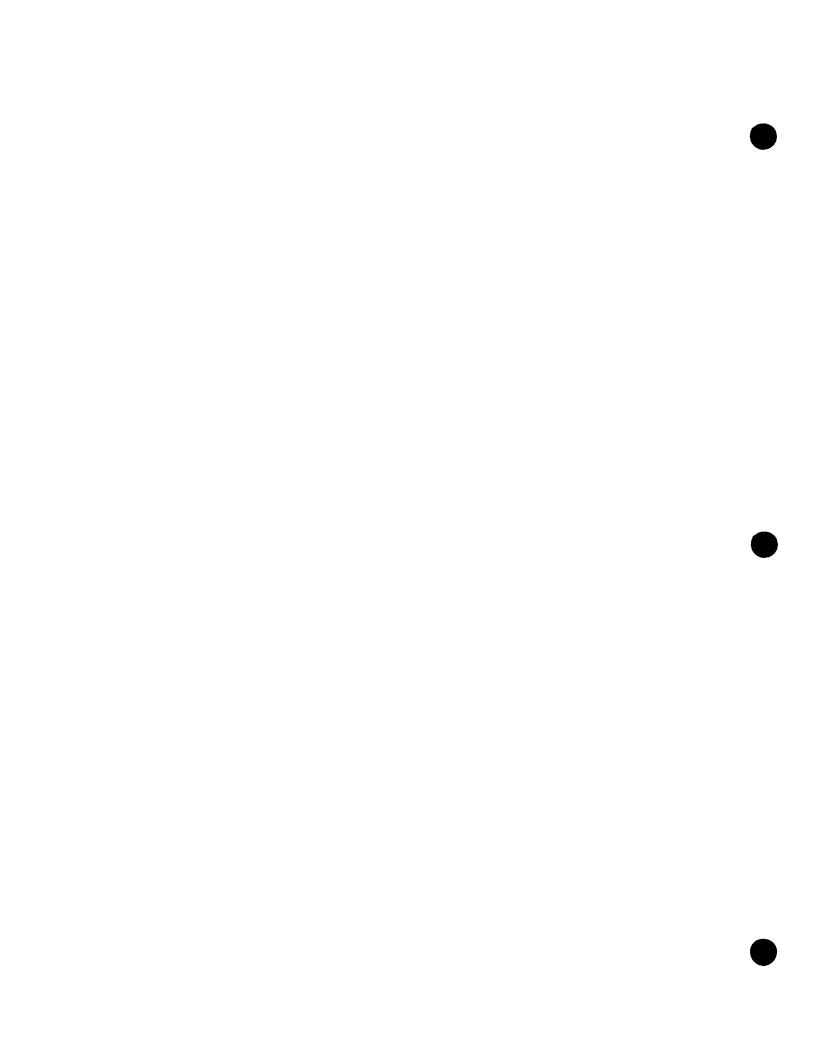
Section 1.(b) of the bill would require DHHS to make in interim report of its findings and recommendations to the 2018 Regular Session of the 2017 General Assembly on or before May 1, 2018, and to make a final report of its findings and recommendations, including proposed legislation, to the 2019 General Assembly.

EFFECTIVE DATE: This bill would be effective when it becomes law.





Legislative Analysis Division 919-733-2578



HOUSE BILL 741

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Sponsors:

Short Title:

DHHS Study/Maternal and Neonatal Care.

(Public)

Representatives Murphy, Boswell, Adcock, and Cunningham (Primary

For a complete list of sponsors, refer to the North Carolina General Assembly web site.

Referred to: Health

April 13, 2017

A BILL TO BE ENTITLED

AN ACT DIRECTING THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO PERTAINING TO HIGH-QUALITY, RISK-APPROPRIATE STUDY ISSUES MATERNAL AND NEONATAL CARE.

Whereas, pregnant and postpartum women require timely, comprehensive medical services matched to their clinical complexity; and

Whereas, medically complex pregnant mothers and newborns should be cared for in a medical facility that can meet their specific medical needs; and

Whereas, maternity and newborn care providers are not geographically distributed to best meet health care needs; and

Whereas, studies have demonstrated that timely access to risk appropriate neonatal and obstetric care can reduce infant mortality and maternal severe morbidity and mortality; and

Whereas, health care facilities across North Carolina have varied capabilities to care for mothers and newborns with complex needs; and

Whereas, designating facilities with specific "levels of care" offers uniform criteria about the capability of health care facilities to provide complexity of care to pregnant women and newborns; and this approach is endorsed by the American College of Obstetricians and Gynecologists, the Society for Maternal-Fetal Medicine, the American Academy of Pediatrics, and a number of other national medical organizations; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1.(a) The Department of Health and Human Services shall study and analyze North Carolina's ability to provide women with timely and equitable access to high-quality, risk-appropriate maternal and neonatal care. The study shall examine at least all of the following:

- The complexity levels of care currently being provided by all delivering (1) hospitals in caring for birth mothers and newborns.
- How current systems of referral and transport to different facilities and (2) specialty providers based on patient risk are being managed.
- Disparities in access to risk-appropriate maternal and hospital care. (3)
- (4) Service gaps.
- Issues that impact the ability to most appropriately match patient need with (5)provider skill.
- (6) Recommendations for actionable steps that can be taken in North Carolina to best ensure that pregnant women receive quality prenatal care and that



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	General Assembly Of North Carolina Session 2017
1	mothers and newborns are cared for in a facility that can meet their specific
2	clinical needs.
3	(7) Any other issues the Department deems relevant to this study.
4	SECTION 1.(b) The Department shall make an interim report of its findings and
5	recommendations to the 2018 Regular Session of the 2017 General Assembly on or before May
6	1, 2018, and a final report of its findings and recommendations, including any recommended
7	legislation, to the 2019 General Assembly.
8	SECTION 2. This act is effective when it becomes law.



HOUSE BILL 725: Mental Health Support Funding/Study.

2017-2018 General Assembly

Committee: House Health. If favorable, re-refer to Date: April 19, 2017

Education - K-12

Introduced by: Reps. B. Turner, Dobson, Dollar, Prepared by: Jason Moran-Bates

Cunningham Staff Attorney

Analysis of: First Edition

OVERVIEW: House Bill 725 would direct the Department of Public Instruction (DPI) to study and make recommendations regarding the funding structures in place to provide mental health support in public schools.

BILL ANALYSIS:

Section 1 of the bill would direct DPI to study and make recommendations regarding the funding structures in place to provide mental health support in public schools. The study must include a review and analysis of the following:

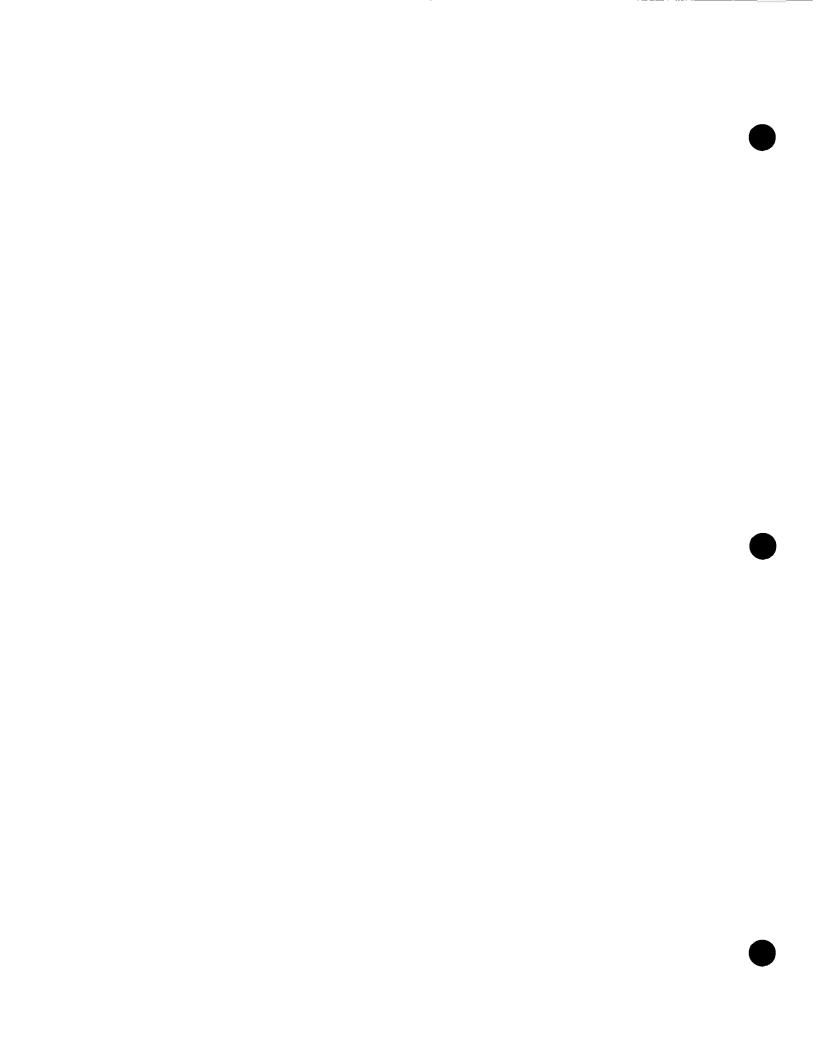
- The ways mental health support in public schools is funded, including the personnel involved in providing services and the salaries, operational costs, and contracts for services associated with those individuals.
- Whether salaried positions or contracts for services are a more cost-effective means for providing mental health support.
- The extent to which funding should be tied to the level of need at a particular school.
- The advisability of tying funding to particular measures, which may include each student's Adverse Childhood Experiences score.
- Any other matter DPI deems relevant to the study.

Section 2 would require DPI to report its findings and recommendations, including any legislative proposals, to the Joint Legislative Education Oversight Committee no later than December 15, 2018.

EFFECTIVE DATE: This bill would be effective when it becomes law.







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HOUSE BILL 725

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Short Title: Mental Health Support Funding/Study. (Public)

Sponsors: Representatives B. Turner, Dobson, Dollar, and Cunningham (Primary Sponsors).

For a complete list of sponsors, refer to the North Carolina General Assembly web site.

Referred to: Health, if favorable, Education - K-12

April 11, 2017

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A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DEPARTMENT OF PUBLIC INSTRUCTION TO STUDY FUNDING FOR MENTAL HEALTH SUPPORT SERVICES IN PUBLIC SCHOOLS. The General Assembly of North Carolina enacts:

SECTION 1. Study. – The Department of Public Instruction shall study and make recommendations regarding the funding structures in place to provide mental health support in public schools. The study shall include, but not be limited to, a review and analysis of all of the following:

- 9 10
- (1) The different ways in which mental health support in public schools receives funding in North Carolina. This shall include, but not be limited to, the following:
- 11 12 13

a. The personnel involved in providing mental health support, including, but not limited to, nurses, psychologists, school counselors, social workers, and special education teachers.

14 15 16

b. Salaries, operational costs, and contracts for services associated with the mental health support personnel identified pursuant to sub-subdivision a. of subdivision (1) of this section.

17 18

c. Programs to support at-risk students.

19 20 (2) Whether salaried positions or contracts for services are a more cost-effective means of providing mental health support in schools.

21 22 23 (3) The extent to which mental health support funding is or should be tied to the level of need at a particular school or within a particular local school administrative unit.

24 25 (4) The advisability of tying mental health support funding to a particular measure or combination of measures. Measures may include, for example, a confidential and anonymous score for each student based on survey information and physical examinations similar to the Adverse Childhood Experiences (ACEs) score.

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(5) Any other matter the Department deems relevant to the study.

30 31 **SECTION 2.** Report. – The Department of Public Instruction shall report its findings and recommendations, including any legislative proposals, to the Joint Legislative Education Oversight Committee no later than December 15, 2018.

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SECTION 3. Effective Date. – This act is effective when it becomes law.

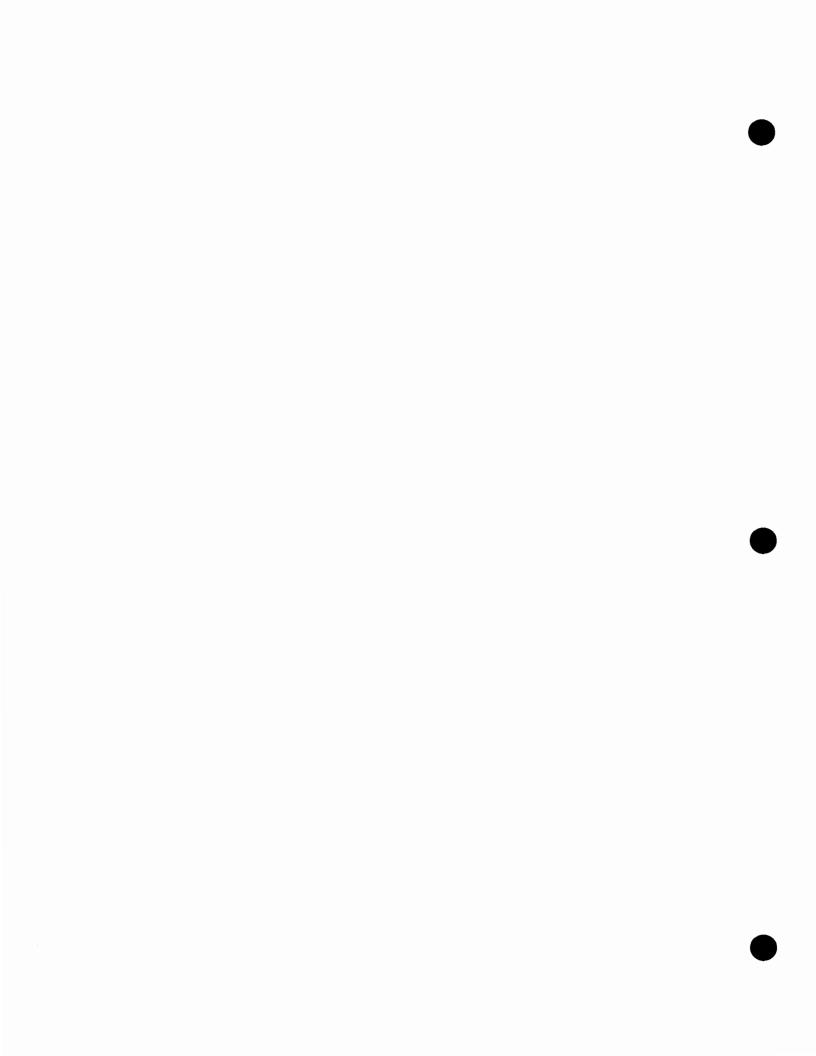


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Committee Sergeants at Arms

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1 Name:	REGGIE SILLS	House Sgt-At Arms:	
	TERRY McCRAW		
	THOMAS TERRY		
		Senate Sgt-At Arms:	
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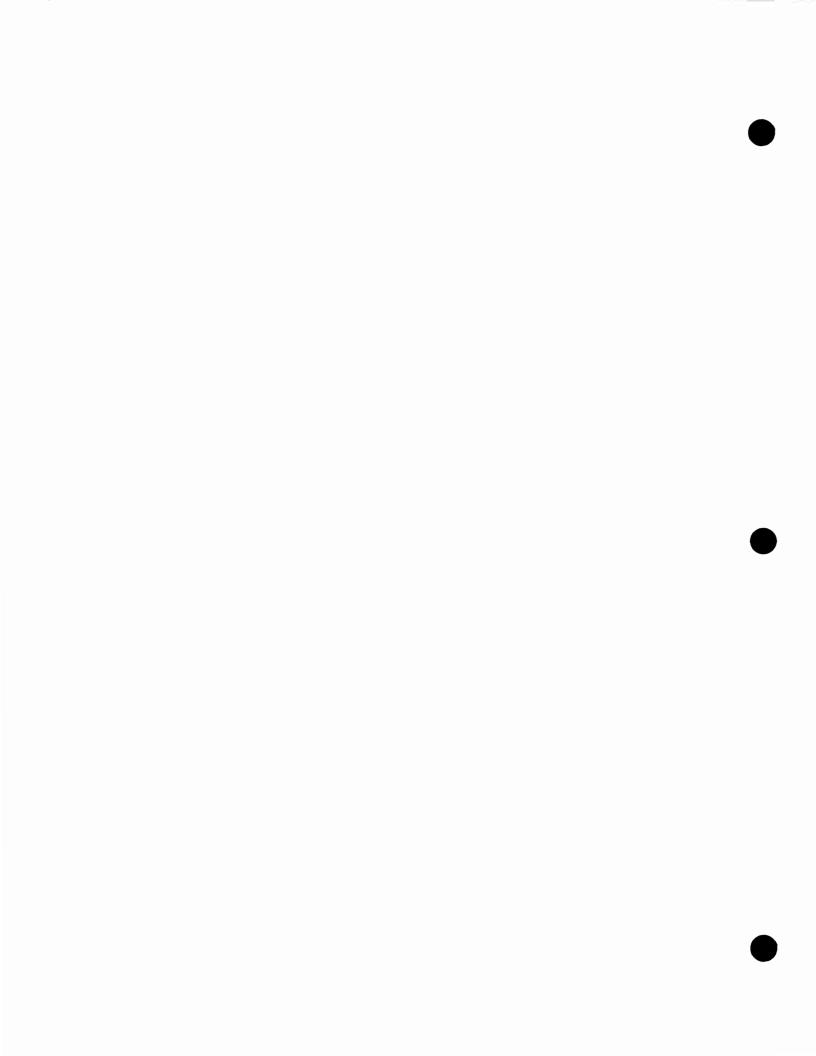
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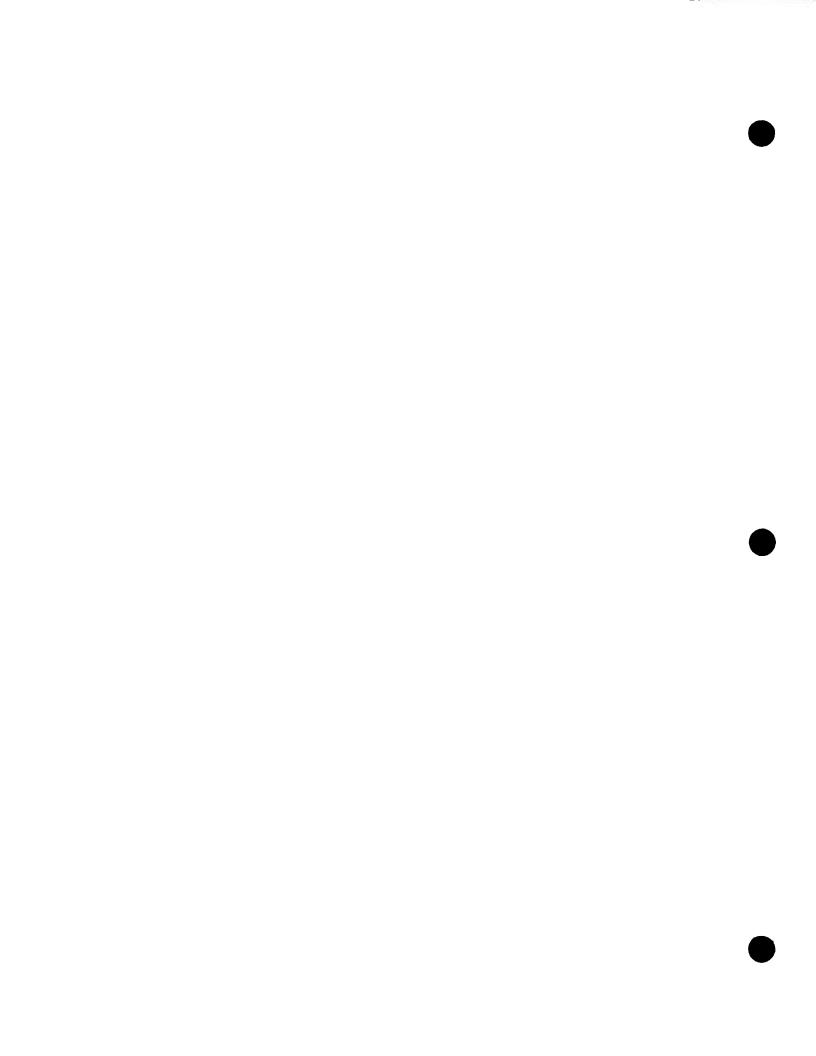
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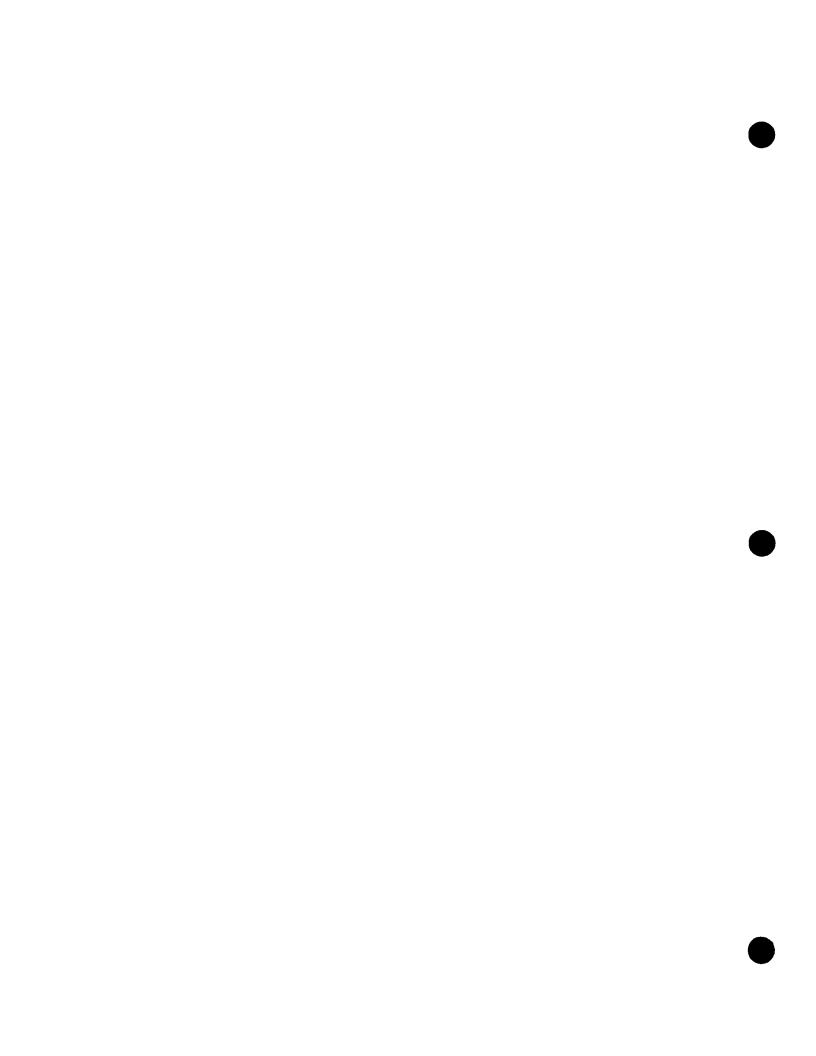


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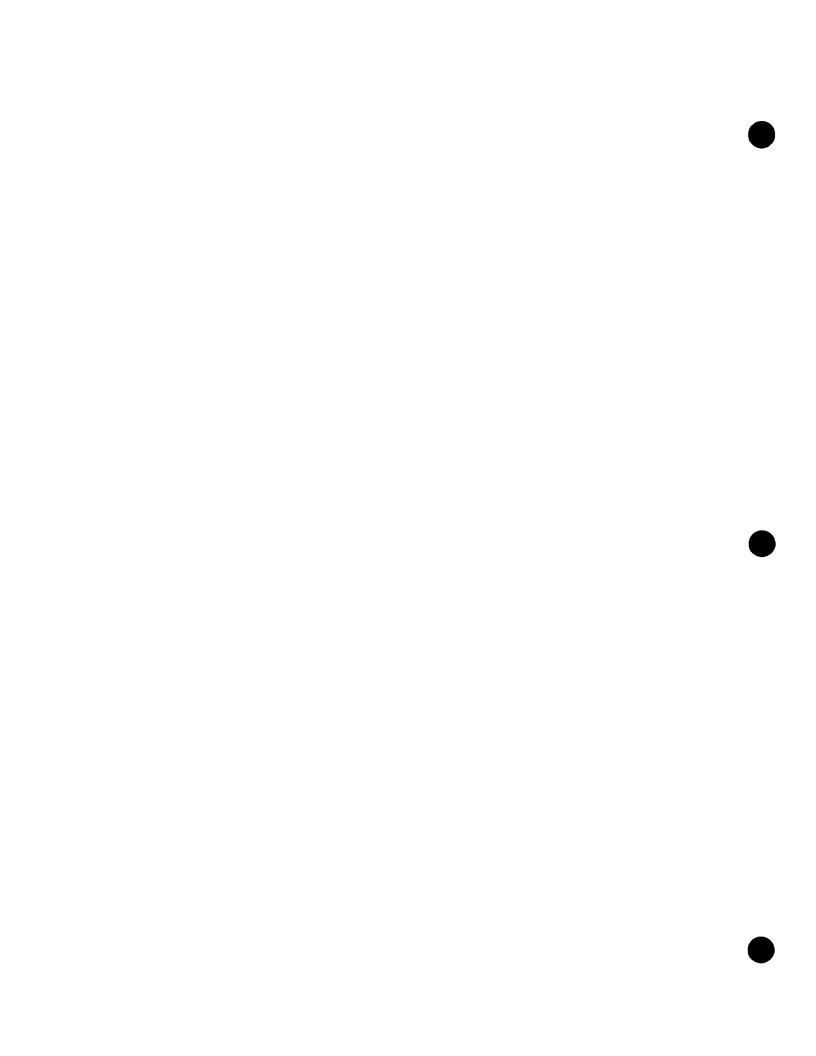
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David Heiren	SHrace BHC.
David Heiren	NC Conter for Nonprofits
Atel a Babook	PPAB
Ann Rodiguez	NC Conneil of Comm. Programs
Kettykingsby	30
Heather Burkhardt	NC DHHS, Div of Aging and Adult Sorvics

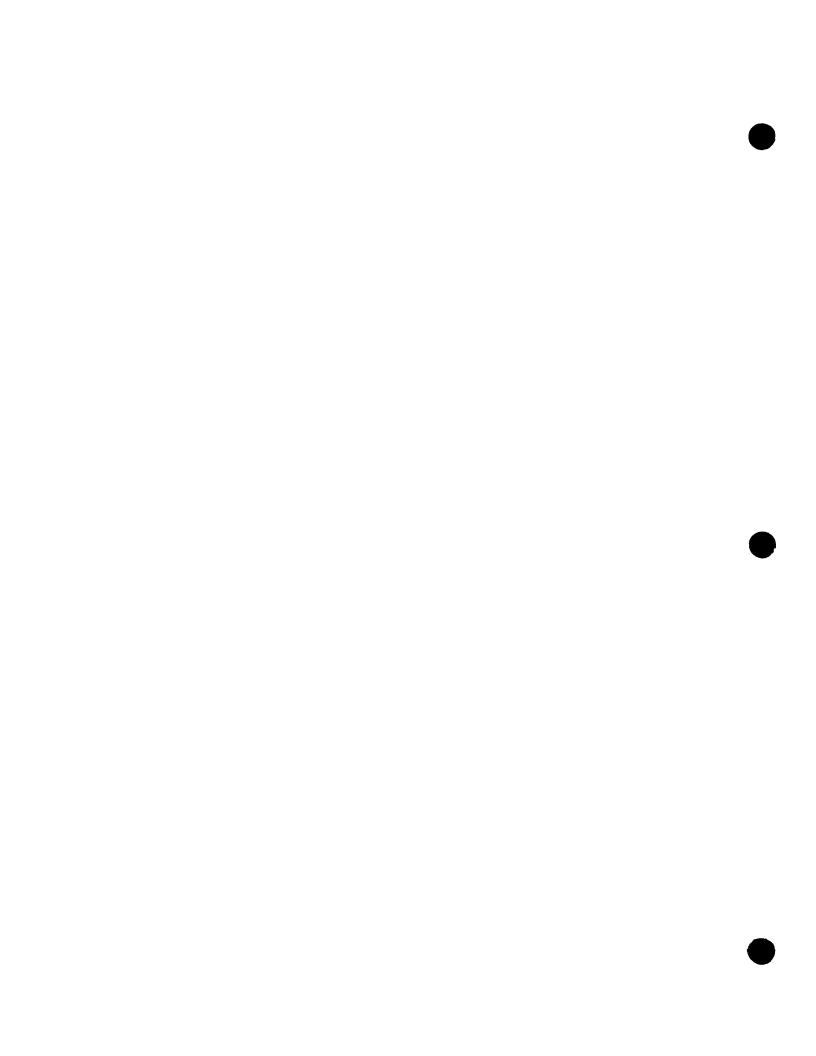


Name of Committee

Date 04-19-2017

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Stephanie Billiam	DHSR
JESSE GODMON	D HH3/D H32
Sarah Walf	MWC
Mary Bethel	Nc Co.liti Ajing
Kimayran	Visia Straignes
Charmaine Fuller Cooper	AARP
Kella Hotches	NCCFTF
DOB LANIER	T55
Julie Sixe	NCFPC
Caroline Miller	AUMA
Mike MeBroky	Biogen



Graff	
Name of Committee	ec

Date 04-19 - 2017

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS		
Suzanne Merrill	DHHS/DAAS		
Suzanne Merrill William Lams	tarevols of Residents in Lorg rum Core Colors and assoc		
Tony adams	adams and assoc		

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House Committee on Health Tuesday, April 25, 2017 at 8:30 AM Room 643 of the Legislative Office Building

MINUTES

The House Committee on Health met at 8:30 AM on April 25, 2017 in Room 643 of the Legislative Office Building. Representatives Adcock, Ball, Blackwell, Boswell, Burr, Carney, Dobson, Dollar, Earle, Ford, Bert Jones, Lambeth, Malone, Murphy, Potts, Rogers, Szoka, White, and Yarborough attended.

Representative Bert Jones, Chair, presided.

The following bills were considered:

HB 187 Modernize Physical Therapy Practice. (Representatives Dollar, Torbett, S. Martin, Dobson)

Representative Dollar explained the bill. Rep. Adcock motioned for a Favorable Report for HB 187. The bill passed and will be sent to the House floor.

HB 489 Child Abuse & Neglect/Military Affiliation. (Representatives G. Martin, Szoka, Hardister, Strickland)

Representative Grier Martin explained the bill. Rep. Dollar motioned for a Favorable Report for HB 489. The bill passed with referral to Judiciary IV.

HB 615 Amend Substance Abuse Professional Pract. Act. (Representatives Malone, S. Martin)

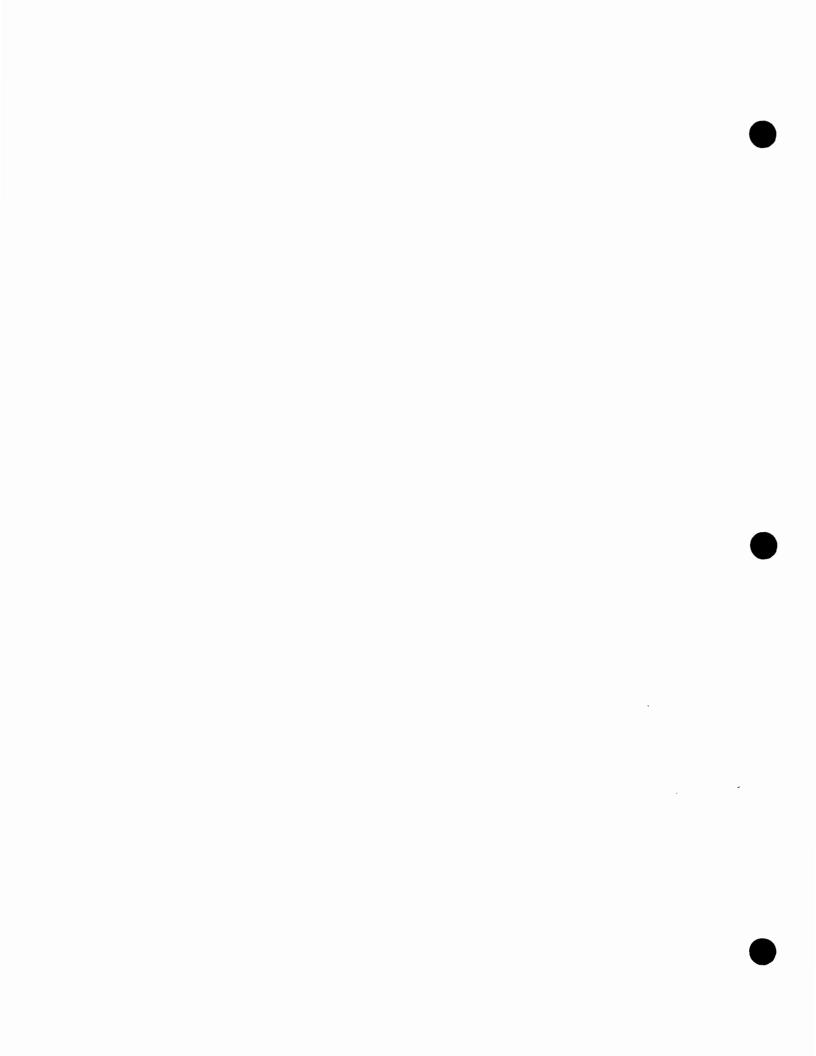
Representative Malone explained the bill and offered an amendment which rolls the bill into a new PCS. Rep. Dobson motioned for passage of that amendment. The amendment passed. Rep. Adcock motioned for a Favorable to the Committee Substitute, Unfavorable to the Original Bill. The bill passed.

HB 411 Hypertension Awareness Day. (Representatives Carney, Murphy, Holley, Yarborough)

Representative Carney explained the bill. Rep. Ball motioned for a Favorable Report. All in favor, HB 411 passed and will be sent to Rules, Calendar, Operations of the House.

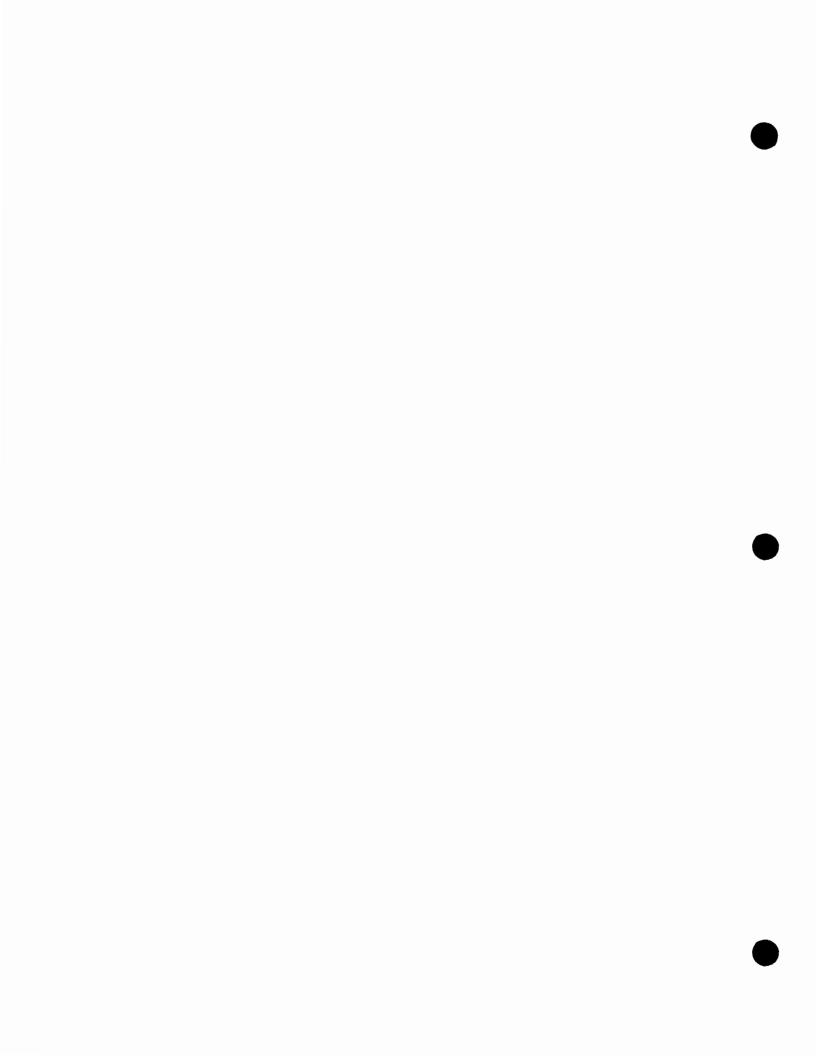
HB 657 Improve Adult Care Home Regulation. (Representatives Burr, Dobson, White, Sauls)

Representative Burr explained the bill. Rep. Dollar motioned for a Favorable Report. HB 657 passed and will be sent to Judiciary I.



The meeting adjourned at 8:50.

Representative Bert Jones, Chair Presiding



Corrected #1: Add HB 411 and HB 657

NORTH CAROLINA HOUSE OF REPRESENTATIVES COMMITTEE MEETING NOTICE AND BILL SPONSOR NOTIFICATION 2017-2018 SESSION

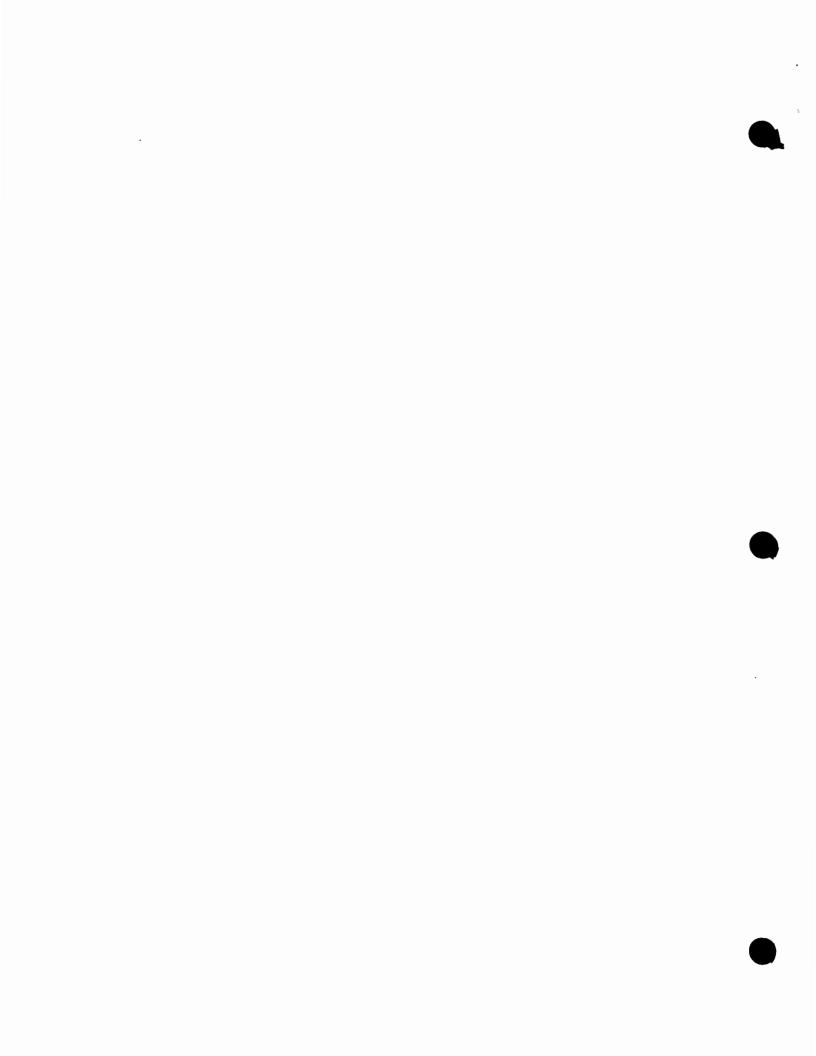
You are hereby notified that the House Committee on Health will meet as follows:

DAY & DATE: Tuesday, April 25, 2017

TIME: 8:30 AM LOCATION: 643 LOB

The following bills will be considered:

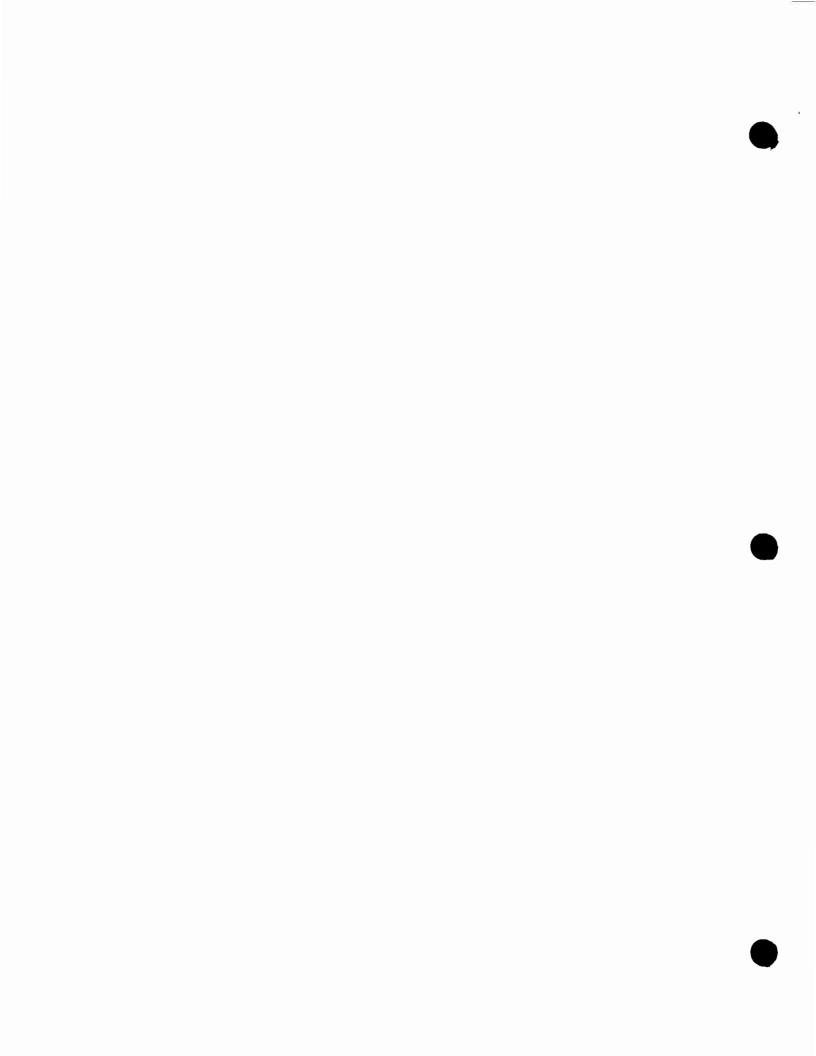
BILL NO.	SHORT TITLE	SPONSOR
<u>HB 187</u>	Modernize Physical Therapy Practice.	Representative Dollar
		Representative Torbett
		Representative S. Martin
		Representative Dobson
HB 489	Child Abuse & Neglect/Military	Representative G. Martin
	Affiliation.	Representative Szoka
		Representative Hardister
		Representative Strickland
HB 615	Amend Substance Abuse Professional	Representative Malone
	Pract. Act.	Representative S. Martin
<u>HB 411</u>	Hypertension Awareness Day.	Representative Carney
		Representative Murphy
		Representative Holley
		Representative Yarborough
<u>HB 657</u>	Improve Adult Care Home Regulation.	Representative Burr
		Representative Dobson
		Representative White
		Representative Sauls



Respectfully,

Representative Josh Dobson, Co-Chair Representative Nelson Dollar, Co-Chair Representative Bert Jones, Co-Chair Representative Donny Lambeth, Co-Chair Representative Gregory F. Murphy, MD, Co-Chair

I hereby certify this notice was filed by the committee assistant at the following offices at 3:27 PM on Tuesday, April 25, 2017.
Principal Clerk Reading Clerk – House Chamber
Brenda Olls (Committee Assistant)



House Committee on Health Tuesday, April 25, 2017, 8:30 AM 643 Legislative Office Building

AGENDA

Welcome and Opening Remarks

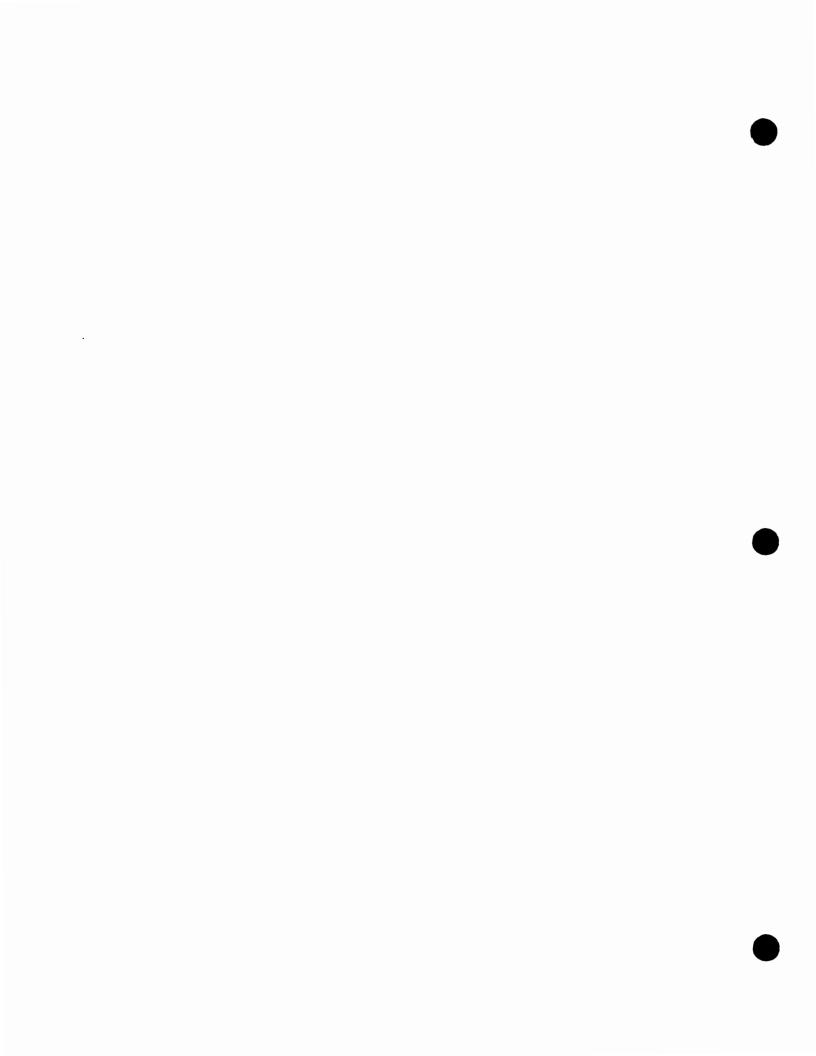
Introduction of Pages

Bills

Presentations

Other Business

Adjournment





HOUSE BILL 187: Modernize Physical Therapy Practice.

2017-2018 General Assembly

Committee: House Health Date: April 21, 2017
Introduced by: Reps. Dollar, Torbett, S. Martin, Dobson First Edition Prepared by: Gommittee Co-Counsel

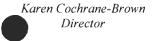
OVERVIEW: House Bill 187 would remove the prohibition on manipulation of the spine from the definition of "physical therapy" in G.S. 90-270.24(4).

[As introduced, this bill was identical to S177, as introduced by Sens. Pate, Rabin, Krawiec, which is currently in Senate Rules and Operations of the Senate.]

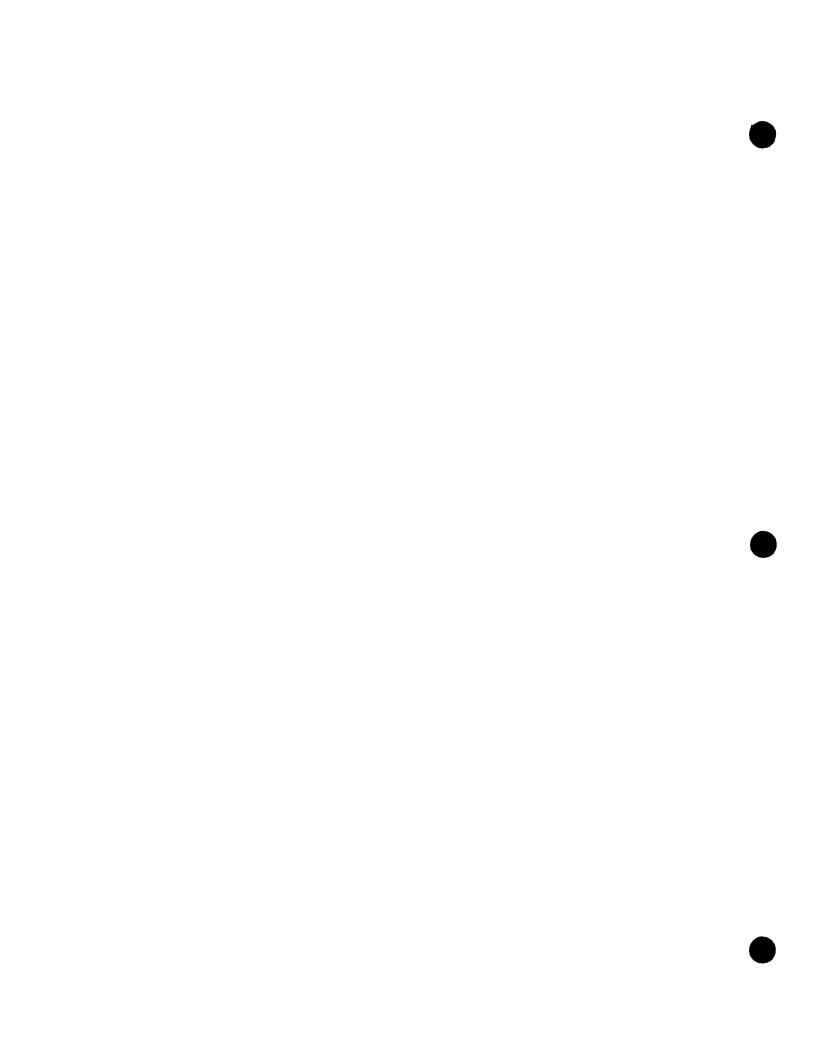
CURRENT LAW: Under current law, the practice of physical therapy does not include the manipulation of the spine, unless prescribed by a physician.

BILL ANALYSIS: The bill would amend the definition of "physical therapy" in G.S. 90-270.24(4) to remove the prohibition of manipulating the spine without a prescription from a licensed physician.

EFFECTIVE DATE: This bill would become effective on October 1, 2017.







GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2017

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HOUSE BILL 187

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Short Title: Modernize Physical Therapy Practice. (Public)

Sponsors: Representatives Dollar, Torbett, S. Martin, and Dobson (Primary Sponsors).

For a complete list of sponsors, refer to the North Carolina General Assembly web site.

Referred to: Health

February 27, 2017

A BILL TO BE ENTITLED

AN ACT UPDATING THE DEFINITION OF PHYSICAL THERAPY TO INCLUDE MANIPULATION OF THE SPINE WITHOUT A PRESCRIPTION FROM A PHYSICIAN

LICENSED TO PRACTICE MEDICINE IN THIS STATE.

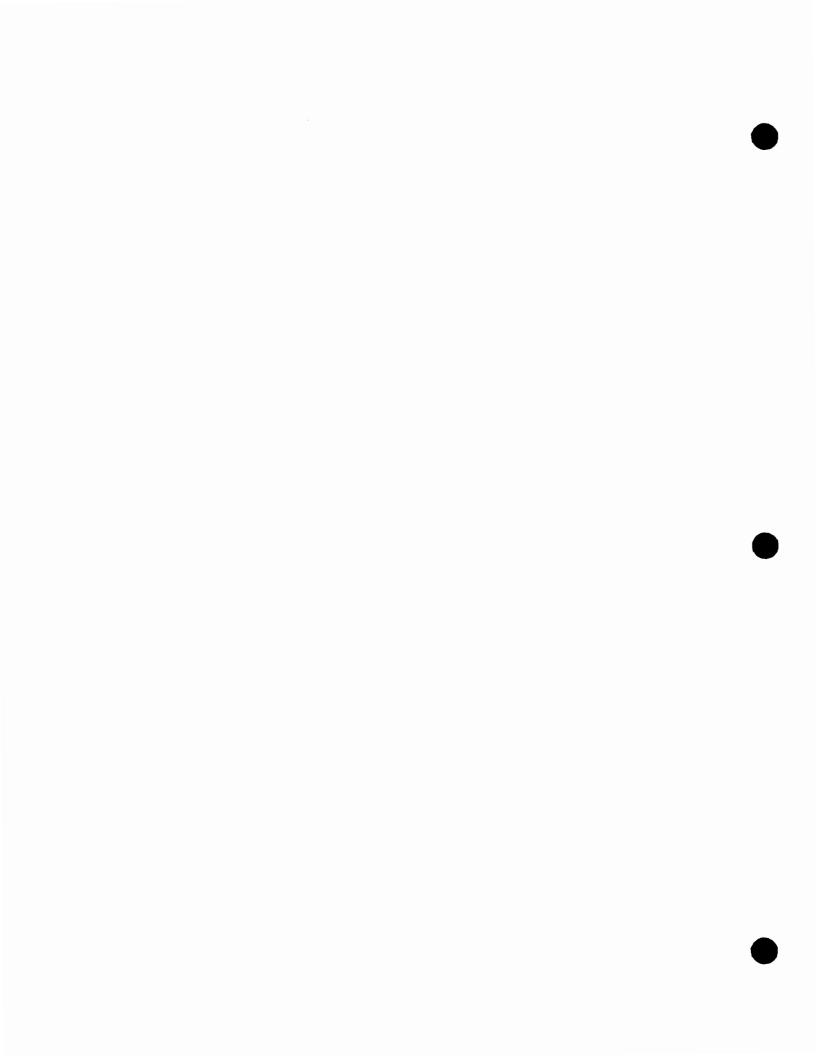
The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-270.24(4) reads as rewritten:

"Physical therapy" means the evaluation or treatment of any person by the use "(4) of physical, chemical, or other properties of heat, light, water, electricity, sound, massage, or therapeutic exercise, or other rehabilitative procedures, with or without assistive devices, for the purposes of preventing, correcting, or alleviating a physical or mental disability. Physical therapy includes the performance of specialized tests of neuromuscular function, administration of specialized therapeutic procedures, interpretation and implementation of referrals from licensed medical doctors or dentists, and establishment and modification of physical therapy programs for patients. Evaluation and treatment of patients may involve physical measures, methods, or procedures as are found commensurate with physical therapy education and training and generally or specifically authorized by regulations of the Board. Physical therapy education and training shall include study of the skeletal manifestations of systemic disease. Physical therapy does not include the application of roentgen rays or radioactive materials, surgery, manipulation of the spine unless prescribed by a physician licensed to practice medicine in North Carolina, or medical diagnosis of disease."

SECTION 2. This act becomes effective October 1, 2017.







HOUSE BILL 411: Hypertension Awareness Day.

2017-2018 General Assembly

Committee: House Health. If favorable, re-refer to Rules, Date: April 25, 2017

Calendar, and Operations of the House

Introduced by: Reps. Carney, Murphy, Holley, Yarborough Prepared by: Augustus D. Willis

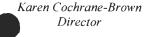
Analysis of: First Edition Committee Counsel

OVERVIEW: House Bill 411 would designate the third Wednesday in May of each year as Hypertension/High Blood Pressure Awareness Day.

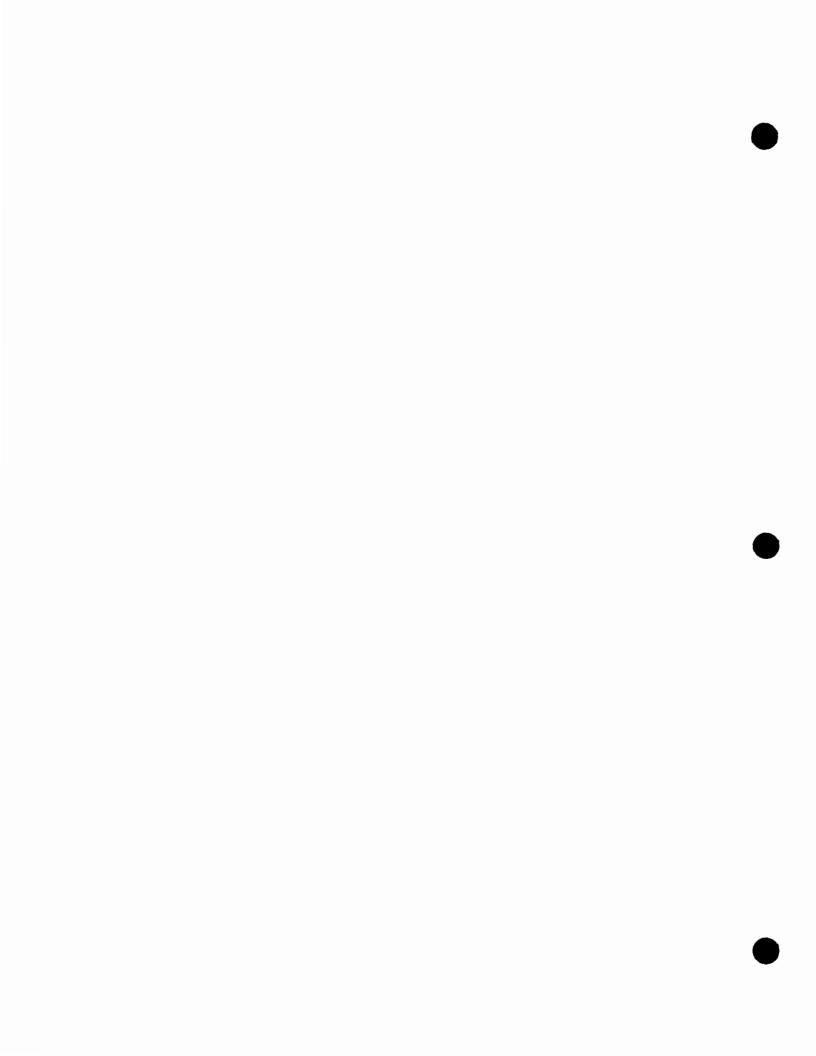
[As introduced, this bill was identical to S317, as introduced by Sens. Krawiec, Pate, Hise which is currently in Senate Rules.]

BILL ANALYSIS: House Bill 411 would add a new section to Chapter 130 of the General Statutes (Sundays, Holidays, and Special Days) to designate the third Wednesday in May of each year as Hypertension/High Blood Pressure Awareness Day in North Carolina.

EFFECTIVE DATE: This act would be effective when it becomes law.







GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2017

HOUSE BILL 411*

Hypertension Awareness Day.

(Public)

1

Sponsors:

Short Title:

H

Representatives Carney, Murphy, Holley, and Yarborough (Primary Sponsors).

For a complete list of sponsors, refer to the North Carolina General Assembly web site.

Referred to:

Health, if favorable, Rules, Calendar, and Operations of the House

March 21, 2017

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A BILL TO BE ENTITLED

AN ACT DESIGNATING THE THIRD WEDNESDAY IN MAY OF EACH YEAR AS HYPERTENSION/HIGH BLOOD PRESSURE AWARENESS DAY.

Whereas, the health of our citizens is the foundation for a caring and productive society; and our future rests with our ability to treat and ultimately to prevent a variety of illnesses including high blood pressure; and

Whereas, heart disease and stroke are the second and fourth leading causes of death in North Carolina; and high blood pressure, also known as hypertension, is a major and modifiable risk factor for heart disease and stroke and is a major contributor to adult disability; and

Whereas, in 2015, 35.2% of North Carolina adults recalled being told that they had hypertension; and

Whereas, current awareness and treatment for high blood pressure is not adequate;

and

Whereas, more than two out of every three people who have a first heart attack also have high blood pressure, and three out of every four people who have a first stroke also have high blood pressure; and

Whereas, adequate medical treatments and proven preventive health strategies that include a low-salt diet with more fruits and vegetables are beneficial; and

Whereas, patients with high blood pressure who are treated early have a longer life expectancy; and

Whereas, education can help with early diagnosis, prevention, and better treatment;

23 and24

Whereas, the Justus-Warren Heart Disease and Stroke Prevention Task Force, the American Heart Association/American Stroke Association, and the North Carolina Academy of Family Physicians are organizations that have agreed to support Hypertension/High Blood Pressure Awareness Day, scheduled for the third Wednesday in May in 2017 and continuing in perpetuity; and these partners seek ways to improve the health of the citizens of North Carolina by improving prevention and treatment of high blood pressure through support of education, advocacy, and awareness; Now therefore,

The General Assembly of North Carolina enacts:

SECTION 1. Chapter 103 of the General Statutes is amended by adding a new section to read:

"§ 103-15. Hypertension/High Blood Pressure Awareness Day.



General	Assembly	Of North	Carolina
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Session 2017

The third Wednesday in May of each year is designated as Hypertension/High Blood 1 2 Pressure Awareness Day in North Carolina." 3

SECTION 2. This act is effective when it becomes law.



HOUSE BILL 489: Child Abuse & Neglect/Military Affiliation.

2017-2018 General Assembly

Committee: House Health. If favorable, re-refer to Date: April 21, 2017

Judiciary IV

Introduced by: Reps. G. Martin, Szoka, Hardister, Strickland Prepared by: Theresa Matula

Analysis of: First Edition Committee Staff

OVERVIEW: House Bill 489 would require that when a juvenile is alleged to have been abused or neglected, directors of departments of social services must 1) determine if the parent, guardian, custodian, or caretaker of that juvenile has a military affiliation and 2) notify the appropriate military authority, including disclosing confidential information to the appropriate military authority, when there is a report or allegation of abuse or neglect relating to the parent, guardian, custodian, or caretaker with the military affiliation. This bill would become effective when it becomes law.

[As introduced, this bill was identical to S403, as introduced by Sens. Britt, J. Jackson, which is currently in Senate Rules and Operations of the Senate.]

CURRENT LAW:

G.S. 7B-101(1) defines abused juvenile.

G.S. 7B-101 (15) defines neglected juvenile.

BILL ANALYSIS:

<u>Section 1</u> of House Bill 489 would amend G.S. 7B-302 to require that in addition making a prompt and thorough assessment of the facts of the case when a report of abuse or neglect is received, the director of the department of social services must also collect information concerning the military affiliation of a parent, guardian, custodian, or caretaker of a juvenile alleged to have been abused or neglected.

Under G.S. 7B-302(a1)(1), the department is required to disclose confidential information to any federal, State, or local government entity or its agent, or any private child placing or adoption agency in order to protect a juvenile from abuse or neglect. The bill requires this disclosure to include sharing information with the appropriate military authority if the department determines the parent, guardian, custodian, or caretaker of the juvenile alleged to have been abused or neglected has a military affiliation. Under current law, any confidential information disclosed to a federal, State, or local government entity pursuant to G.S. 7B-302(a1)(1), must remain confidential with the other entity or its agent and only redisclosed for purposed directly connected with carrying out the entity's mandated responsibilities.

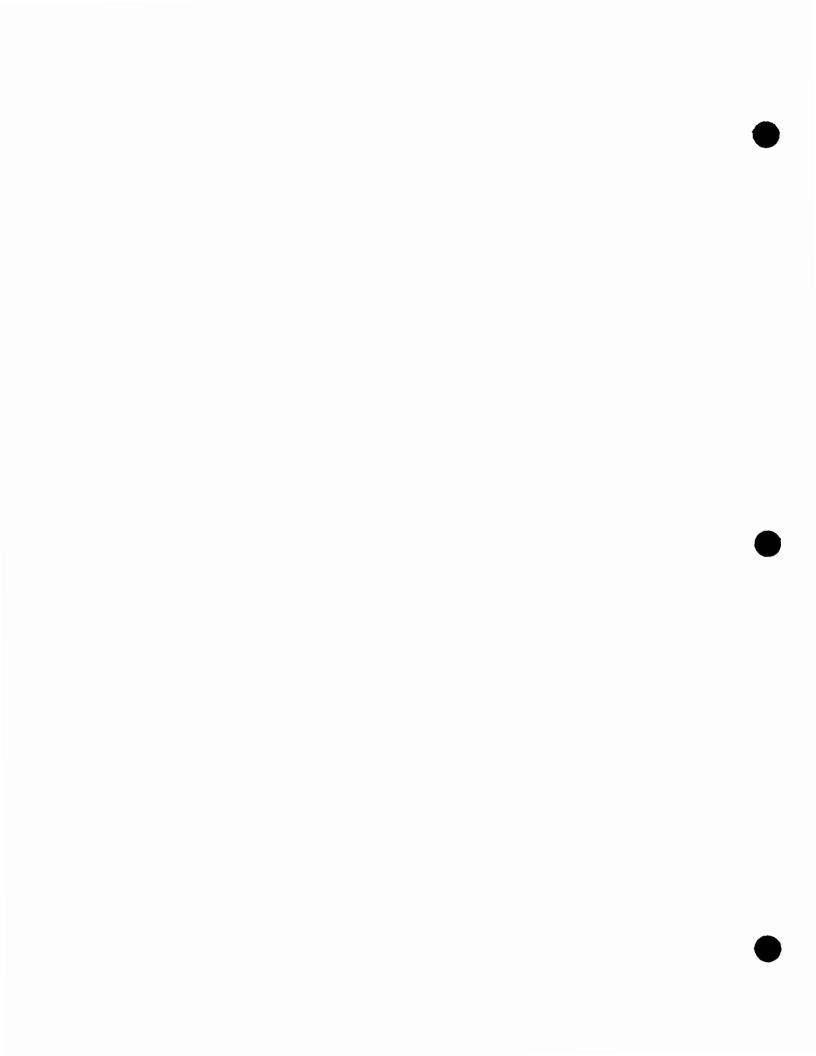
<u>Section 2</u> would amend G.S. 7B-307 to require that if a director finds evidence that a juvenile may have been abused or neglected and that juvenile has a parent, guardian, custodian or caretaker with a military affiliation, the director must notify the appropriate military authority within 48 hours that there is an allegation of abuse or neglect relating to the parent, guardian, custodian, or caretaker with a military affiliation.

EFFECTIVE DATE: House Bill 489 would become effective when it becomes law.

Karen Cochrane-Brown
Director



Legislative Analysis Division 919-733-2578



GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2017

H HOUSE BILL 489

Short Title: Child Abuse & Neglect/Military Affiliation. (Public)

Sponsors: Representatives G. Martin, Szoka, Hardister, and Strickland (Primary Sponsors).

For a complete list of sponsors, refer to the North Carolina General Assembly web site.

Referred to: Health, if favorable, Judiciary IV

March 28, 2017

A BILL TO BE ENTITLED

AN ACT AUTHORIZING A LOCAL DIRECTOR OF SOCIAL SERVICES TO DETERMINE IF A JUVENILE WHO IS ALLEGED TO HAVE BEEN ABUSED, NEGLECTED, OR DEPENDENT HAS AN ASSOCIATION WITH THE MILITARY AND TO SHARE THAT INFORMATION WITH THE APPROPRIATE MILITARY AUTHORITIES, WHEN APPLICABLE.

The General Assembly of North Carolina enacts:

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SECTION 1. G.S. 7B-302 reads as rewritten:

"§ 7B-302. Assessment by director; <u>military affiliation</u>; access to confidential information; notification of person making the report.

When a report of abuse, neglect, or dependency is received, the director of the department of social services shall make a prompt and thorough assessment, using either a family assessment response or an investigative assessment response, in order to ascertain the facts of the case, including collecting information concerning the military affiliation of the parent, guardian, custodian, or caretaker of the juvenile alleged to have been abused or neglected, the extent of the abuse or neglect, and the risk of harm to the juvenile, in order to determine whether protective services should be provided or the complaint filed as a petition. When the report alleges abuse, the director shall immediately, but no later than 24 hours after receipt of the report, initiate the assessment. When the report alleges neglect or dependency, the director shall initiate the assessment within 72 hours following receipt of the report. When the report alleges abandonment of a [juvenile] or unlawful transfer of custody under G.S. 14-321.2, the director shall immediately initiate an assessment. When the report alleges abandonment, the director shall also take appropriate steps to assume temporary custody of the juvenile, and take appropriate steps to secure an order for nonsecure custody of the juvenile. The assessment and evaluation shall include a visit to the place where the juvenile resides, except when the report alleges abuse or neglect in a child care facility as defined in Article 7 of Chapter 110 of the General Statutes. When a report alleges abuse or neglect in a child care facility as defined in Article 7 of Chapter 110 of the General Statutes, a visit to the place where the juvenile resides is not required. When the report alleges abandonment, the assessment shall include a request from the director to law enforcement officials to investigate through the North Carolina Center for Missing Persons and other national and State resources whether the juvenile is a missing child.

(a1) All information received by the department of social services, including the identity of the reporter, shall be held in strictest confidence by the department, except under the following circumstances:



 (1) The department shall disclose confidential information to any federal, State, or local government entity or its agent, or any private child placing or adoption agency licensed by the Department of Health and Human Services, in order to protect a juvenile from abuse or neglect. The disclosure of confidential information pursuant to this subdivision shall include sharing information with the appropriate military authority if the department determines the parent, guardian, custodian, or caretaker of the juvenile alleged to have been abused or neglected has a military affiliation. Any confidential information disclosed to any federal, State, or local government entity or its agent under this subsection shall remain confidential with the other entity or its agent and shall only be redisclosed for purposes directly connected with carrying out that entity's mandated responsibilities.

SECTION 2. G.S. 7B-307 reads as rewritten:

"§ 7B-307. Duty of director to report evidence of abuse, neglect; investigation by local law enforcement; <u>notification to appropriate military authority;</u> notification of Department of Health and Human Services.

(a) If the director finds evidence that a juvenile may have been abused as defined by G.S. 7B-101, the director shall make an immediate oral and subsequent written report of the findings to the district attorney or the district attorney's designee and the appropriate local law enforcement agency agency, including notifying the appropriate military authority that there is an allegation of abuse or neglect relating to the parent, guardian, custodian, or caretaker with the military affiliation, within 48 hours after receipt of the report. The local law enforcement agency shall immediately, but no later than 48 hours after receipt of the information, initiate and coordinate a criminal investigation with the protective services assessment being conducted by the county department of social services. Upon completion of the investigation, the district attorney shall determine whether criminal prosecution is appropriate and may request the director or the director's designee to appear before a magistrate.

If the director receives information that a juvenile may have been physically harmed in violation of any criminal statute by any person other than the juvenile's parent, guardian, custodian, or caretaker, the director shall make an immediate oral and subsequent written report of that information to the district attorney or the district attorney's designee and to the appropriate local law enforcement agency within 48 hours after receipt of the information. The local law enforcement agency shall immediately, but no later than 48 hours after receipt of the information, initiate a criminal investigation. Upon completion of the investigation, the district attorney shall determine whether criminal prosecution is appropriate.

If the report received pursuant to G.S. 7B-301 involves abuse or neglect of a juvenile or child maltreatment, as defined in G.S. 110-105.3, in child care, the director shall notify the Department of Health and Human Services within 24 hours or on the next working day of receipt of the report.

The director of the department of social services shall submit a report of alleged abuse, neglect, or dependency cases or child fatalities that are the result of alleged maltreatment to the central registry under the policies adopted by the Social Services Commission.

(b), (c) Repealed by Session Laws 2015-123, s. 5, effective January 1, 2016." **SECTION 3.** This act is effective when it becomes law.



HOUSE BILL 615: Amend Substance Abuse Professional Pract. Act.

2017-2018 General Assembly

Committee: House Health. If favorable, re-refer to Date: April 25, 2017

Judiciary III

Introduced by: Reps. Malone, S. Martin Prepared by: Jason Moran-Bates

Analysis of: First Edition Committee Co-Counsel

OVERVIEW: House Bill 615 would remove the certified substance abuse residential facility director credential from the North Carolina Substance Abuse Professionals Practice Act (Act). It would clarify the definition of "independent study" and add a new definition for "traditional classroom-based study." It would make changes in the composition of the North Carolina Substance Abuse Professional Practice Board (Board) and increase the number of education hours required for certain credentials. Finally, it would create a program to provide screening, referral, monitoring, education, and support services for substance abuse professionals suffering from impairment due to illness and substance abuse, or those who have engaged in professional sexual misconduct.

CURRENT LAW: Under current law, the Board can issue credentials to certified substance abuse residential facility directors, and 270 educational hours are required for certification as a substance abuse counselor, substance abuse prevention consultant, and criminal justice addiction professional. The Board is comprised of 11 professionals credentialed under the North Carolina Substance Abuse Professionals Act, three laypersons elected by the Board, two individuals from DHHS, and three members of the public, appointed by the governor, Speaker of the House, and President Pro Tempore of the Senate, respectively.

BILL ANALYSIS:

Section 1.(a)-(d) of House Bill 615 would repeal the credential for certified substance abuse residential facility directors and make conforming changes throughout the Act.

Section 2 would clarify that independent study is undertaken with little or no supervision and that it does not include study that must be approved by the Board or instruction that involves transfer of knowledge or skills from teacher to student. It also would define "traditional classroom-based study" as an educational method that involves shared communication.

Section 3.(a) would modify the membership of the Board. It would eliminate the three laypersons elected by the Board and the members of the public at large nominated by the Speaker of the House and President Pro Tempore of the Senate, respectively. It would replace these members by increasing the number of members of the public at large appointed by the governor from one to two, and by adding four professionals credentialed by the Act to be appointed by the General Assembly. Two of those members would be recommended by the Speaker of the House and two by the President Pro Tempore of the Senate.

Section 3.(b) would make the current terms of the laypersons on the Board expire on December 31, 2017, and the terms of the members appointed by the General Assembly under this bill commence on January 1, 2018.

Karen Cochrane-Brown Director



Legislative Analysis Division 919-733-2578

House Bill 615

Page 2

Sections 4 and 5 would increase the number of education hours required for credentialing as a Substance Abuse Counsellor, Substance Abuse Prevention Consultant, or Criminal Justice Addictions Professional from 270 to 300.

Section 6 would create the North Carolina Impaired Professionals Program (Program) to provide screening, referral, monitoring, education, and support services for substance abuse professionals suffering from impairment due to illness and substance abuse, or those who have engaged in professional sexual misconduct. The Program would enter into agreements with professionals credentialed under the Substance Abuse professional Practice Act to identify their ability to function in their professional capacity and coordinate regimens for treatment credentialed professionals. The Program would report to the Board about any professionals who 1) constitute an imminent danger to patient care, 2) refuse to submit to an assessment ordered by the Program, 3) fail to comply with a monitoring contract with the Program, or 4) are still unable to meet their professional obligations after completing Program services.. Information collected by the Program could not be disclosed in any civil action, and participation in the Program by credentialed professionals could not be a basis for bringing a civil action. Any written assessment made by the Program must be provided to a credentialed professional on request, and the Board would be required to adopt rules to apply to the operation of the Program.

EFFECTIVE DATE: The provisions repealing the certified substance abuse residential facility director credential would be effective when the bill becomes law, and the conforming changes would be effective when the last credential issued by the Board expires. The remainder of the bill would be effective October 1, 2017.

GENERAL ASSEMBLY OF NORTH CAROLINA **SESSION 2017**

H

HOUSE BILL 615

(Public)

1

Short Title:

Amend Substance Abuse Professional Pract. Act.

Sponsors:

Representatives Malone and S. Martin (Primary Sponsors).

For a complete list of sponsors, refer to the North Carolina General Assembly web site.

Referred to:

Health, if favorable, Judiciary III

April 10, 2017

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A BILL TO BE ENTITLED

AN ACT AMENDING THE NORTH CAROLINA SUBSTANCE ABUSE PROFESSIONAL PRACTICE ACT BY REPEALING THE CERTIFIED SUBSTANCE ABUSE RESIDENTIAL FACILITY DIRECTOR CREDENTIAL; CLARIFYING CONSTITUTES INDEPENDENT STUDY; MODIFYING THE MEMBERSHIP OF THE NORTH CAROLINA SUBSTANCE ABUSE PROFESSIONAL PRACTICE BOARD; INCREASING THE NUMBER OF BOARD-APPROVED EDUCATION HOURS REQUIRED FOR CERTIFICATION AS A SUBSTANCE ABUSE COUNSELOR, SUBSTANCE ABUSE PREVENTION CONSULTANT, OR CRIMINAL JUSTICE ADDICTIONS PROFESSIONAL; AND ESTABLISHING A PROGRAM FOR IMPAIRED SUBSTANCE ABUSE PROFESSIONALS.

The General Assembly of North Carolina enacts:

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PART I. REPEAL OF CERTIFIED SUBSTANCE ABUSE RESIDENTIAL FACILITY DIRECTOR CREDENTIAL

SECTION 1.(a) The certified substance abuse residential facility director credential is repealed. The North Carolina Substance Abuse Professional Practice Board shall no longer issue or renew a certified substance abuse residential facility director credential to any person.

SECTION 1.(b) G.S. 90-113.31A(8) and G.S. 90-113.31B are repealed.

SECTION 1.(c) G.S. 90-113.42(d) reads as rewritten:

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Only individuals registered, certified, or licensed under this Article may use the title "Certified Substance Abuse Counselor", "Certified Substance Abuse Prevention Consultant", "Certified Clinical Supervisor", "Licensed Clinical Addictions Specialist Associate", "Certified Substance Abuse Residential Facility Director", "Certified Criminal Justice Addictions Professional", "Substance Abuse Counselor Intern", "Provisional Licensed Clinical Addictions Specialist", "Clinical Supervisor Intern", or "Registrant"."

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SECTION 1.(d) G.S. 90-113.43(a) reads as rewritten:

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Except as otherwise authorized in this Article, no person shall: "(a) (1) Offer substance abuse professional services, practice, attempt to practice, or

31 32 supervise while holding himself or herself out to be a certified substance abuse counselor, certified substance abuse prevention consultant, certified clinical supervisor, licensed clinical addictions specialist, licensed clinical addictions specialist associate, certified substance abuse residential facility

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director, certified criminal justice addictions professional, clinical supervisor



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- intern, substance abuse counselor intern, or registrant without first having obtained a notification of registration, certification, or licensure from the Board.
- (2) Use in connection with any name any letters, words, numerical codes, or insignia indicating or implying that this person is a registrant, certified substance abuse counselor, certified substance abuse prevention consultant, certified clinical supervisor, licensed clinical addictions specialist, eertified substance abuse residential facility director, substance abuse counselor intern, certified criminal justice addictions professional, or licensed clinical addictions specialist associate, unless this person is registered, certified, or licensed pursuant to this Article.
- (3) Practice or attempt to practice as a certified substance abuse counselor, certified substance abuse prevention consultant, certified clinical supervisor, licensed clinical addictions specialist, certified criminal justice addictions professional, substance abuse counselor intern, licensed clinical addictions specialist associate, clinical supervisor intern, certified substance abuse residential facility director or registrant with a revoked, lapsed, or suspended certification or license.
- (4) Aid, abet, or assist any person to practice as a certified substance abuse counselor, certified substance abuse prevention consultant, certified criminal justice addictions professional, certified clinical supervisor, licensed clinical addictions specialist, certified substance abuse residential facility director, registrant, substance abuse counselor intern, licensed clinical addictions specialist associate, or clinical supervisor intern in violation of this Article.
- Knowingly serve in a position required by State law or rule or federal law or regulation to be filled by a registrant, certified substance abuse counselor, certified substance abuse prevention consultant, certified criminal justice addictions professional, certified clinical supervisor, licensed clinical addictions specialist, certified substance abuse residential facility director, substance abuse counselor intern, licensed clinical addictions specialist associate, or clinical supervisor intern unless that person is registered, certified, or licensed under this Article.
- (6) Repealed by S.L. 1997-492, s. 13.
- (7) Repealed by Session Laws 2008-130, s. 6, effective July 28, 2008."

SECTION 1.(e) Subsection (a) of this section is effective when this act becomes law. The remaining subsections of this section become effective upon the expiration of the last certified substance abuse residential facility director credential issued prior to the effective date of this act by the North Carolina Substance Abuse Professional Practice Board. The North Carolina Substance Abuse Professional Practice Board shall notify the Revisor of Statutes when the last credential issued by the Board has expired.

PART II. CLARIFICATION OF WHAT CONSTITUTES INDEPENDENT STUDY SECTION 2. G.S. 90-113.31A reads as rewritten:

The following definitions shall apply in this Article:

"§ 90-113.31A. Definitions.

(18) Independent study. — <u>Any course of Directed</u> study <u>undertaken by an individual with little or no supervision</u> that <u>is does</u> not <u>include</u> traditional classroom-based <u>study</u> that must be preapproved by the Board or any organization that has deemed status with the <u>Board-Board</u>, or any online

1 course of study that does not include a network-enabled transfer of skills and 2 knowledge from teacher to student being performed at the same time. 3 4 Traditional classroom-based study. - An educational method of learning (27) 5 involving face-to-face communication or other shared communication being 6 performed in either a shared physical setting or by audio conferencing 7 methods, video conferencing methods, or both." 8 9 PART III. MODIFICATION OF NORTH CAROLINA SUBSTANCE ABUSE 10 PROFESSIONAL PRACTICE BOARD MEMBERSHIP 11 **SECTION 3.(a)** G.S. 90-113.32(c) reads as rewritten: 12 After the initial Board members' terms expire, the Board shall consist of the following members, all of whom shall reside in North Carolina, appointed or elected as 13 14 follows: 15 (1) Eleven professionals credentialed pursuant to this Article and elected by the 16 credentialed professionals, at least two of whom shall serve each of the four 17 Division of Mental Health, Developmental Disabilities, and Substance 18 Abuse Services regions of the State. Three members shall serve as members 19 at large. 20 (2)Three members at large chosen from laypersons or other professional 21 disciplines who have shown a special interest in the field of substance abuse, 22 nominated by the Nominating and Elections Committee established by 23 subsection (d) of this section and elected by the Board. 24 (3) Two members from the Department of Health and Human Services, 25 appointed by the Chief of Community Policy Management of the Division of 26 Mental Health, Developmental Disabilities, and Substance Abuse Services, 27 at least one of whom administers substance abuse services. 28 (4) One member Two members of the public at large with personal interest in, or 29 experience with, substance use disorder recovery modalities, substance use 30 disorder prevention modalities. or both. appointed the 31 Governor. Governor. 32 (5) One member of the public at large Two professionals credentialed pursuant 33 to this Article and appointed by the General Assembly upon the 34 recommendation of the Speaker of the House of Representatives in 35 accordance with G.S. 120-121 and one member of the public at largetwo 36 professionals credentialed pursuant to this Article and appointed by the 37 General Assembly upon the recommendation of the President Pro Tempore 38 of the Senate in accordance with G.S. 120-121. 39 (6) One member shall represent each of the professional disciplines granted 40 deemed status under G.S. 90-113.41A. The member may be appointed by 41 the professional discipline on or before a date set by the Board. If the 42 professional discipline has at least one association in the State, the member 43 shall be chosen from a list of nominees submitted to the association. The 44 members appointed or elected under this subdivision shall be certified as 45 substance abuse specialists by the professional discipline that the members 46 represent. 47 No member of the General Assembly shall serve on the Board." 48 SECTION 3.(b) Notwithstanding G.S. 90-113.32(e), the terms of current members

appointed to the North Carolina Substance Abuse Professional Practice Board pursuant to

G.S. 90-113.32(c)(2) expire on December 31, 2017. The terms of members appointed to the

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North Carolina Substance Abuse Professional Practice Board pursuant to G.S. 90-113.32(c)(4) and G.S. 90-113.32(c)(5), as amended by this act, commence on January 1, 2018.

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PART IV. INCREASE IN NUMBER OF BOARD-APPROVED EDUCATION HOURS REQUIRED FOR CERTIFICATION AS A SUBSTANCE ABUSE COUNSELOR, SUBSTANCE ABUSE PREVENTION CONSULTANT, OR CRIMINAL JUSTICE ADDICTIONS PROFESSIONAL

SECTION 4. G.S. 90-113.40(a)(6) reads as rewritten:

"(6) The applicant has completed 270-300 hours of Board-approved education. The Board may prescribe that a certain number of hours be in a course of study for substance abuse counseling and that a certain number of hours be in a course of study for substance abuse prevention consulting. Independent study hours shall not compose more than fifty percent (50%) of the total number of hours required for initial credentialing."

SECTION 5. G.S. 90-113.40(d1)(1) reads as rewritten:

"(1) Has attained 270-300 hours of Board-approved education or training, unless the applicant has attained a minimum of a masters degree with a clinical application and a substance abuse specialty from a regionally accredited college or university whereby the applicant must only obtain 180 hours. The hours of education shall be specifically related to the knowledge and skills necessary to perform the tasks within the International Certification and Reciprocity Consortium/Alcohol and Other Drug Abuse, Incorporated, "IC&RC/AODA, Inc.," criminal justice addictions professional performance domains as they relate to both adults and juveniles. Independent study may compose up to fifty percent (50%) of the total number of hours obtained for initial certification or renewal."

PART V. ESTABLISHMENT OF PROGRAM FOR IMPAIRED SUBSTANCE ABUSE PROFESSIONALS

SECTION 6. Article 5C of Chapter 90 of the General Statutes is amended by adding a new section to read:

"§ 90-113.48. Program for impaired substance abuse professionals.

- (a) There is created the North Carolina Impaired Professionals Program. The Board may provide funds for the administration of the Program, but the Program shall operate independently of the Board. The purpose of the Program is to provide screening, referral, monitoring, educational, and support services for professionals credentialed pursuant to this Article by reason of an impairment attributed to a physical or mental illness, a substance use disorder, or professional sexual misconduct.
- (b) The Program may enter into an agreement with one or more professionals credentialed pursuant to this Article for the purposes of identifying, reviewing, and evaluating the ability of substance abuse professionals who are referred or self-referred to the Program to (i) function in their professional capacity and (ii) coordinate regimens for treatment and rehabilitation.
- (c) An agreement entered into between the Program and a credentialed professional pursuant to subdivision (b)(2) of this section shall include guidelines for all of the following:
 - (1) Enrollment of credentialed professionals referred to the Program by the Board.
 - (2) Assessment, referral, monitoring, support, and education of credentialed professionals referred to the Program by reason of a physical or mental illness, a substance use disorder, or professional sexual misconduct.

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(h) The Board shall adopt rules to apply to the operation of the Program, with provisions for at least all of the following:

(1) Definitions of impairments attributed to physical or mental illness, substance

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use disorder, and professional sexual misconduct.

(2) Guidelines for Program elements.

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(3) Procedures for receipt and use of information of suspected impairment.
 (4) Procedures for intervention and referral.

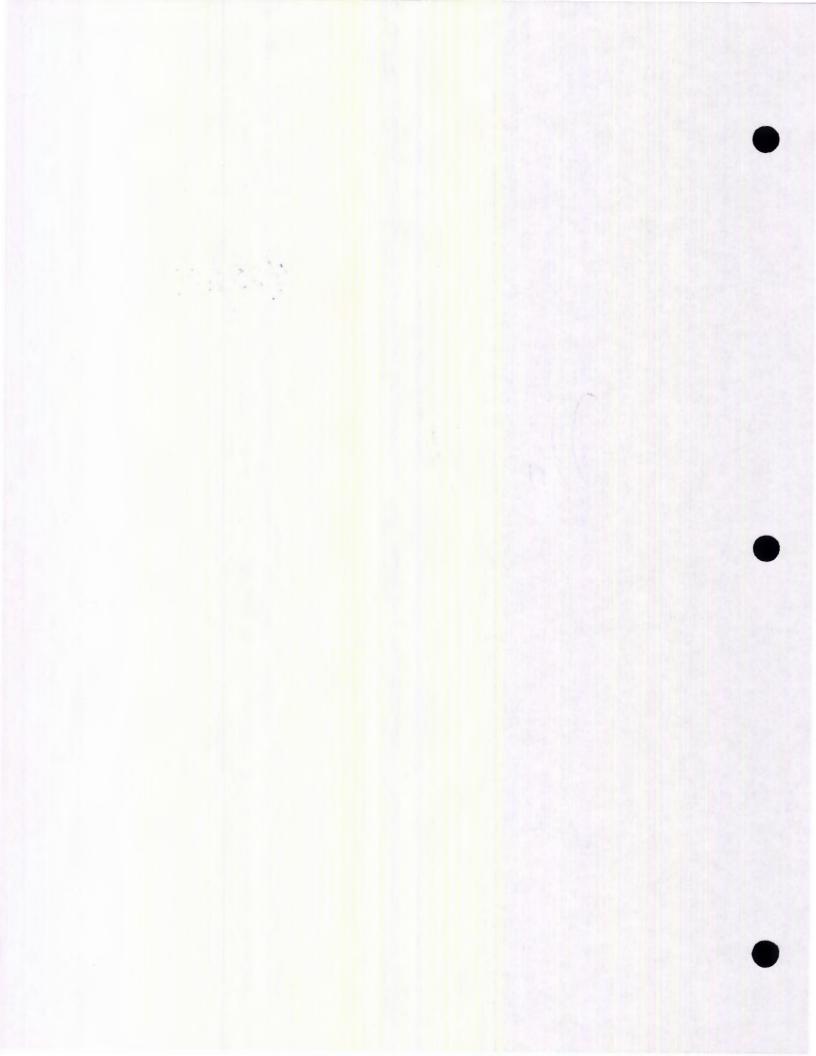
Genera	l Assem	oly Of North Carolina	Session 2017
	(5)	Arrangements for monitoring treatment, rehabi	litation, posttreatment
		support, and performance.	-
	(6)	Reports of individual cases to the Board.	
	(7)	Periodic reporting of statistical information.	
	(8)	Assurance of confidentiality of nonpublic information	<u>ı.</u> "
PART	VI. EFF	ECTIVE DATE	
	SEC'	FION 7. Except as otherwise provided, this act become	nes effective October 1,
2017.			



NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT House Bill 615

	AMENDMENT NO
	(to be filled in by
H615-ABC-14 [v.1]	Principal Clerk)
	Page 1 of 1
Amanda Tidla DIOI	Date 4/25/2017 ,2017
First Edition	Date
Representative Malone	
"SECTION 1.(b) 6.8. 90-113.31A(8) and G.S.	6. 90-113.31B(5) are repealed."
/ / /	
Amendment Spon	sor
SIGNED	
Committee Chair if Senate Comm	nittee Amendment
ADOPTED EALLED	TARLED
	Amends Title [NO] First Edition Representative Malone moves to amend the bill on page 1, line 20, by "SECTION 1.(b) 6, S. 90-113.31A(8) and G.S. SIGNED Amendment Spon







HOUSE BILL 657: Improve Adult Care Home Regulation.

2017-2018 General Assembly

Committee: House Health. If favorable, re-refer to Date: April 24, 2017

Judiciary I

Introduced by: Reps. Burr, Dobson, White, Sauls Prepared by: Theresa Matula

Analysis of: Second Edition Committee Staff

OVERVIEW: House Bill 657 makes the following changes pertaining to adult care homes: exempts from certificate of need review the acquisition of certain unlicensed adult care homes; implements an informal dispute resolution process for certain findings; changes the training requirements for personal care aides; makes changes to the star-rating program; and requires the Department of Health and Human Services to study the Stat Rated Certificate Program.

CURRENT LAW:

Adult Care Home – Defined in G.S. 131D-2.1(3) as an assisted living residence in which the housing management provides 24-hour scheduled and unscheduled personal care services to two or more residents, either directly or for scheduled needs, through formal written agreement with licensed home care or hospice agencies. Some licensed adult care homes provide supervision to persons with cognitive impairments. Adult care homes that provide care to two to six unrelated residents are commonly called family care homes.

<u>G.S. 131E-184</u> – Allows the Department of Health and Human Services to exempt from certificate of need review a new institutional health service if notice is received that certain specified conditions exist.

BILL ANALYSIS: Section 1 of HB 657 would amend G.S. 131D-2.4 which pertains to the licensure of adult care homes. Subsection (a) would be amended to provide that a facility not currently licensed as an adult care home but licensed as such in the preceding 12 months, is considered and existing health service facility under G.S. 131E-184(a)(8).

Subsection (c) of G.S. 131D-2.4 outlines the circumstances in which new licenses are prohibited from being issued to applicants. This subsection would be amended by the bill to incorporate circumstances in which the owner, principal, or affiliate of a licensable facility was also responsible for the operation and had its license revoked; summarily suspended; was assessed a penalty for a Type A or B violation; had its license downgraded to provisional status or admissions suspended; or where fees, fine, and penalties imposed by the State against the facility have not been paid. The changes also contemplate situations where the owner, principal, or affiliate is not responsible for operation in an effort to avoid emergency resident relocation. The prohibition period on new licenses is increased in certain circumstances where the owner, principal or affiliate was also responsible for operation. A new subdivision (5) is added to prohibit a new license from being issued when the owner, principal, or affiliate is also responsible for the operation of the facility and outstanding fees, fines and penalties have not been paid.

Subsection (f) is amended to provide that the consent of the current licensee is not a required prerequisite to a change of ownership if the current licensee has been: (i) removed from the facility due to summary





Legislative Analysis Division 919-733-2578

House Bill 657

Page 2

ejectment or expedited eviction of drug traffickers and other criminals, or (ii) abandoned the facility, as determined by the reasonable discretion of the Department of Health and Human Services (DHHS).

Subsection (g) is a new subsection that provides that any applicant for licensure who wishes to contest the denial of a license is entitled to an administrative hearing as provided in Chapter 150B (Administrative Procedure). The applicant must file a petition for a contested case within 30 days after the date DHHS mails ta written notice of denial.

<u>Section 2</u> would amend G.S. 131D-2.11 pertaining to inspections, monitoring, and review by the State and county departments of social services. The section is amended to set out an "Informal Dispute Resolution – Division of Health Service Regulation" process (subsection (a2) of the current law) and an "Informal Dispute Resolution – County Department of Social Services" process (new subsection (a3). The new Informal Dispute Resolution – County Department of Social Services process provides the following:

- (1) The Division of Health Service Regulation (DHSR) and county department of social services (DSS) must jointly offer each adult care home an opportunity, at the facility's request and upon the facility's receipt of the official statement of deficiencies, to informally resolve disputed findings from inspections conducted by the county DSS that resulted in the citation of a Type A1 violation, Type A2 violation, Uncorrected Type A1, violation, Uncorrected Type A2 violation, or Uncorrected Type B violation, in accordance with the section.
- (2) Provides that failure of the DHSR and county DSS to complete informal dispute resolution timely does not delay the effective date of any enforcement action taken by the DHSR against an adult care home.
- (3) Provides that an adult care home is not entitled to seek a delay of any enforcement action against it on the grounds that the DHSR and the county DSS has not completed informal dispute resolution prior to the effective date of the enforcement action.
- (4) Provides that if an adult care home successfully demonstrates during informal dispute resolution that any of the deficiencies cited in the official statement of deficiencies should not have been cited, the county DSS shall remove the incorrectly cited deficiencies from the official statement of deficiencies and the DHSR must rescind any enforcement actions imposed on the adult care home solely as a result of the incorrectly cited deficiencies.
- (5) Requires the DHSR to make available on its Internet Web site the informal dispute resolution procedures for adult care homes.

Section 3 of the bill would amend G.S. 131D-4.3 which outlines the minimum rules that must be adopted for adult care homes by the NC Medical Care Commission. Specifically the rules pertaining to personal care aide are being amended to provide that the minimum amount of training is 80 hours regardless of whether the individual is employed in an adult care home or a family care home. (Currently, 75 hours is required for aides performing heavy care tasks and a minimum of 40 hours of training is required for all personal care aides. Also under current law, 20 of the 40 hours of training are required to be classroom training, and family care home aides that do not have heavy care residents are limited to a minimum of 20 hours of training.) The facility is allowed to exempt from the 80-hour training requirement any personal care aides who are or have been either licensed as a health care professional or listed on the Nurse Aide Registry.

<u>Section 4</u> would require the DHSR and county DSSs to establish procedures to implement the requirement of the Informal Dispute Resolution – County Departments of Social Services (G.S. 131D-2.11(a3)), contained in Section 2 of the act, 60 days after the effective date of the act (October 1, 2017). Section 4 of the bill is effective when it becomes law.

House Bill 657

Page 3

<u>Section 5</u> would amend G.S. 131D-10 which provides for the <u>adult care home rated certificates</u>. Subsection (b) of G.S. 131D-10 would be amended to provide that the DHSR must issue ratings to a facility pursuant to rules adopted by the NC Medical Care Commission based on both:

- (1) Inspections and investigations of complaints conducted pursuant to G.S. 131D-2.11 [Inspections, monitoring and review by the State and county DSSs] and G.S. 131D-26 [Enforcement and investigation] that revealed noncompliance with the statutes and rules.
- (2) The facilities participation in any quality improvement programs approved by the Department.

Subsection (c) of G.S. 131D-10 that currently requires Type A penalties to affect the rating for 24 months and Type B penalties to affect the rating for 12 months is being repealed.

A new subsection (c1) would be added to require DHSR to issue a star rating to a facility within 45 days from the date the Division mails the survey or inspection report to the facility, except when a request for an informal dispute resolution is made. If a facility makes a timely request for an informal dispute resolution, the DHSR must issue a star rating to the facility within 15 days from the date the Division mails the decision to the facility.

Subsection (d) would amend the availability of the rating information to require each facility rating and specific information regarding the basis for calculating each facility rating to be available free of charge on the DHSR Web site.

<u>Section 6</u> of the bill would require DHHS to conduct a study of the <u>North Carolina Star Rated Certificate Program</u>. The study must (i) evaluate the effectiveness of the program in providing information to consumers of adult care home services, (ii) examine potential evidence-based alternatives, and (iii) make recommendations for any regulatory or legislative changes that could result in improvement of the current system. By February 1, 2018, the Department is required to report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division on the progress of the study. By October 1, 2018, the Department must conclude the study and report its findings and recommendations, including any recommendations for regulatory or legislative changes, to the Oversight Committee and the Fiscal Research Division. Section 6 becomes effective when the bill becomes law.

<u>Section 7</u> would amend G.S. 131E-184(a)(8) pertaining to the exemption from certificate of need to provide that a facility not currently licensed as an adult care home that was licensed as an adult care home within the preceding 12 months is considered an existing health service facility for purposes of the subdivision when acquiring an existing health service facility, including equipment owned by the health service facility at the time of acquisition. (This conforms to the changes in Section 1 of the bill in G.S. 131D-2.4(a).) Section 7 becomes effective when the bill becomes law.

EFFECTIVE DATE: Except as otherwise provided, the bill would become effective October 1, 2017.

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GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2017

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HOUSE BILL 657 Committee Substitute Favorable 4/20/17

Short Title:	Improve Adult Care Home Regulation.	(Public)
Sponsors:		
Referred to:		

April 11, 2017

A BILL TO BE ENTITLED

AN ACT MODIFYING THE LAWS PROHIBITING ISSUANCE OF ADULT CARE HOME LICENSES DUE TO PRIOR VIOLATIONS; EXEMPTING FROM CERTIFICATE OF NEED REVIEW NEW INSTITUTIONAL HEALTH SERVICES INVOLVING THE ACQUISITION OF AN UNLICENSED ADULT CARE HOME THAT WAS PREVIOUSLY LICENSED; ESTABLISHING A PROCESS FOR ADULT CARE HOMES TO REQUEST INFORMAL DISPUTE RESOLUTION OF CERTAIN ADVERSE INSPECTION FINDINGS BY COUNTY DEPARTMENTS OF SOCIAL SERVICES PRIOR TO IMPOSITION OF A PENALTY OR ISSUANCE OF A STAR RATING CERTIFICATE BASED ON THE ADVERSE INSPECTION FINDINGS; AMENDING THE RULES PERTAINING TO MINIMUM TRAINING FOR PERSONAL CARE AIDES; ELIMINATING THE TWELVE- TO TWENTY-FOUR-MONTH PENALTY ON ADULT CARE HOME STAR RATINGS; AND DIRECTING THE

PROGRAM FOR ADULT CARE HOMES.
The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131D-2.4 reads as rewritten:

"§ 131D-2.4. Licensure of adult care homes for aged and disabled individuals; impact of prior violations on licensure; compliance history review; license renewal.

DEPARTMENT OF HEALTH AND HUMAN SERVICES TO STUDY THE

EFFECTIVENESS OF THE NORTH CAROLINA STAR-RATED CERTIFICATE

- (a) Licensure. Except for those facilities exempt under G.S. 131D-2.3, the Department of Health and Human Services shall inspect and license all adult care homes. The Department shall issue a license for a facility not currently licensed as an adult care home for a period of six months. If the licensee demonstrates substantial compliance with Articles 1 and 3 of this Chapter and rules adopted thereunder, the Department shall issue a license for the balance of the calendar year. A facility not currently licensed as an adult care home that was licensed as an adult care home within the preceding 12 months is considered an existing health service facility for the purposes of G.S. 131E-184(a)(8).
- (b) Compliance History Review. Prior to issuing a new license or renewing an existing license, the Department shall conduct a compliance history review of the facility and its principals and affiliates. The Department may refuse to license a facility when the compliance history review shows a pattern of noncompliance with State law by the facility or its principals or affiliates, or otherwise demonstrates disregard for the health, safety, and welfare of residents in current or past facilities. The Department shall require compliance history information and make its determination according to rules adopted by the Medical Care Commission.





NORTH CAROLINA GENERAL ASSEMBLY HOUSE OF REPRESENTATIVES

HEALTH COMMITTEE REPORT

Representative Josh Dobson, Co-Chair Representative Nelson Dollar, Co-Chair Representative Bert Jones, Co-Chair Representative Donny Lambeth, Co-Chair Representative Gregory F. Murphy, MD, Co-Chair

FAVORABLE

HB 187 Modernize Physical Therapy Practice.

Draft Number:

None

Serial Referral:

None

Recommended Referral: None

No

Long Title Amended:

Floor Manager:

Dollar

FAVORABLE AND RE-REFERRED

HB 411

Hypertension Awareness Day.

Draft Number:

None

Serial Referral:

RULARS, CALBUSDAR, AND

OPERATIONS OF THE HOUSE

Recommended Referral:

None

Long Title Amended:

No

Floor Manager:

Carney

HB 489 Child Abuse & Neglect/Military Affiliation.

Draft Number:

None

Serial Referral:

JUDICIARY IV

Recommended Referral:

None

Long Title Amended:

No

Floor Manager:

G. Martin

HB 657 (CS#1) Improve Adult Care Home Regulation.

Draft Number:

None

Serial Referral: JUDICIARY I

Recommended Referral: None Long Title Amended:

No

Floor Manager:

Burr



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FAVORABLE COM SUB, UNFAVORABLE ORIGINAL BILL

HB 615 Amend Substance Abuse Professional Pract. Act.

Draft Number: H615-PCS30391-BC-18

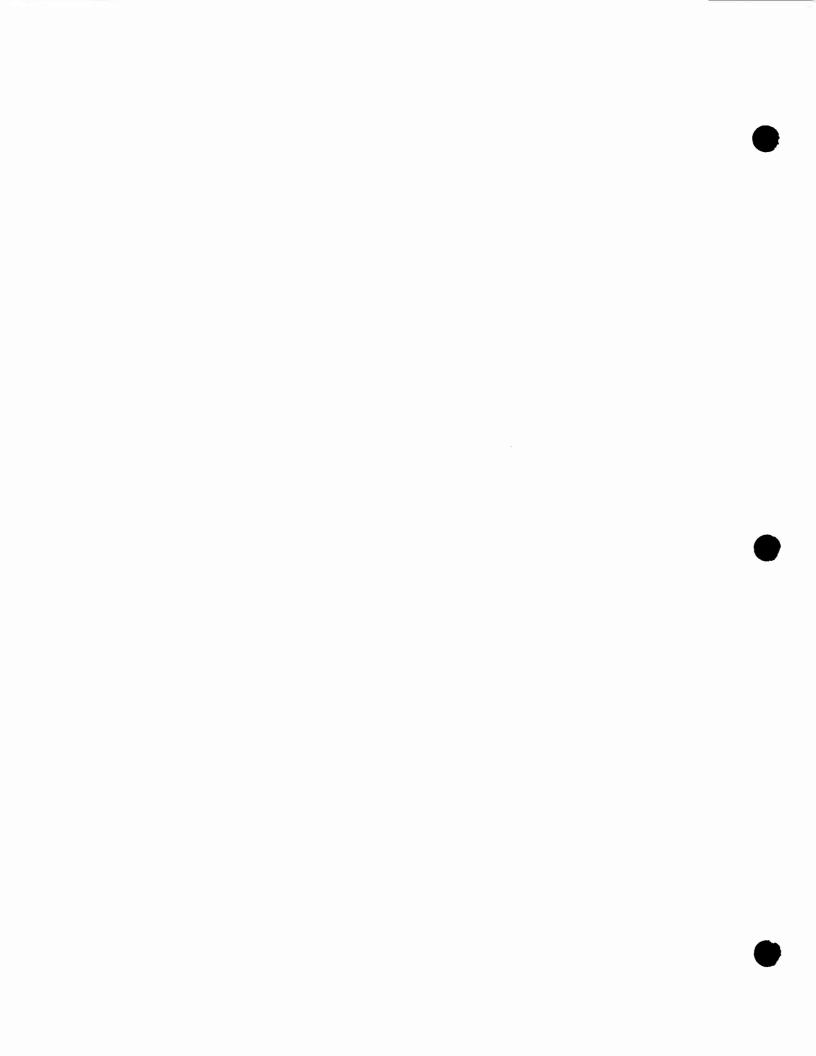
Serial Referral: None
Recommended Referral: None
Long Title Amended: No
Floor Manager: Malone

TOTAL REPORTED: 5



Committee Sergeants at Arms

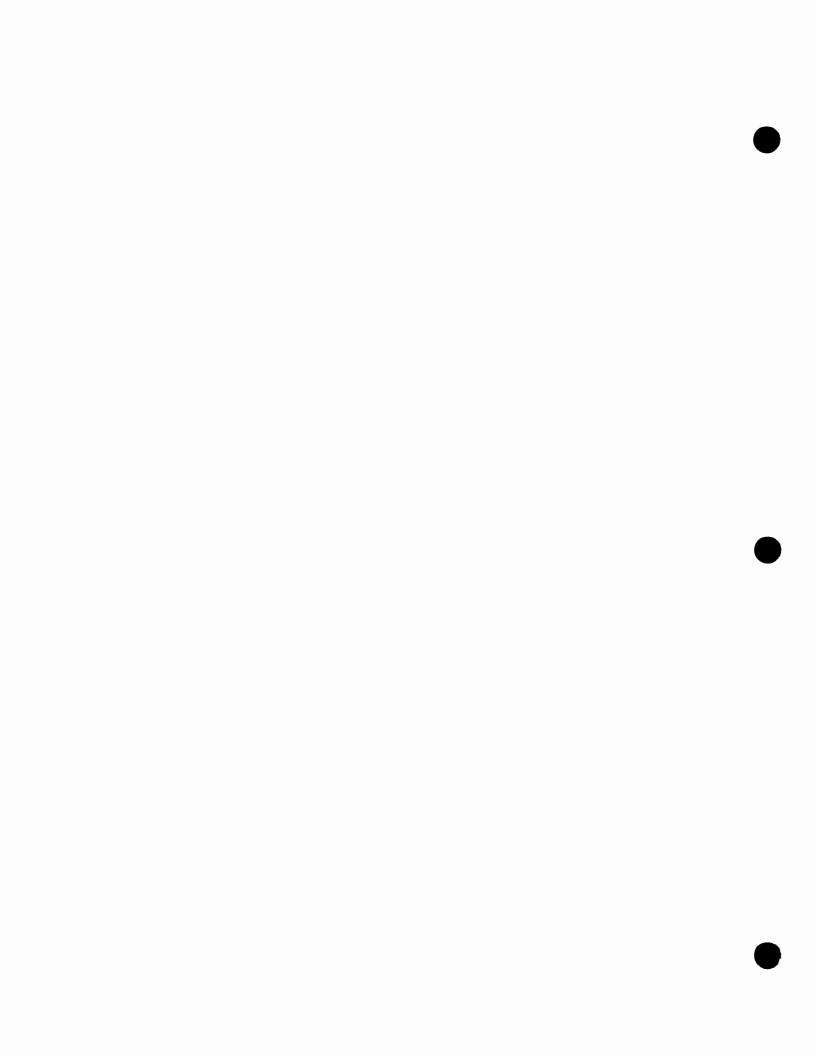
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DATE:04/2	25/17	Room:	643
		House Sgt-At Ar	'mic'
1. Name: YOU	ng Bae		
2. Name: <u>Jim</u>	Moran		
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HOUSE PAGES

Health

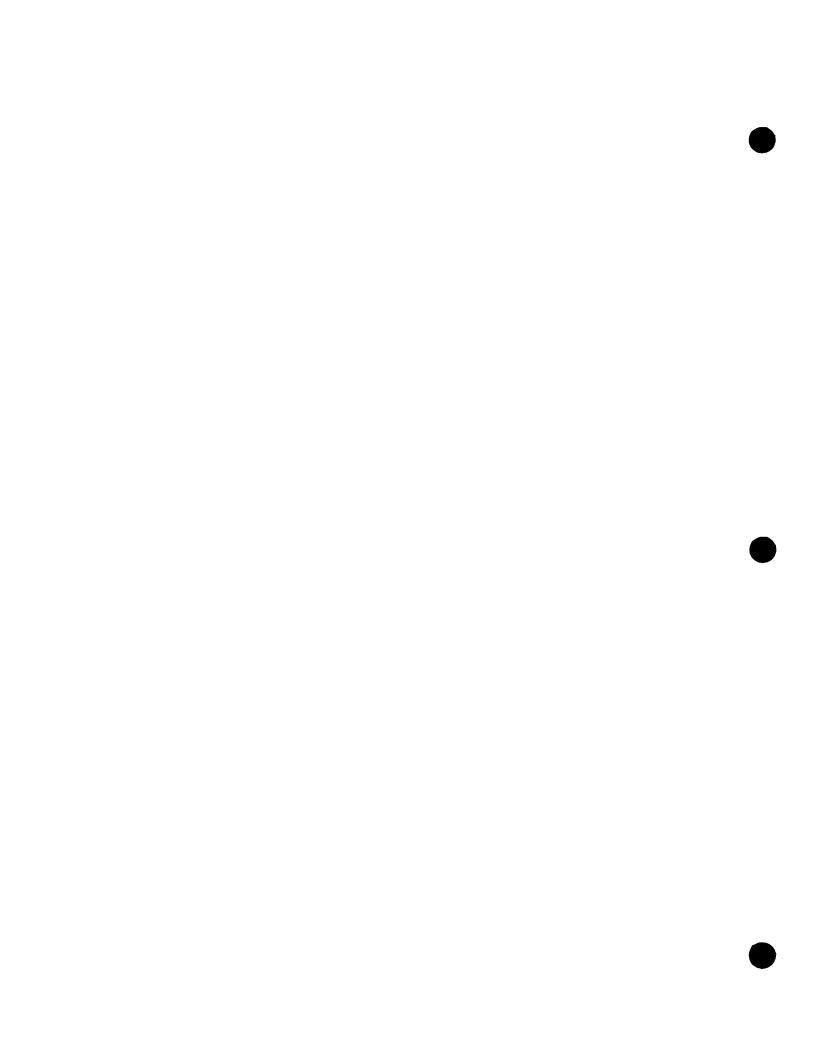
Name:	County:	Sponsor:
Christopher Barber	Johnston	Donna White
Claire Morris-Benedict	Durham	Mickey Michaux, Jr.
Marko Stefanovic	Union	Speaker Tim Moore



House Comm. on Health

04/25/17

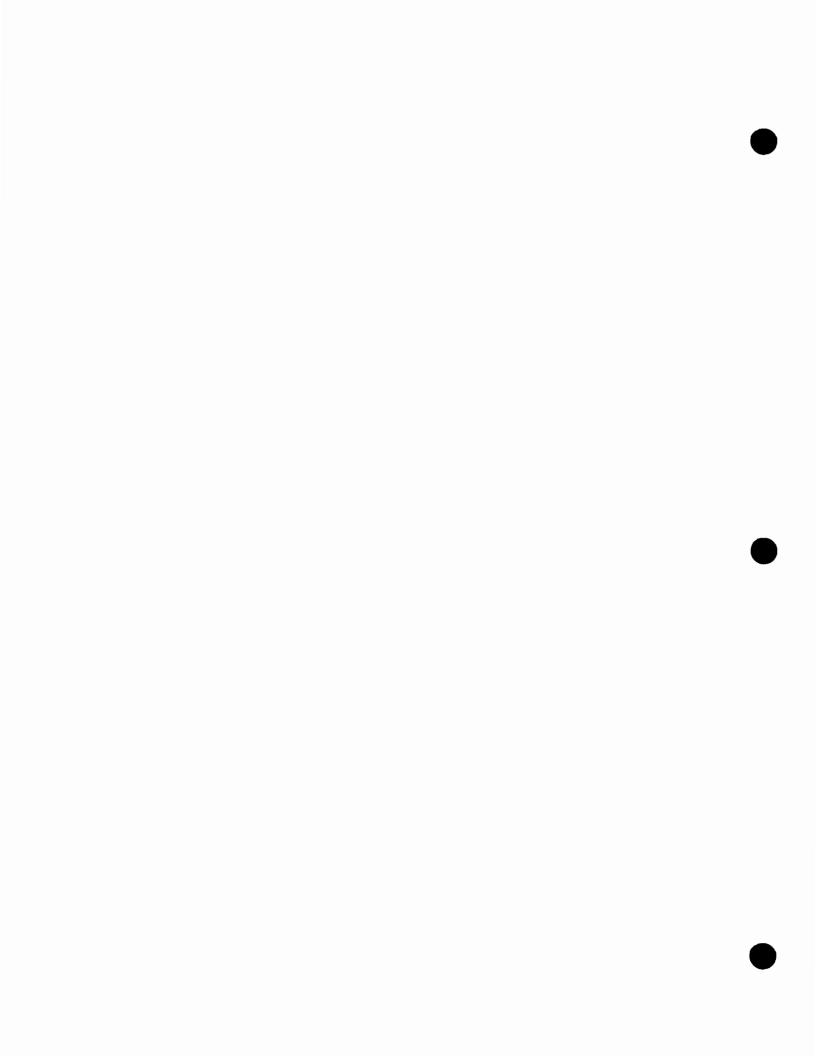
NAME	FIRM OR AGENCY AND ADDRESS
Barden Colbreth	NCSAPPB
Davy Elis	P. Charan.
Man Miller	AMGA
Deborah Giving	NCPTA
HonryBrework	MD
Duncon Berry	MD
Mary Kary Harnan	NCPTA
Nancy Garland	NCPTA
Kyle Courston	NCPTA
Fran Bonn	MD (MCSEPS)
Chad Brasington	MD NUSEPS
Hall Johan	NAU



House Comm. on Health Name of Committee

04/25/17

NAME	FIRM OR AGENCY AND ADDRESS	
JAMES BRYAN	MO NESEPS	
Caroline Miller	AMGA	
Christine Lee	MD NESERS	
Chris Proventon	MNC	
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House Comm. on Health

04/25/17

NAME	FIRM OR AGENCY AND ADDRESS
7622 C000 MON	DH45/D45R
Megan Lamphere	DHHs / DHSR
Adrian Dellinger	NCDOJ/Coursel for DHHS
Parcy truly	500
	84
Sarall Gillooly	ACLU
THEEN3	CS5
Alex Tomson	AARP
Truman Adoodle	Caromona Health
George Adoock MD	Carment Health
Bre Hager	CaroMont

House Comm. on Health

04/25/17

Name of Committee

Date

NAME	FIRM OR AGENCY AND ADDRESS
Omanda Daravar	KTS

House Committee on Health Wednesday, April 26, 2017 at 11:00 AM Room 643 of the Legislative Office Building

MINUTES

The House Committee on Health met at 11:00 AM on April 26, 2017 in Room 643 of the Legislative Office Building. Representatives Adcock, Ball, Blackwell, Boswell, Burr, Cunningham, Dobson, Dollar, Dulin, Earle, Farmer-Butterfield, Ford, Hunter, Insko, Jackson, Lambeth, Lucas, Murphy, Potts, Setzer, Shepard, Szoka, White, and Yarborough attended.

Representative Nelson Dollar, Chair, presided.

The following bills were considered:

HB 512 Monitor Implementation of TBI Waiver. (Representative Torbett)

There is a PCS for HB512. Representative Blackwell motions for the PCS to be heard and hearing no objections Representative Torbett was recognized to explain the bill.

HB 512 would require the Department of Health and Hurnan Services to report quarterly on the status and implementation of the 1915(c) waiver for individuals with traumatic brain injury (TBI) to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice; the Joint Legislative Oversight Committee on Health and Human Services; the chairs of the Senate Appropriations Committee on Health and Human Services; the chairs of the House of Representatives Committee on Appropriations, Health and Human Services; and the Fiscal Research Division. The Department is also required to adopt rules or medical coverage policies relating to service programs for individuals with TBI, develop a best practice model and strive to maintain adequate reimbursement rates.

Representative Insko makes a motion for an unfavorable report to the original bill favorable to the PCS. The motion carries.

HB 466 The Pharmacy Patient Fair Practices Act. (Representative Brenden Jones)

Representative B. Jones was recognized to explain the bill.

House Bill 466 would permit pharmacists to discuss lower-cost alternative drugs with, and sell lower-cost alternative drugs to, consumers. It would prohibit pharmacy benefits managers from using contract terms to prevent pharmacies from providing store direct delivery services. Pharmacy benefits managers would be prohibited from charging insureds a co-pay that exceeds the total submitted charges by a network pharmacy. Finally, it would allow pharmacy benefits managers to charge pharmacies a fee for costs related to claim adjudication only if the fee was set out in a contract or reported on the remittance advice of the claim.

Representative Lucas makes a motion for a favorable report. The motion carries.

HB 683 Indian Child Welfare Agreement Form. (Representative C. Graham)

There is a PCS to HB 683. Representative Potts makes the motion for the PCS to be heard and hearing no objections Representative C. Graham was recognized to explain the bill.

House Bill 683 requires the Division of Social Services in the Department of Health and Human Services to develop a standard form to be used to establish agreements with state recognized Indian tribes on behalf of Indian children under their authority involved in matters of foster care, adoption assistance, and kinship guardianship assistance programs under Title IV-E of the Social Security Act.

Representative Earle makes a motion for an unfavorable report to the original bill favorable to the PCS. The motion carries.

The meeting adjourned at 10:40.

Representative Welson Dollar, Chair

Presiding

Theresa Lopez, Committee Clerk

Corrected #1: Added HB 466 and HB 683

NORTH CAROLINA HOUSE OF REPRESENTATIVES COMMITTEE MEETING NOTICE AND BILL SPONSOR NOTIFICATION 2017-2018 SESSION

You are hereby notified that the House Committee on Health will meet as follows:

DAY & DATE: Wednesday, April 26, 2017

TIME: 11:00 AM LOCATION: 643 LOB

The following bills will be considered:

BILL NO.	SHORT TITLE	SPONSOR
HB 512	Monitor Implementation of TBI	Representative Torbett
	Waiver.	
HB 466	The Pharmacy Patient Fair Practices	Representative Brenden Jones
	Act.	•
HB 683	Indian Child Services Changes.	Representative C. Graham

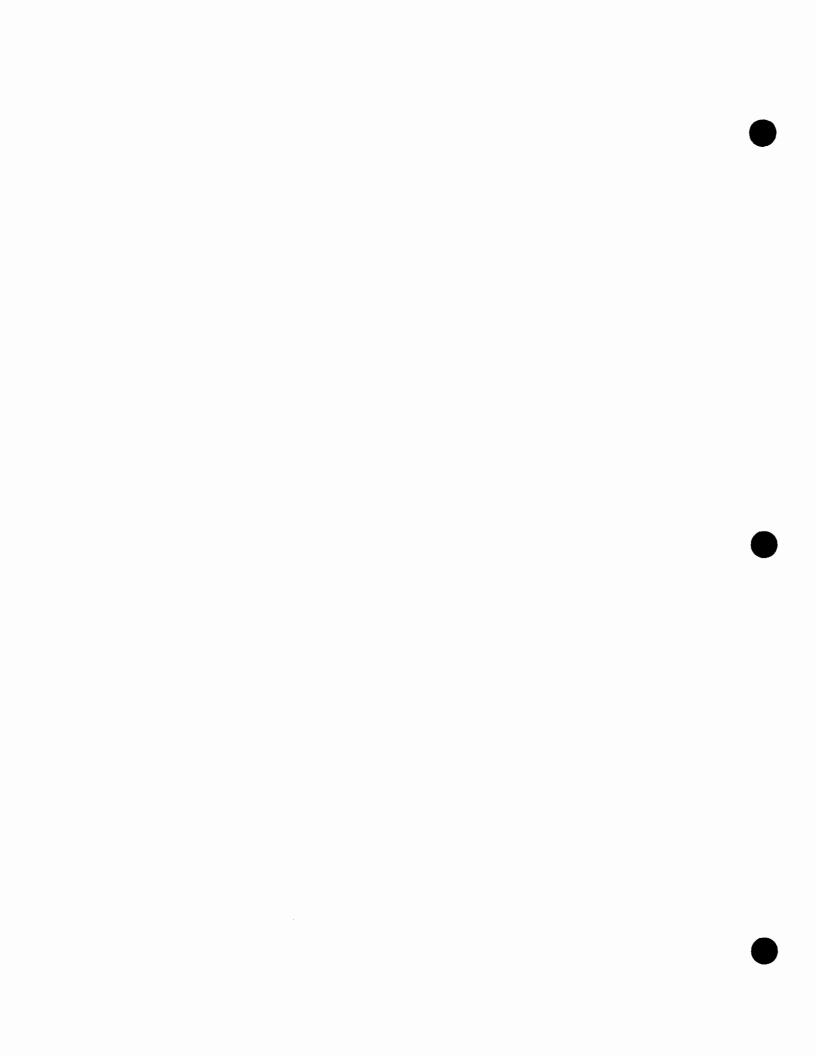
Respectfully,

Representative Josh Dobson, Co-Chair Representative Nelson Dollar, Co-Chair Representative Bert Jones, Co-Chair Representative Donny Lambeth, Co-Chair Representative Gregory F. Murphy, MD, Co-Chair

I hereby certify this notice was filed by the committee assistant at the following offices at 10:10 AM on Wednesday, April 26, 2017.

	Principal Clerk
	Reading Clerk - House Chamber

Brenda Olls (Committee Assistant)



NORTH CAROLINA HOUSE OF REPRESENTATIVES COMMITTEE MEETING NOTICE AND BILL SPONSOR NOTIFICATION 2017-2018 SESSION

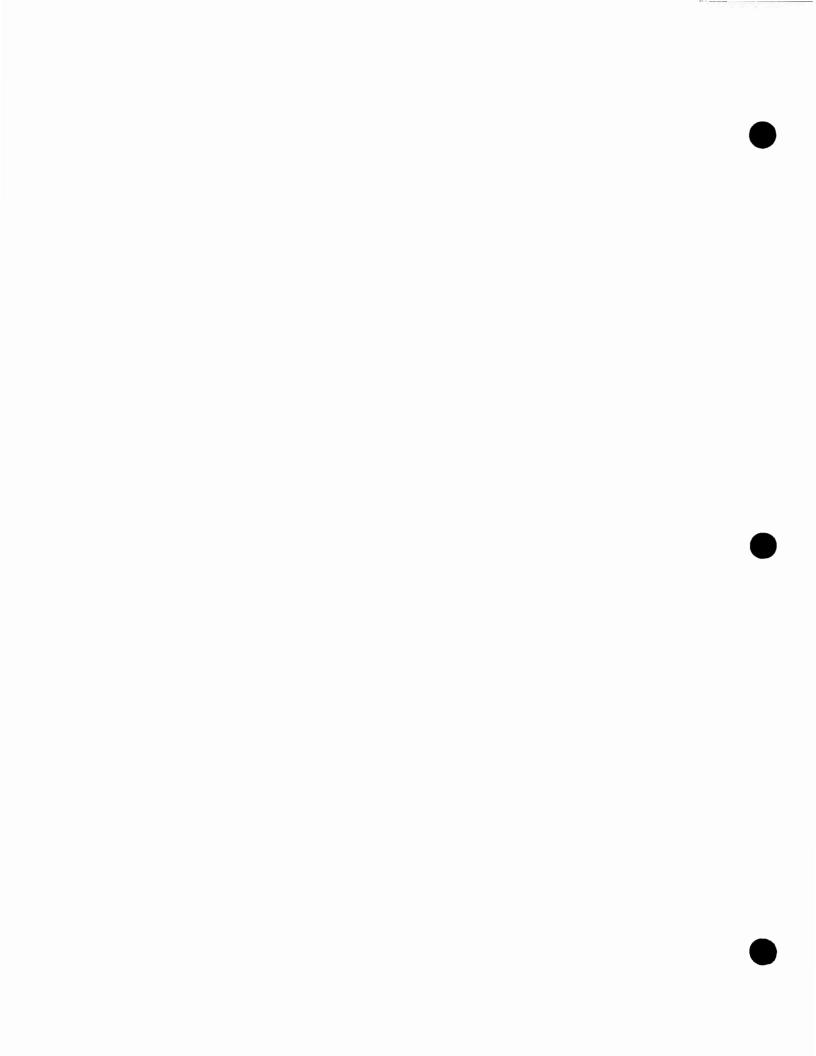
You are hereby notified that the House Committee on Health will meet as follows:

DAY & DATE: Wednesday, April 26, 2017

11:00 AM

TIME:

LOCATION	N: 643 LOB	
The followin	g bills will be considered:	
BILL NO. HB 512	SHORT TITLE Monitor Implementation of TBI Waiver.	SPONSOR Representative Torbett
		Respectfully,
		Representative Josh Dobson, Co-Chair Representative Nelson Dollar, Co-Chair Representative Bert Jones, Co-Chair Representative Donny Lambeth, Co-Chair Representative Gregory F. Murphy, MD, Co-Chair
I hereby certi Tuesday, Apr		mmittee assistant at the following offices at 3:31 PM on
	Principal Clerk Reading Clerk – House Char	mber
Brenda Olls ((Committee Assistant)	



House Committee on Health Wednesday, April 26, 2017, 11:00 AM 643 Legislative Office Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

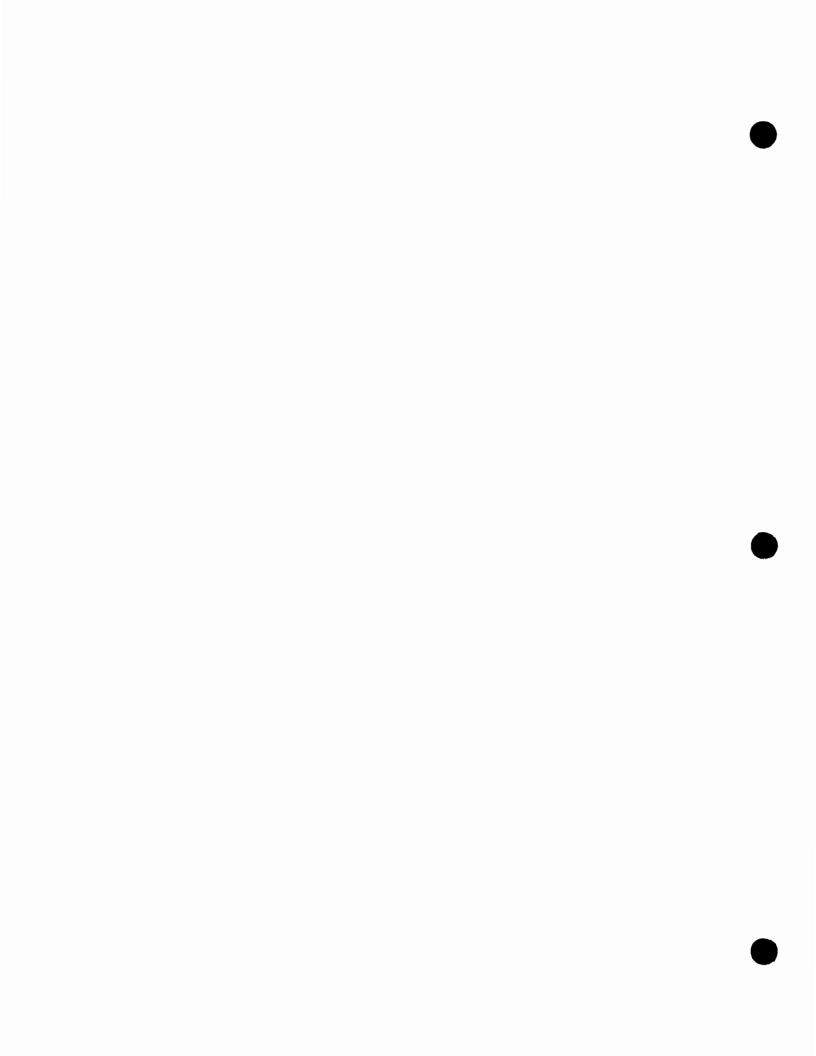
Bills

BILL NO.	SHORT TITLE	SPONSOR
HB 512	Monitor Implementation of TBI	Representative Torbett
	Waiver.	-
HB 466	The Pharmacy Patient Fair Practices	Representative Brenden Jones
	Act.	
HB 683	Indian Child Services Changes.	Representative C. Graham

Presentations

Other Business

Adjournment





HOUSE BILL 512: Monitor Implementation of TBI Waiver.

2017-2018 General Assembly

House Health Committee:

Introduced by: Rep. Torbett

PCS to First Edition Analysis of:

H512-CSSH-19

Date:

April 25, 2017

Prepared by: Theresa Matula

Committee Staff

OVERVIEW: House Bill 512 would require the Department of Health and Human Services (Department) to report quarterly on the status and implementation of the 1915(c) waiver for individuals with traumatic brain injury (TBI) to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice; the Joint Legislative Oversight Committee on Health and Human Services; the chairs of the Senate Appropriations Committee on Health and Human Services; the chairs of the House of Representatives Committee on Appropriations, Health and Human Services; and the Fiscal Research Division. The Department is also required to adopt rules or medical coverage policies relating to service programs for individuals with TBI, develop a best practice model and strive to maintain adequate reimbursement rates. The bill would become effective when it becomes law.

The PCS makes only technical changes.

House Bill 512 requires the Department of Health and Human Services **BILL ANALYSIS:** (Department) to report quarterly on the status and implementation of the 1915(c) waiver for individuals with traumatic brain injury (TBI) to the:

- Joint Legislative Oversight Committee on Medicaid and NC Health Choice;
- Joint Legislative Oversight Committee on Health and Human Services;
- Chairs of the Senate Appropriations Committee on Health and Human Services;
- Chairs of the House of Representatives Committee on Appropriations, Health and Human Services: and the
- Fiscal Research Division.

The Department is also required to do the following three things:

- 1. Adopt rules or medical coverage policies relating to service programs for individuals with TBI, including setting standards that ensure that individuals with brain injuries who require residential treatment receive appropriate, effective and high-quality treatment in community-based residential settings
- 2. Develop a best practice model system that includes a comprehensive continuum of care, shortterm and long-term treatments, rehabilitation options, and home and community support services.
- 3. Strive to maintain adequate reimbursement rates for residential and community-based care programs that serve individuals with traumatic brain injury.

EFFECTIVE DATE: House Bill 512 becomes effective when it becomes law.





Legislative Analysis Division 919-733-2578

House PCS 512

Page 2

BACKGROUND: 1915(c) Waivers for Home and Community Based Services allow states to meet the needs of people who prefer to get long-term care services and support in their home or community rather than an institutional setting.

S.L. 2015-241, Section 12H.6:

TRAUMATIC BRAIN INJURY MEDICAID WAIVER

SECTION 12H.6.(a) The Department of Health and Human Services, Division of Medical Assistance and Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (Department), shall submit to the Centers for Medicare and Medicaid Services a request for approval of the 1915(c) waiver for individuals with traumatic brain injury (TBI) that the Department designed pursuant to Section 12H.6 of S.L. 2014-100, which the Joint Legislative Oversight Committee on Health and Human Services recommended as part of its December 2014 report to the General Assembly, and which is further described in the Department's February 1, 2015, report to the General Assembly.

SECTION 12H.6.(b) The Department shall report to the Joint Legislative Oversight Committee on Health and Human Services on the status of the Medicaid TBI waiver request and the plan for implementation no later than December 1, 2015. The Department shall submit an updated report by March 1, 2016. Each report shall include the following:

- (1) The number of individuals who are being served under the waiver and the total number of individuals expected to be served.
- (2) The expenditures to date and a forecast of future expenditures.
- (3) Any recommendations regarding expansion of the waiver.

SECTION 12H.6.(c) Of the funds appropriated to the Department of Health and Human Services, Division of Medical Assistance, one million dollars (\$1,000,000) for fiscal year 2015-2016 and two million dollars (\$2,000,000) for fiscal year 2016-2017 shall be used to fund the Medicaid TBI waiver.

SECTION 12H.6.(d) The waiver and any State Plan amendments required to implement this section shall not be subject to the 90-day prior submission requirement of G.S. 108A-54.1A(e).

The NCGA received an interim report on December 1, 2015 and a final report on March 1, 2016.

GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2017

H

HOUSE BILL 512 PROPOSED COMMITTEE SUBSTITUTE H512-CSSH-19 [v.1]

D

04/25/2017 9:55:02 AM

Short Title: Monitor Implementation of TBI Waiver. (Public)

Sponsors:

Referred to:

March 29, 2017

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A BILL TO BE ENTITLED

AN ACT REGARDING IMPLEMENTATION OF THE 1915(C) MEDICAID WAIVER FOR INDIVIDUALS WITH TRAUMATIC BRAIN INJURY.

The General Assembly of North Carolina enacts:

SECTION 1. Beginning October 1, 2017, the Department of Health and Human Services (DHHS) shall report quarterly to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice, the Joint Legislative Oversight Committee on Health and Human Services, the chairs of the Senate Appropriations Committee on Health and Human Services, the chairs of the House of Representatives Committee on Appropriations, Health and Human Services, and the Fiscal Research Division on the status and implementation of the 1915(c) waiver for individuals with traumatic brain injury (TBI) that has been submitted to the Centers for Medicare and Medicaid Services in accordance with Section 12H.6 of S.L. 2015-241.

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As part of the process of implementing the TBI waiver, DHHS shall adopt rules or medical coverage policies relating to service programs for individuals with traumatic brain injury, including setting standards that ensure that individuals with brain injuries who require residential treatment receive appropriate, effective, and high-quality treatment in community-based residential settings. Additionally, DHHS shall develop a best practice model system that includes a comprehensive continuum of care and an array of short-term and long-term treatments, rehabilitation options, and home and community support services as part of the TBI waiver. Finally, DHHS shall strive to maintain adequate reimbursement rates for residential and community-based care programs that serve individuals with traumatic brain injury, which will aid in attracting and retaining quality and highly specialized providers and programs into North Carolina.

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SECTION 2. This act is effective when it becomes law.



GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2017

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HOUSE BILL 512

Short Title: Monitor Implementation of TBI Waiver. (Public)

Sponsors: Representative Torbett.

For a complete list of sponsors, refer to the North Carolina General Assembly web site.

Referred to: Health

March 29, 2017

A BILL TO BE ENTITLED

AN ACT REGARDING IMPLEMENTATION OF THE 1915(C) MEDICAID WAIVER FOR INDIVIDUALS WITH TRAUMATIC BRAIN INJURY.

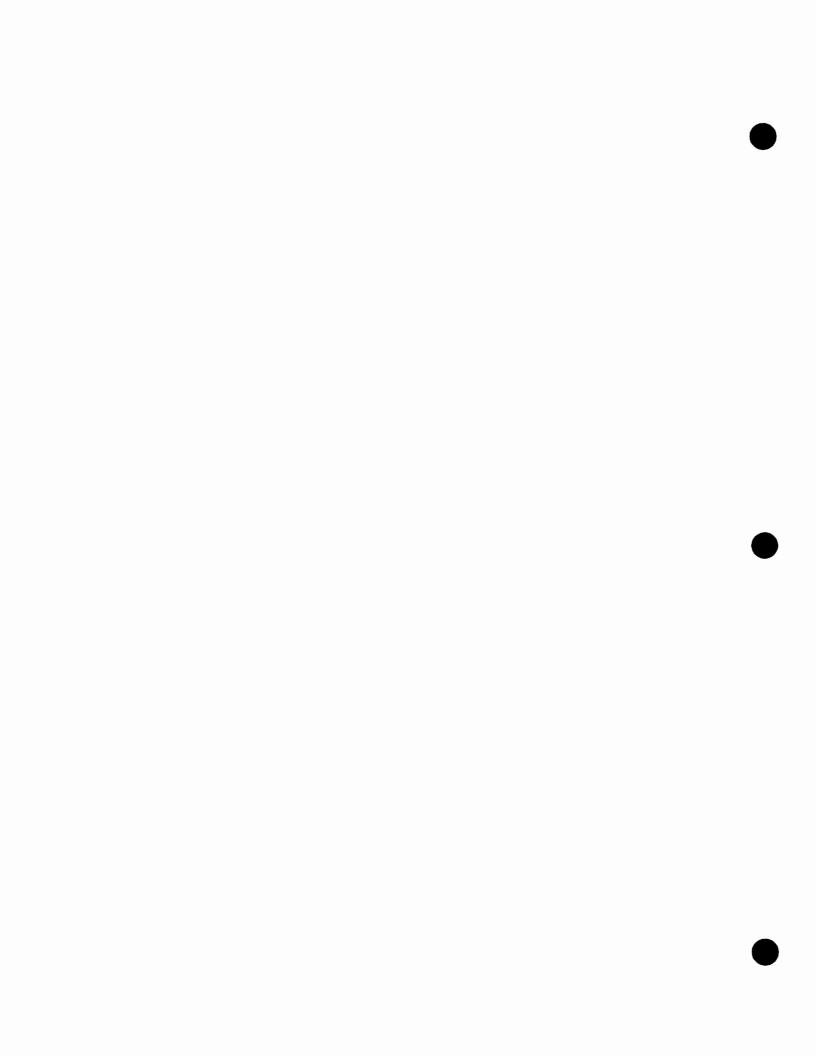
The General Assembly of North Carolina enacts:

SECTION 1. Beginning October 1, 2017, the Department of Health and Human Services (DHHS) shall report quarterly to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice, the Joint Legislative Oversight Committee on Health and Human Services, the chairs of the Senate Appropriations on Health and Human Services, the chairs of the House of Representatives Committee on Appropriations, Health and Human Services, and the Fiscal Research Division on the status and implementation of the 1915(c) waiver for individuals with traumatic brain injury (TBI) that has been submitted to the Centers for Medicare and Medicaid in accordance with Section 12H.6 of S.L. 2015-241.

As part of the process of implementing the TBI waiver, DHHS shall adopt rules or medical coverage policies relating to service programs for individuals with traumatic brain injury, including setting standards that ensure that individuals with brain injuries who require residential treatment receive appropriate, effective, and high-quality treatment in community-based residential settings. Additionally, DHHS shall develop a best practice model system that includes a comprehensive continuum of care and an array of short-term and long-term treatments, rehabilitation options, and home and community support services as part of the TBI waiver. Finally, DHHS shall strive to maintain adequate reimbursement rates for residential and community-based care programs that serve individuals with traumatic brain injury, which will aid in attracting and retaining quality and highly specialized providers and programs into North Carolina.

SECTION 2. This act is effective when it becomes law.







HOUSE BILL 466:The Pharmacy Patient Fair Practices Act.

2017-2018 General Assembly

Committee: House Health
Introduced by: Rep. Brenden Jones
Analysis of: PCS to First Edition

H466-CSBC-19

Date: April 25, 2017

Prepared by: Jason Moran-Bates

Committee Co-Counsel

OVERVIEW: House Bill 466 would permit pharmacists to discuss lower-cost alternative drugs with, and sell lower-cost alternative drugs to, consumers. It would prohibit pharmacy benefits managers from using contract terms to prevent pharmacies from providing store direct delivery services. Pharmacy benefits managers would be prohibited from charging insureds a co-pay that exceeds the total submitted charges by a network pharmacy. Finally, it would allow pharmacy benefits managers to charge pharmacies a fee for costs related to claim adjudication only if the fee was set out in a contract or reported on the remittance advice of the claim.

[As introduced, this bill was identical to S384, as introduced by Sen. Britt, which is currently in Senate Judiciary.]

CURRENT LAW: Pharmacy benefits managers are entities who contract with pharmacies on behalf of insurers to administer prescription drug benefits. Currently, they are regulated in their placement of drugs on the maximum allowable cost price list by Article 56A of Chapter 58, but they are not subject to additional regulation.

BILL ANALYSIS: House Bill 466 would amend Article 56A of Chapter 58 by adding additional requirements for pharmacy benefits managers.

Section 1 would add definitions for "insured" and "pharmacist" to G.S.58-56A-1.

Section 2 would require pharmacy benefits managers to permit pharmacists to discuss an insured's cost share for a drug, disseminate information about lower-priced alternative drugs, and sell a lower-priced alternative drugs without penalty. Pharmacy benefits managers would be prohibited from using contractual terms to prevent pharmacies from providing store direct delivery services, from charging insureds co-payments that exceed the total charges submitted by a network pharmacy, and from charging fees or otherwise holding pharmacies responsible for the costs of adjudicating a claim, unless the fee was set out in contract or reported on the remittance advice of the adjudicated claim. Section 2 would also require contracts between pharmacy benefits managers and insurers to be made available to the Department of Insurance for review and require the Department of Insurance to report any violations of G.S. 58-56A-3 or G.S. 58-56A-4 to the Attorney General.

Section 3 would permit the Commissioner of Insurance to adopt rules to implement the act.

EFFECTIVE DATE: The bill would become effective October 1, 2017 and apply to all contracts entered into, renewed, or amended on or after that date.

*Staff Attorney Gus Willis contributed substantially to the preparation of this summary.





Legislative Analysis Division 919-733-2578



GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2017

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HOUSE BILL 466* Committee Substitute Favorable 4/25/17

		Committee Substitute Favorable 4/25/17	
Short Title:	The	e Pharmacy Patient Fair Practices Act.	(Public)
Sponsors:			
Referred to:			
		March 27, 2017	
		A BILL TO BE ENTITLED	
AN ACT RE	ELAT	ING TO THE REGULATION OF PHARMACY BENEFIT MA	ANAGERS.
		mbly of North Carolina enacts:	
		ION 1. G.S. 58-56A-1 reads as rewritten:	
"§ 58-56A-1			
	_	definitions apply in this Article:	
(1)	Health benefit plan. – As defined in G.S. 58-50-110(11). T specifically excludes the State Health Plan for Teache Employees.	
(2)	Insured. – An individual covered by a health benefit plan.	
	3)	Insurer. – Any entity that provides or offers a health benefit pla	ın.
_	(3) (4)	Maximum allowable cost price. – The maximum per unit reim multiple source prescription drugs, medical products, or device	
	<u>(5)</u>	Pharmacist. – A person licensed to practice pharmacy under Chapter 90 of the General Statutes.	
(4) (6)	Pharmacy. – A pharmacy registered with the North Carol Pharmacy.	
((5) (7)	Pharmacy benefits manager. – An entity who contracts with a behalf of an insurer or third-party administrator to administ prescription drug benefits.	
((8) (8)	Third-party administrator. – As defined in G.S. 58-56-2."	
5	SECT	ION 2. Article 56A of Chapter 58 of the General Statutes is	s amended by
		ections to read:	
		nsumer protections.	
(a) A	A pha	rmacy or pharmacist shall have the right to provide an insure	d information
		ount of the insured's cost share for a prescription drug. Neither a	
		be penalized by a pharmacy benefits manager for discussing ar	
		ection or for selling a lower-priced drug to the insured if one is	
		macy benefits manager shall not, through contract, prohibit a p	
		iding direct and limited delivery services to an insured as an an	
	nacy,	as delineated in the contract between the pharmacy benefits ma	mager and the
pharmacy.	A pho	rmacy benefits manager shall not charge, or attempt to col	llect from on
		nent that exceeds the total submitted charges by the network pha	
		ontract for the provision of a network to deliver health care serv	
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pharmacy benefits manager and insurer shall be made available for review by the Department.

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1	(e) The Department shall report to the Attorney General any violations of this section or
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2	G.S. 58-56A-4 in accordance with G.S. 58-2-40(5).
3	"§ 58-56A-4. Pharmacy and pharmacist protections.
4	A pharmacy benefits manager may only charge a fee or otherwise hold a pharmacy
5	responsible for a fee relating to the adjudication of a claim if the fee is reported on the

A pharmacy benefits manager may only charge a fee or otherwise hold a pharmacy responsible for a fee relating to the adjudication of a claim if the fee is reported on the remittance advice of the adjudicated claim or is set out in contract between the pharmacy benefits manager and the pharmacy. This section shall not apply with respect to claims under an employee benefit plan under the Employee Retirement Income Security Act of 1974 or Medicare Part D."

SECTION 3. The Commissioner of Insurance may adopt rules to implement this act.

SECTION 4. This act becomes effective October 1, 2017, and applies to all contracts entered into, renewed, or amended on or after that date.



HOUSE BILL 683: Indian Child Welfare Agreement Form.

2017-2018 General Assembly

Committee:House HealthDate:April 25, 2017Introduced by:Rep. C. GrahamPrepared by:Tawanda N. Foster

Analysis of: PCS to First Edition Staff Attorney H683-CSTV-5

OVERVIEW: The PCS to House Bill 776 requires the Division of Social Services in the Department of Health and Human Services to develop a standard form to be used to establish agreements with state recognized Indian tribes on behalf of Indian children under their authority involved in matters of foster care, adoption assistance, and kinship guardianship assistance programs under Title IV-E of the Social Security Act.

CURRENT LAW: G.S. 143B-139.5 requires the Department of Health and Human Services, Division of Social Services (DSS) to collaborate with the Commission of Indian Affairs on Indian Child Welfare issues.

BILL ANALYSIS: This PCS adds three subsections to the current law to require DSS to develop a standard form to be used to establish agreements with any state recognized Indian tribe who requests an agreement to provide specific actions to be taken on behalf of an Indian child under their authority involved in matters of foster care, adoption assistance, and kinship guardianship assistance programs under Title IV-E of the Social Security Act. The Division must also do the following:

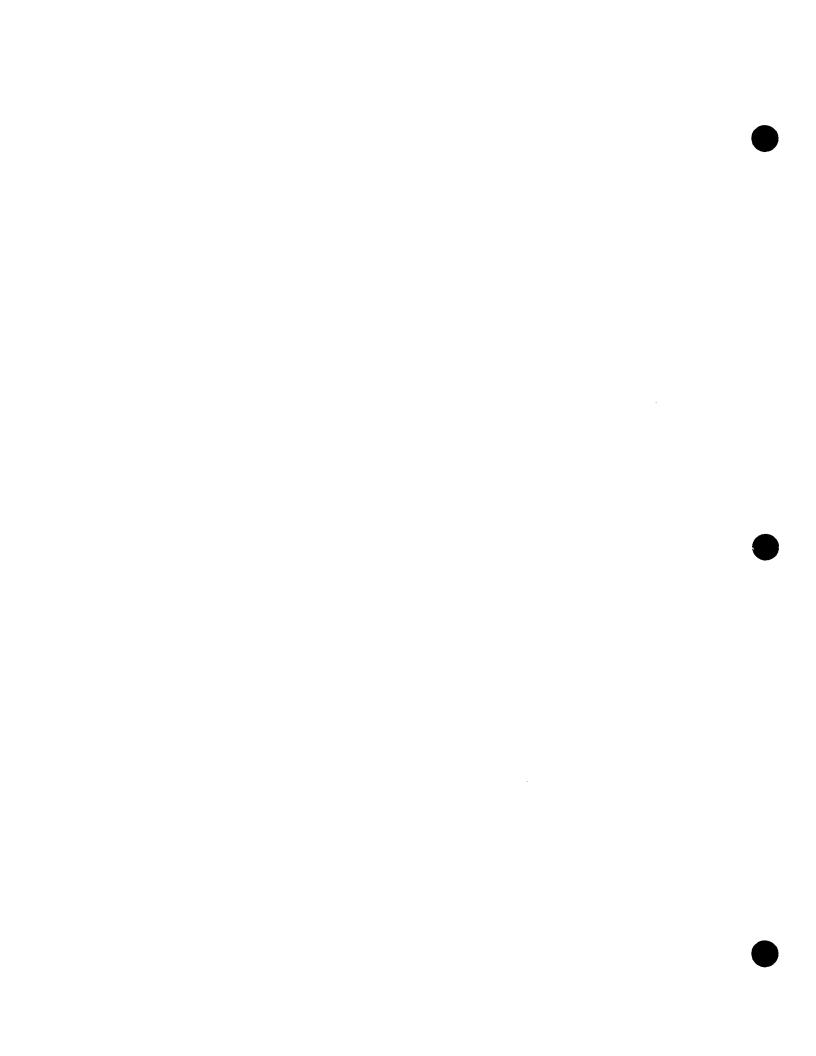
- Incorporate similar provisions in the form as established for federally recognized tribes in the Indian Child Welfare Act (ICWA).
- Consult with representatives of state recognized tribes and related organizations or consortia that represent members of state recognized tribes in development of the standard form.
- Submit an interim report to the Joint Legislative Oversight Committee on Health and Human Services (Committee) no later than June 30, 2018 detailing any resources and actions needed, including legislation needed to effectively develop and implement the standard form.
- Submit a final report, including its standard form and any recommendations for legislation in accordance with subsection (b) of this section to the Committee by December 1, 2018.

EFFECTIVE DATE: The PCS would become effective when it becomes law.





Legislative Analysis Division 919-733-2578



GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2017

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HOUSE BILL 683 PROPOSED COMMITTEE SUBSTITUTE H683-CSTV-5 [v.4]

04/25/2017 7:58:16 PM

Short Title:	Indian Child Welfare Agreement Form.	(Public)	
Sponsors:			
Referred to:			

April 11, 2017

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THE DIVISION OF SOCIAL SERVICES IN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO DEVELOP A STANDARD FORM TO BE USED TO ESTABLISH AGREEMENTS WITH STATE RECOGNIZED INDIAN TRIBES ON BEHALF OF INDIAN CHILDREN UNDER THEIR AUTHORITY INVOLVED IN MATTERS OF FOSTER CARE, ADOPTION ASSISTANCE, AND KINSHIP GUARDIANSHIP ASSISTANCE PROGRAMS UNDER TITLE IV-E OF THE SOCIAL SECURITY ACT.

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The General Assembly of North Carolina enacts:

SECTION 1. G.S. 143B-139.5A reads as rewritten:

"§ 143B-139.5A. Collaboration between Division of Social Services and Commission of Indian Affairs on Indian Child Welfare Issues.

- (a) The Division of Social Services, Department of Health and Human Services, shall work in collaboration with the Commission of Indian Affairs, Department of Administration, and the North Carolina Directors of Social Services Association to develop, in a manner consistent with federal law, an effective process through which the following can be accomplished:
 - (1) Establishment of a relationship between the Division of Social Services and the Indian tribes set forth in G.S. 143B-407(a), either separately or through a central entity, that will enable these tribes, in general, and tribal councils or other tribal organizations, in particular, to receive reasonable notice of identified Indian children who are being placed in foster care or adoption or who otherwise enter the child protective services system, and to be consulted on policies and other matters pertinent to placement of Indian children in foster care or adoption.
 - (2) Agreement on a process by which North Carolina Indians might be identified and recruited for purposes of becoming foster care and adoptive parents.
 - (3) Agreement on a process by which the cultural, social, and historical perspective and significance associated with Indian life may be taught to appropriate child welfare workers and to foster and adoptive parents.
 - (4) Identification or formation of Indian child welfare advocacy, placement and training entities with which the Department of Health and Human Services might contract or otherwise form partnerships for the purpose of implementing the provisions of this act.



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- (5) Development of a valid and reliable process through which Indian children within the child welfare system can be identified.
 - (6) Identify the appropriate roles of the State and of Indian tribes, organizations and agencies to ensure successful means for securing the best interests of Indian children.
- (b) The Department of Health and Human Services, Division of Social Services, shall develop a standard form to be used to establish an agreement with any state recognized Indian tribe who requests such an agreement to provide specific actions to be taken on behalf of an Indian child under their authority involved in matters of foster care, adoption assistance, and kinship guardianship assistance programs under Title IV-E of the Social Security Act. The agreement shall incorporate similar provisions to apply to state recognized tribes as provided in the federal Indian Child Welfare Act, 25 U.S.C. § 1901, et seq. applicable to Indian children in federally recognized Indian tribes.
- (c) The Department of Health and Human Services, Division of Social Services shall consult with representatives of state recognized tribes and related organizations or consortia that represent members of state recognized tribes in development of the standard form.
- (d) The Department of Health and Human Services, Division of Social Services shall submit an interim report to the Joint Legislative Oversight Committee on Health and Human Services (Committee) no later than June 30, 2018 detailing any resources and actions needed, including legislation needed to effectively develop and implement the standard form. The Department of Health and Human Services shall submit a final report, including its standard form and any recommendations for legislation in accordance with subsection (b) of this section to the Committee by December 1, 2018."

SECTION 2. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA **SESSION 2017**

HOUSE BILL 683

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Short Title: Indian Child Services Changes. (Public) Sponsors: Representative C. Graham. For a complete list of sponsors, refer to the North Carolina General Assembly web site. Referred to: Health

April 11, 2017

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THE DIVISION OF SOCIAL SERVICES IN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO NEGOTIATE IN GOOD FAITH WITH INDIAN TRIBES AND ORGANIZATIONS THAT REQUEST TO DEVELOP AGREEMENTS TO ADMINISTER PROGRAMS UNDER THE FEDERAL FOSTERING CONNECTIONS TO SUCCESS AND INCREASING ADOPTIONS ACT AND TO REQUIRE THE DIVISION OF SOCIAL SERVICES IN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO ADOPT THE FEDERAL INDIAN CHILD WELFARE ACT AS A BEST PRACTICE IN THE PLACEMENT OF ALL INDIAN CHILDREN IN THE STATE, AS RECOMMENDED BY THE 2011 STUDY COMMITTEE TO PRESERVE THE CULTURE AND CUSTOMS OF INDIAN CHILDREN.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 143B-139.5A reads as rewritten:

"§ 143B-139.5A. Collaboration between Division of Social Services and Commission of Indian Affairs on Indian Child Welfare Issues.

- The Division of Social Services, Department of Health and Human Services, shall (a) work in collaboration with the Commission of Indian Affairs, Department of Administration, and the North Carolina Directors of Social Services Association to develop, in a manner consistent with federal law, an effective process through which the following can be accomplished:
 - Establishment of a relationship between the Division of Social Services and (1) the Indian tribes set forth in G.S. 143B-407(a), either separately or through a central entity, that will enable these tribes, in general, and tribal councils or other tribal organizations, in particular, to receive reasonable notice of identified Indian children who are being placed in foster care or adoption or who otherwise enter the child protective services system, and to be consulted on policies and other matters pertinent to placement of Indian children in foster care or adoption.
 - Agreement on a process by which North Carolina Indians might be (2) identified and recruited for purposes of becoming foster care and adoptive
 - (3) Agreement on a process by which the cultural, social, and historical perspective and significance associated with Indian life may be taught to appropriate child welfare workers and to foster and adoptive parents.



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	General Assem	bly Of North Carolina	Session 2017
1 2 3 4	(4)	Identification or formation of Indian child welfare advoct training entities with which the Department of Health a might contract or otherwise form partnerships for implementing the provisions of this act.	nd Human Services
5	(5)	Development of a valid and reliable process through wh within the child welfare system can be identified.	nich Indian children
7 8	(6)	Identify the appropriate roles of the State and of Indian t and agencies to ensure successful means for securing t	
9	(b) The l	Indian children. Department of Health and Human Services, Division of So	ocial Services, shall
11		od faith with Indian tribes, organizations, and consort an agreement with the State to administer foster care, adoption	
13	kinship guardian	ship assistance programs under Title IV-E of the Social Sec	curity Act on behalf
14 15		en under their authority, as authorized and required by the Success and Increasing Adoptions Act.	ie iederai Fostering

(c) The Department of Health and Human Services, Division of Social Services, shall adopt the federal Indian Child Welfare Act, 25 U.S.C. § 1901, et seq., as a best practice in the placement of all Indian children in foster care or adoption by the Division."

SECTION 2. This act is effective when it becomes law.

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NORTH CAROLINA GENERAL ASSEMBLY HOUSE OF REPRESENTATIVES

HEALTH COMMITTEE REPORT

Representative Josh Dobson, Co-Chair Representative Nelson Dollar, Co-Chair Representative Bert Jones, Co-Chair Representative Donny Lambeth, Co-Chair Representative Gregory F. Murphy, MD, Co-Chair

FAVORABLE

HB **466** (CS#1) The Pharmacy Patient Fair Practices Act.

Draft Number: None
Serial Referral: None
Recommended Referral: None
Long Title Amended: No

Floor Manager: Brenden Jones

${\bf FAVORABLE\ COM\ SUB\ ,\ UNFAVORABLE\ ORIGINAL\ BILL}$

HB 512 Monitor Implementation of TBI Waiver.

Draft Number: H512-PCS30410-SH-19

Serial Referral: None
Recommended Referral: None
Long Title Amended: No
Floor Manager: Torbett

HB **683** Indian Child Services Changes.

Draft Number: H683-PCS10339-TV-5

Serial Referral: None Recommended Referral: None Long Title Amended: Yes

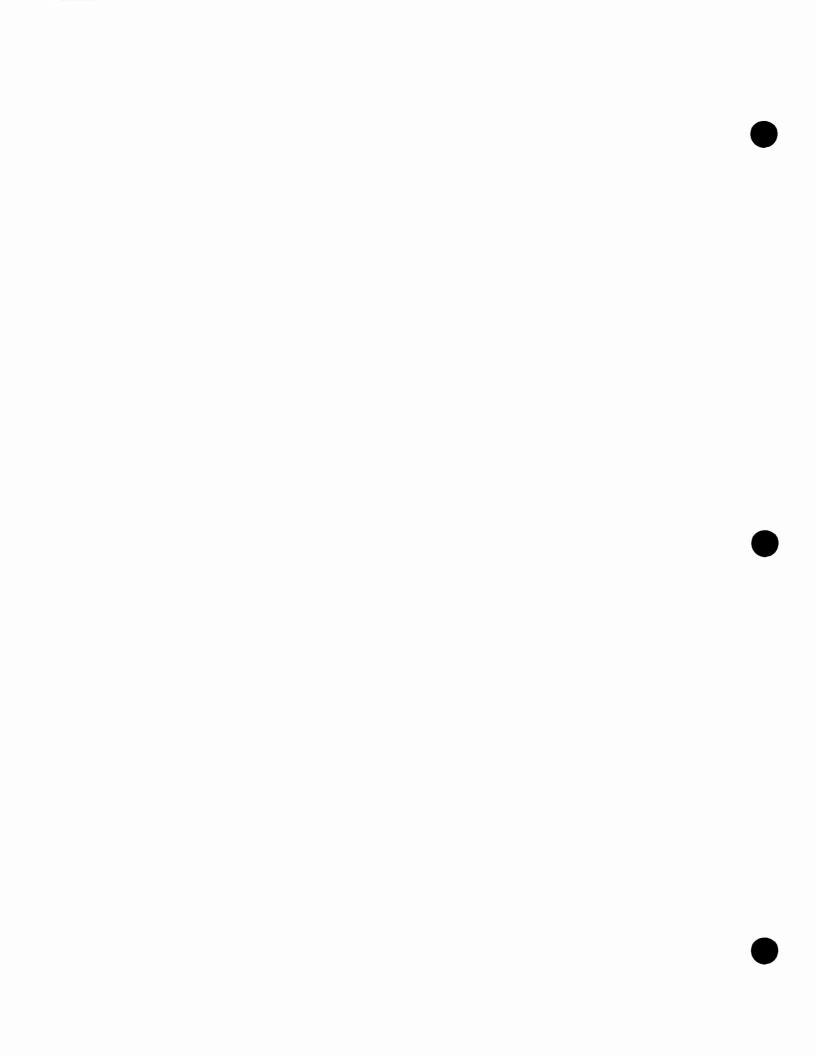
Floor Manager: C. Graham

TOTAL REPORTED: 3



Committee Sergeants at Arms

NAME	DE COMMITTEE _ [ioușe Comm.	OH Hea
DATE: _	04/26/17	Room:	643
		House Sgt-At Arms:	
1. Name:	Young Bae	**************************************	
2. Name:	Jim Moran		man man de la communicación de
3. Маше:	Rex Foster		
4. Name:	David Linthic	um	
5. Name:			
		Senate Sgt-At Arms:	
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House Pages Assignments Wednesday, April 26, 2017

Session: 2:00 PM

Committee	Room	Time	Staff	Comments	Member
Judiciary IV	1228/1327	1:00 PM	Alyssa Scott		Rep. Jimmy Dixon
			Marko Stefanovic		Speaker Tim Moore
Rules, Calendar, and Operations of the House	544	10:00 AM	Christopher Barber		Rep. Donna White
			Zaccary Grierson		Rep. John Szoka
Education - Community Colleges	423	11:00 AM	Angel Wagner		Rep. Donna White
			Jordan Goode		Rep. Terry Garrison
Health	643	11:00 AM	Duncan Mills		Rep. Brian Turner
			Arran Walton		Speaker Tim Moore
Judiciary III	421	12:00 PM	Claire Morris- Benedict		Rep. Mickey Michaux, Jr.
			Marko Stefanovic		<u>\$p</u> eaker Tim Moore
State Personnel	1228/1327	12:00 PM	Jessica Lanier Alyssa Scott		Rep. George Graham Rep. Jimmy Dixon
Energy and Public Utilities	643	1:00 PM	Angel Wagner		Rep. Donna White
			Jordan Goode		Rep. Terry Garrison
Judiciary I	415	1:00 PM	Christopher Barber		Rep. Donna White
			Zaccary Grierson		Rep. John Szoka

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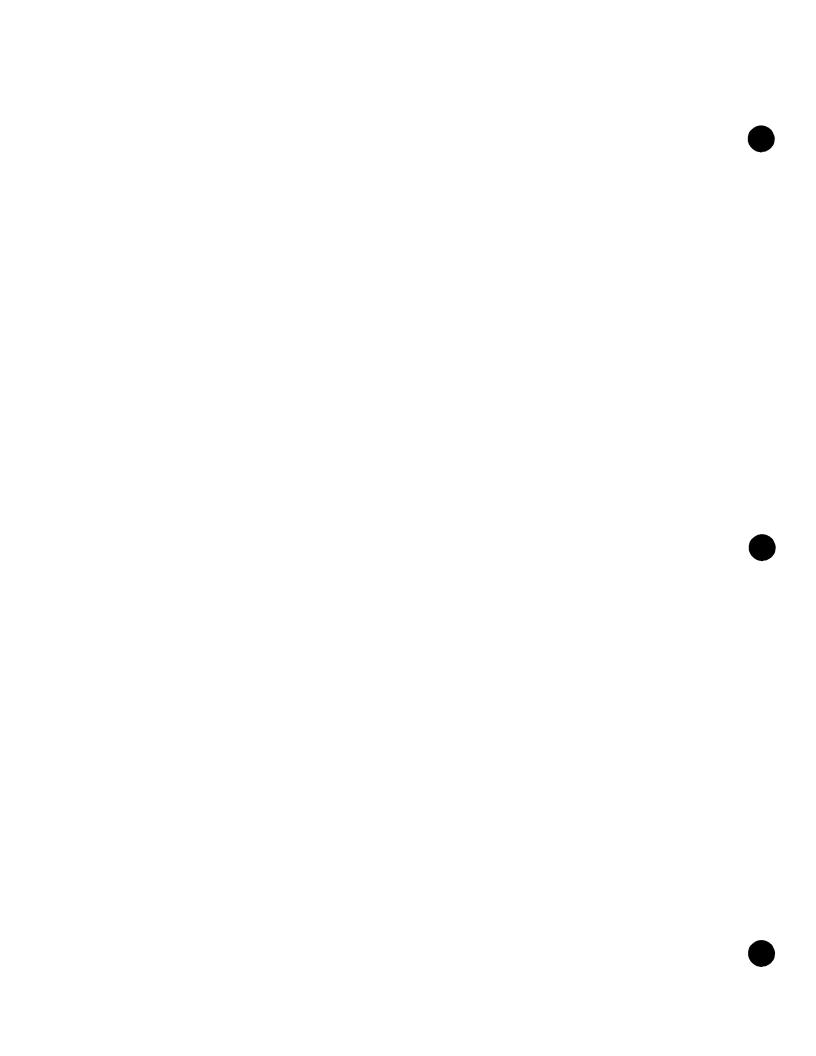
House Comm. on Health

04/26/17

Name of Committee

Date

NAME	FIRM OR AGENCY AND ADDRESS
Cliff Lovery	AARP
Louanne Mobiley	AARP
Patricia M. Tomac	aarp
Carol La Sano	AARP
Kendall Casper	Studelt
JANIE CASPER	sptemet my
Joyce Evans	AARP
Tom Murdock	AARP-Charlotte
Sara Stoneburner,	mo NCSEPS
Odette Houghton	Neseps



House Comm. on Health

04/26/17

Name of Committee

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NAME	FIRM OR AGENCY AND ADDRESS
Jenni Gar Turner	BCBSMC
Selle Porkman	Parkusin Law
MARJONE	DG.
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Dodg Berter	CCR
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Raylana	Showy Chropinic & Natural Medicae (Wilmigm)
Caroline Shaver	Shaver Chiropractic 3 Natural Medicine
Dr. R. Todd Shaver	Shaver Chiropractic & Natural Medicine

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House Comm. on Health

04/26/17

Name of Committee

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Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

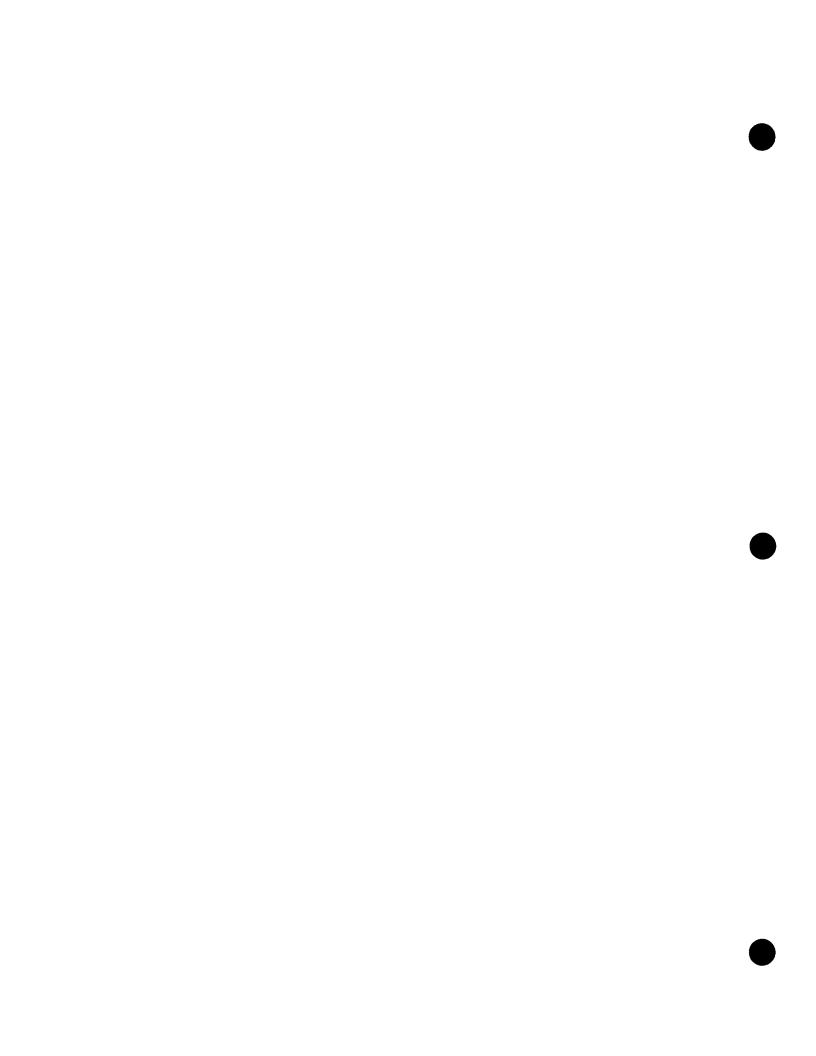
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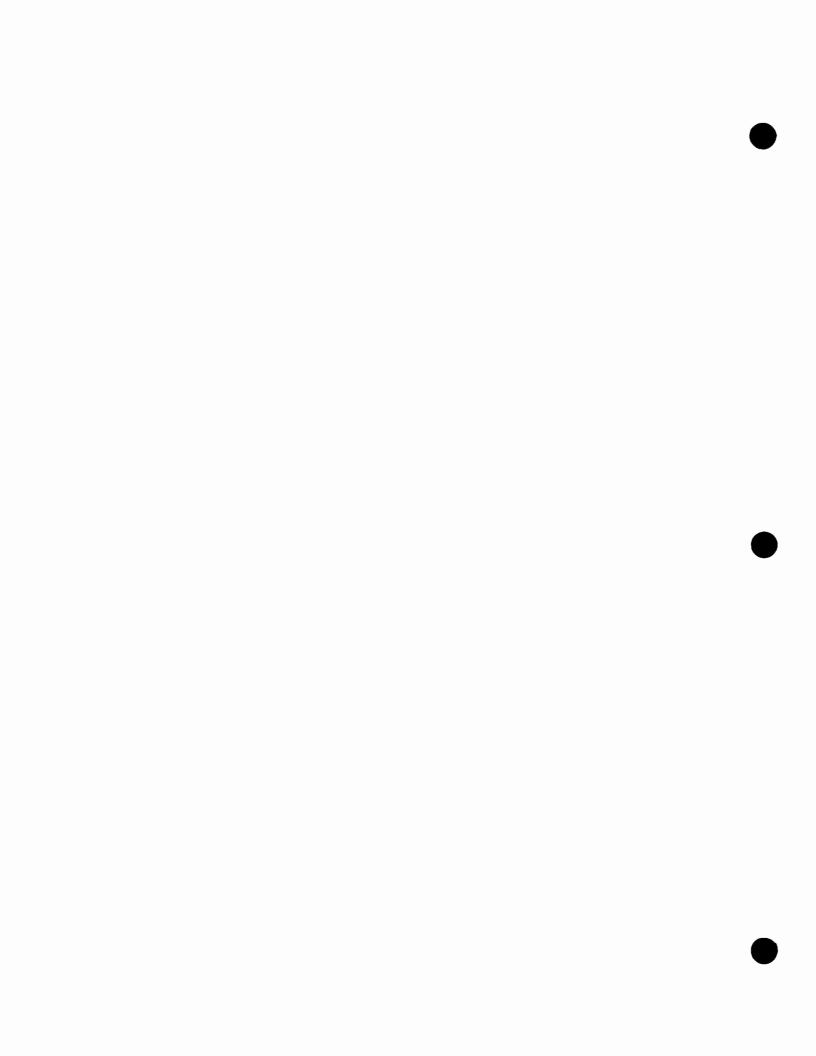
House Comm. on Health

04/26/17

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House Comm. on Health

04/26/17

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Ben Papkon	DHHS
Panyl Childre	0016
Angel Sams	Devivori gang
LTMcChmmon	DHHS
Colleen Kochanek	KC6
JOHN MIDGETTE	NC PBA.
HaB Lambe	PEA.
Thom Maufield	NCMB
Evelyn Contre	NCMB

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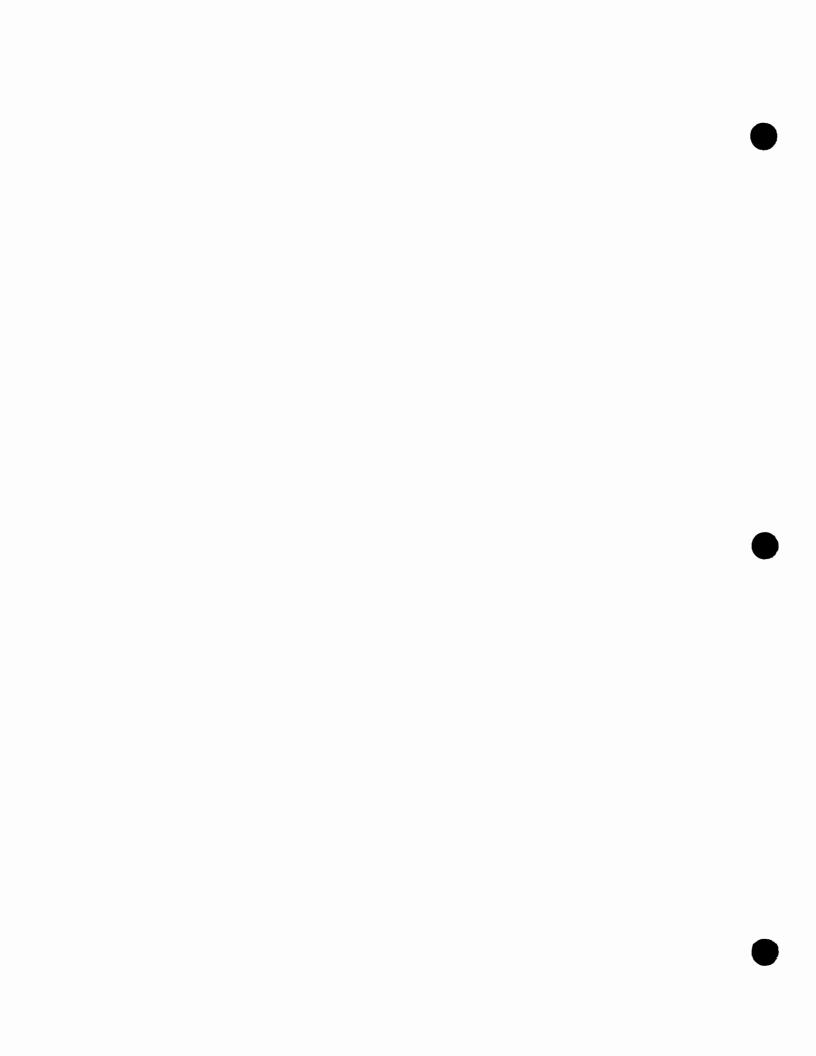
House Comm. on Health

04/26/17

Name of Committee

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Lauril Onevio	Walk West
Casey Mathys	Christenbury Exe, CLT Nº
Susann Poidera	. Acm-ne
Kay Castillo	NASW-NC
Carla Obioe	Care 4 Carolina
Sava Wilson	Alliance BHC
Chris Broughton	Mic
Mutter 2x11	SP NE
Elena Ceberio	TTPLUSTQ@ADL.Com



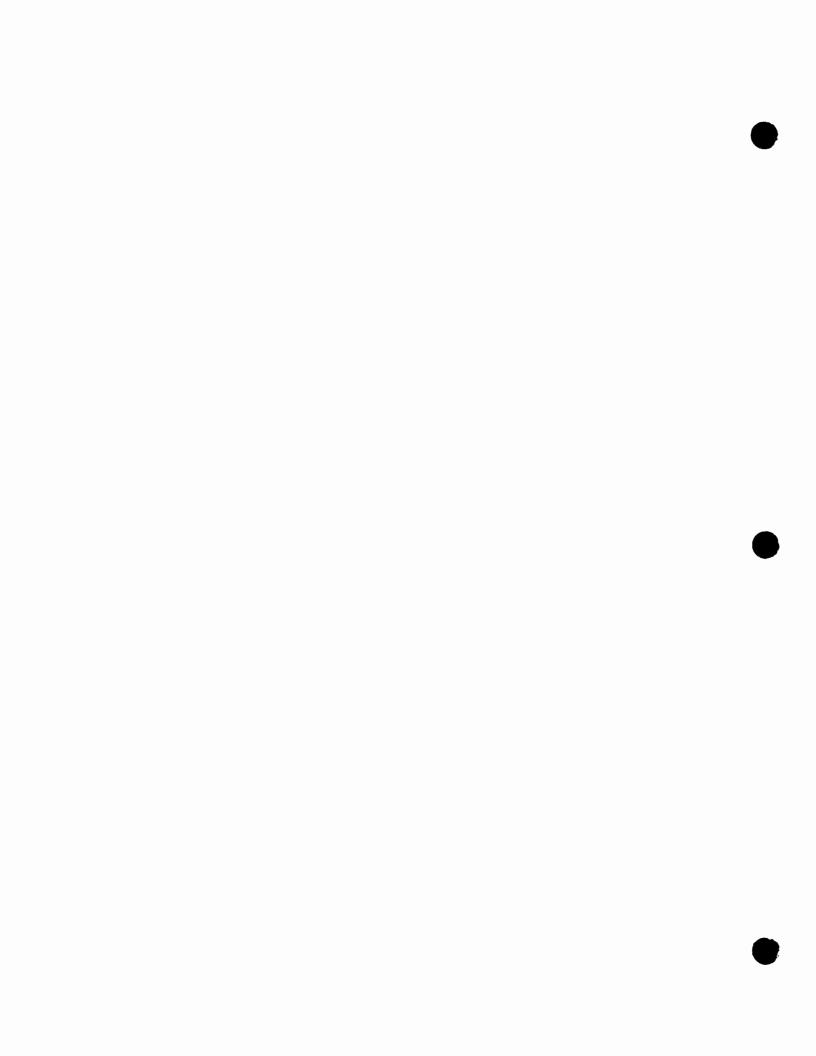
House Comm. on Health

04/26/17

Name of Committee

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House Committee on Health Thursday, April 27, 2017 at 9:00 AM Room 643 of the Legislative Office Building

MINUTES

The House Committee on Health met at 9:00 AM on April 27, 2017 in Room 643 of the Legislative Office Building. Representatives Adcock, Ball, Blackwell, Boswell, Brisson, Burr, Cunningham, Dobson, Dollar, Dulin, Earle, Farmer-Butterfield, Ford, Howard, Hunter, Jackson, Lambeth, Murphy, Potts, Rogers, Setzer, Shepard, Szoka, White, and Yarborough attended.

Representative Donny Lambeth, Chair, presided.

The following bills were considered:

HB 36 NC IOM Study of Eye Care Access. (Representatives Burr, Collins, Dobson, Howard)

Representative Dollar made the motion for the PCS for HB36 be set before the committee. Hearing none Representative Burr was recognized to explain the Proposed Committee Substitute (PCS) for House Bill 36.

The PCS would direct the North Carolina Institute of Medicine (NC IOM) to study the issues addressed in House Bill 36 Enact Enhanced Access to Eye Care Act as introduced during the 2017 Regular Session of the 2017 General Assembly and direct the NC IOM to report findings and recommendations pertaining to enhanced access to eye care, including draft legislation if appropriate, to the Joint Legislative Oversight Committee on Health and Human Services on or before October 1, 2018.

Representative Brisson motioned for an unfavorable report to the original bill favorable to the PCS. The motion carried.

The meeting adjourned at 9:25.

Representative Donny Lambeth, Chair

Day C. Fanheth

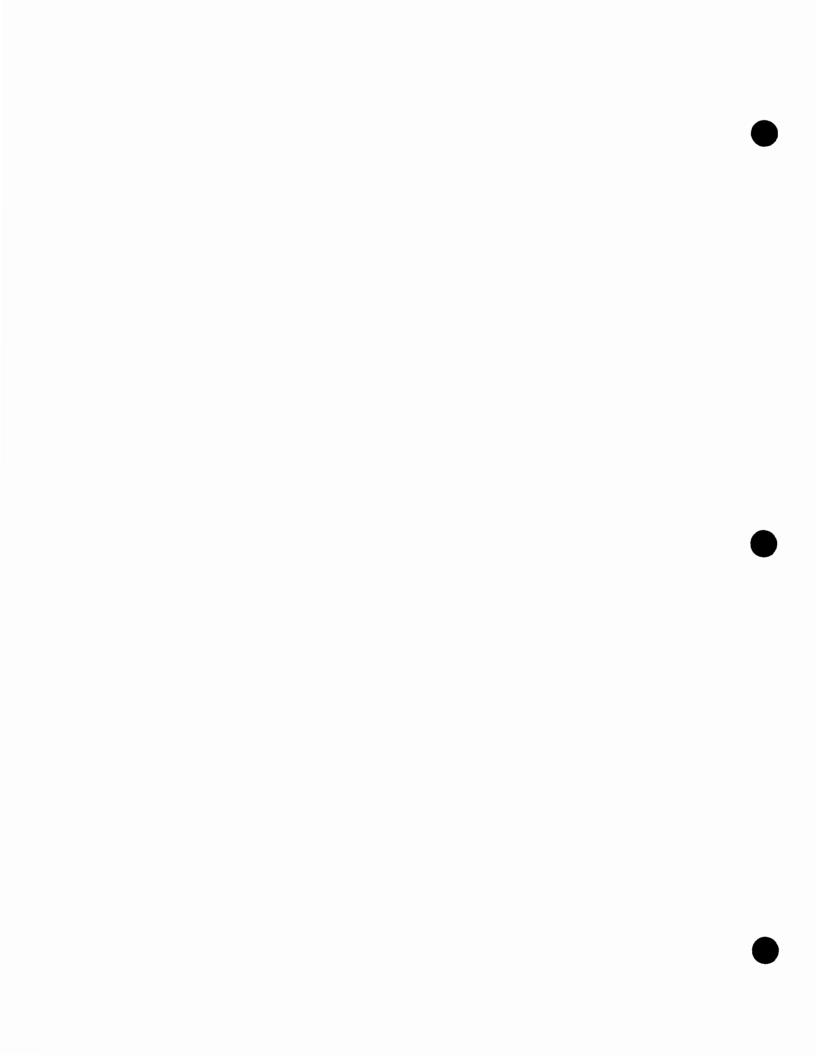
Presiding

Theresa Lopez, Committee Clerk

NORTH CAROLINA HOUSE OF REPRESENTATIVES COMMITTEE MEETING NOTICE AND BILL SPONSOR NOTIFICATION 2017-2018 SESSION

You are hereby notified that the House Committee on Health will meet as follows:

DAY & DA' TIME: LOCATION		Thursday, April 27, 2017 9:00 AM 643 LOB		
The following	ng bill	s will be considered:		
BILL NO. HB 36			Care	SPONSOR Representative Burr Representative Collins Representative Dobson Representative Howard
			Respectfu	illy,
			Represent Represent	tative Josh Dobson, Co-Chair tative Nelson Dollar, Co-Chair tative Bert Jones, Co-Chair tative Donny Lambeth, Co-Chair tative Gregory F. Murphy, MD, Co-Chair
I hereby cert Wednesday,		•	nmittee as	sistant at the following offices at 4:15 PM on
		Principal Clerk Reading Clerk – House Chan	nber	
Brenda Olls	(Com	mittee Assistant)		



House Committee on Health Thursday, April 27, 2017, 9:00 AM 643 Legislative Office Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

BILL NO. SHORT TITLE

HB 36 Enact Enhanced Access to Eye Care

Act.

(STUDY BILL)

SPONSOR

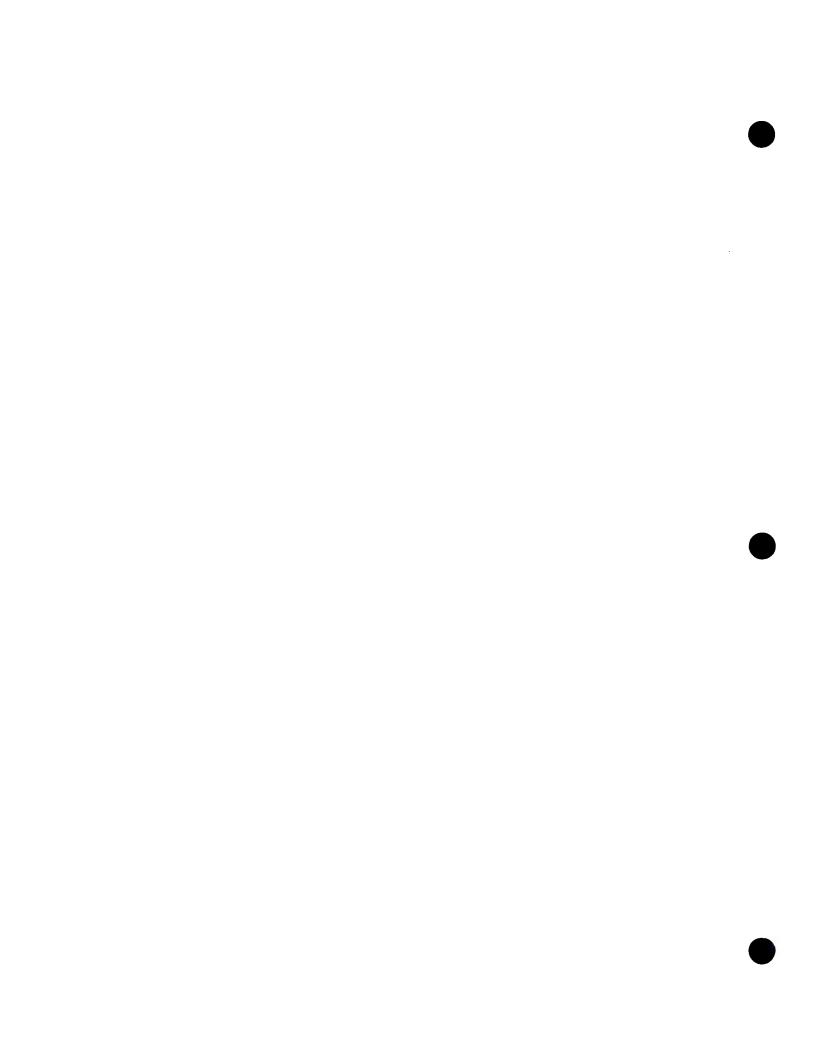
Representative Burr

Representative Collins Representative Dobson Representative Howard

Presentations

Other Business

Adjournment





HOUSE BILL 36: NC IOM Study of Eye Care Access.

2017-2018 General Assembly

Committee: House Health. If favorable, re-refer to Date: April 26, 2017

Insurance. If favorable, re-refer to

Appropriations

Introduced by: Reps. Burr. Collins, Dobson, Howard

Analysis of: PCS to First Edition

H36-CSSH-21

Prepared by: Theresa Matula

Committee Staff

OVERVIEW: The Proposed Committee Substitute for House Bill 36 would direct the North Carolina Institute of Medicine to study the issues addressed in House Bill 36 Enact Enhanced Access to Eye Care Act and to report to the Joint Legislative Oversight Committee on Health and Human Services on or before October 1, 2018.

CURRENT LAW:

Article 31 of Chapter 90 pertains to the Institute of Medicine.

G.S. 90-470(b) provides that the Institute of Medicine is organized to:

- (1) Be concerned with the health of the people of North Carolina;
- (2) Monitor and study health matters;
- (3) Respond authoritatively when found advisable;
- (4) Respond to requests from outside sources for analysis and advice when this will aid in forming a basis for health policy decisions.

BILL ANALYSIS:

<u>Section 1</u> of the Proposed Committee Substitute (PCS) for House Bill 36 would direct the North Carolina Institute of Medicine (NC IOM) to study the issues addressed in House Bill 36 Enact Enhanced Access to Eye Care Act as introduced during the 2017 Regular Session of the 2017 General Assembly.

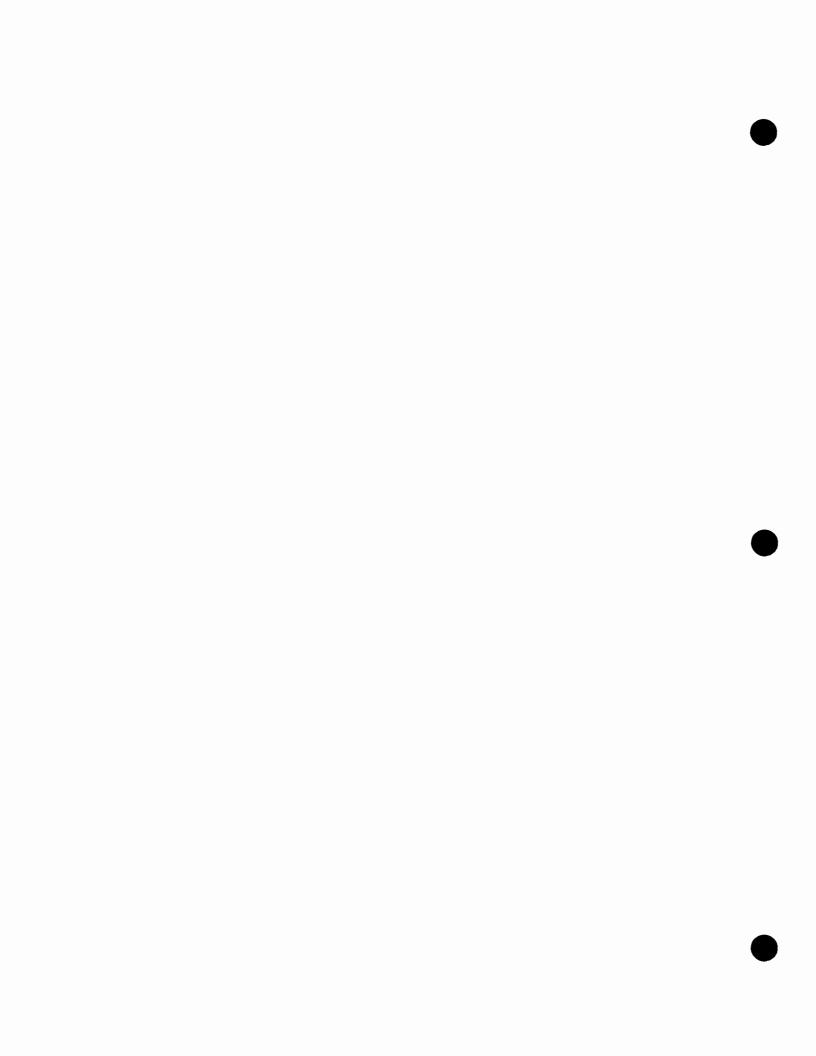
<u>Section 2</u> of the PCS would direct the NC IOM to report findings and recommendations pertaining to enhanced access to eye care, including draft legislation if appropriate, to the Joint Legislative Oversight Committee on Health and Human Services on or before October 1, 2018.

EFFECTIVE DATE: House Bill 36 would become effective when it becomes law.





Legislative Analysis Division 919-733-2578



GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2017

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HOUSE BILL 36 PROPOSED COMMITTEE SUBSTITUTE H36-CSSH-21 [v.2] 04/26/2017 3:01:15 PM

Short Title:	NC IOM Study of Eye Care Access.	(Public)
Sponsors:		
Referred to:		

February 2, 2017

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE NORTH CAROLINA INSTITUTE OF MEDICINE TO STUDY ENHANCED ACCESS TO EYE CARE AND TO REPORT TO THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON HEALTH AND HUMAN SERVICES.

The General Assembly of North Carolina enacts:

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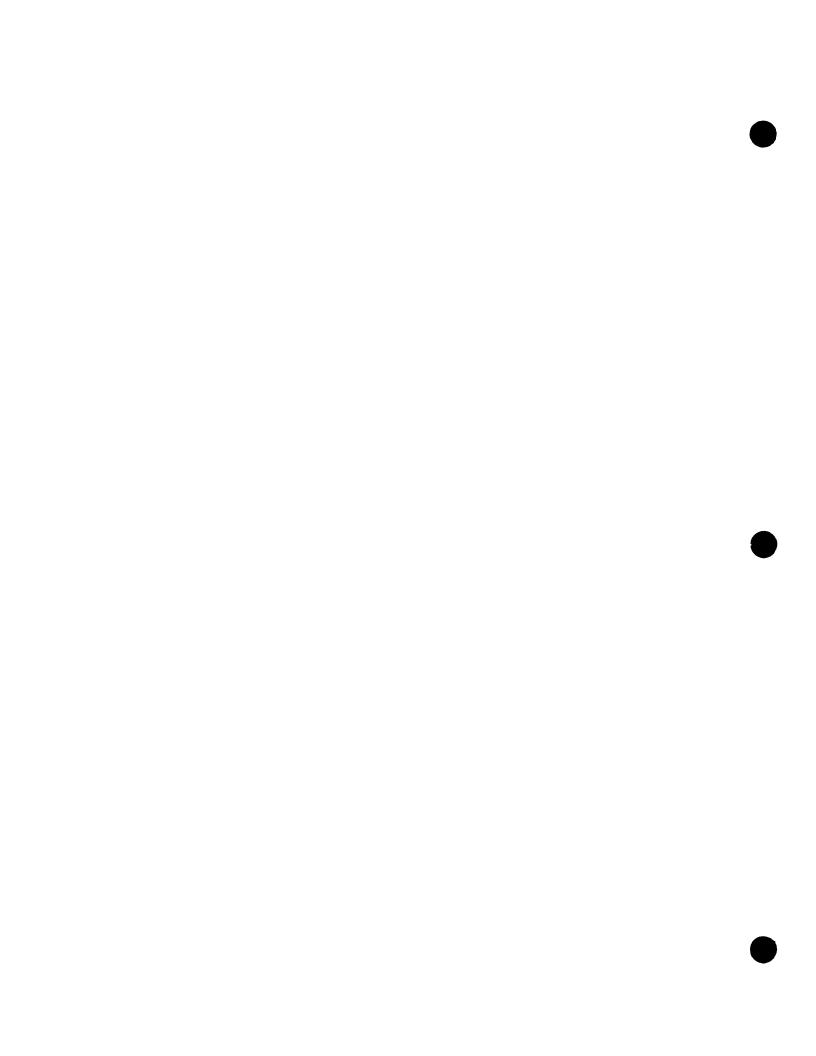
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SECTION 1. Pursuant to G.S. 90-470(b), the North Carolina Institute of Medicine (NC IOM) is organized to be concerned with the health of the people of North Carolina, to monitor and study health matters, to respond authoritatively when found advisable, and to respond to requests from outside sources for analysis and advice when it will aid in forming a basis for health policy decisions. As such, the NC IOM is directed to study the issues addressed in House Bill 36 Enact Enhanced Access to Eye Care Act, as introduced during the 2017 Regular Session of the 2017 General Assembly.

SECTION 2. The NC IOM shall report findings and recommendations pertaining to enhanced access to eye care, including draft legislation if appropriate, to the Joint Legislative Oversight Committee on Health and Human Services on or before October 1, 2018.

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





GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2017

H HOUSE BILL 36

Short Title:	Enact Enhanced Access to Eye Care Act.	(Public)		
Sponsors:	Representatives Burr, Collins, Dobson, and Howard (Primary Sponsors).			
,	For a complete list of sponsors, refer to the North Carolina General Assembly web	site.		
Referred to:	Health, if favorable, Insurance, if favorable, Appropriations			

February 2, 2017

A BILL TO BE ENTITLED

AN ACT AMENDING THE SCOPE OF PRACTICE OF OPTOMETRY IN ORDER TO ENHANCE ACCESS TO EYE CARE IN NORTH CAROLINA.

The General Assembly of North Carolina enacts:

Whereas, the provision of eye care is rapidly evolving through advances in technology, pharmacology, and biotechnology; and

Whereas, the health care profession of optometry is dedicated to providing patient-centered eye care of the highest quality; and

Whereas, 1180 licensed Doctors of Optometry now provide the majority of primary eye care in North Carolina due to widespread geographic distribution and excellence in practice; and

Whereas, Doctors of Optometry provide eye care in 98 North Carolina counties, with primary office locations in 88 counties; and

Whereas, the wide availability of practicing Doctors of Optometry in North Carolina provides access to high quality eye care throughout the State; and

Whereas, the optometric profession has steadily evolved in expansion of practice while maintaining an exemplary record of safety and care since being first statutorily defined in 1909; and

Whereas, the statutes governing the practice of optometry have not been substantively updated to acknowledge advances in technology since 1977; and

Whereas, the continued expansion of optometric services in North Carolina will greatly improve access and affordability of eye care to the citizens of North Carolina; Now, therefore, The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-114 reads as written:

"§ 90-114. Optometry defined.

- (a) Any one or any combination of the following practices shall constitute the practice of optometry:
 - (1) The examination of the human eye by any method, other than surgery, method to diagnose, to treat, or to refer for consultation or treatment any abnormal condition of the human eye and its adnexa; or
 - (2) The employment of instruments, devices, pharmaceutical agents and procedures, other than surgery, procedures intended for the purposes of investigating, examining, treating, diagnosing or correcting visual defects or abnormal conditions of the human eye or its adnexa; or



General	Assemb	ly Of North Carolina	Session 2017
	(3)	The prescribing and application of lenses, devices containing contact lenses, orthoptics, vision training, pharmaceutical agent devices to correct, relieve, or treat defects or abnormal conditional eye or its adnexa.	nts, and prosthetic
(b)	Perfor	mance of the following procedures shall not constitute the prac	tice of optometry.
		operative and postoperative care associated with these procedure	
<u>-11-4</u>	(1)	Retina laser procedures, LASIK, and PRK.	
	(2)	Nonlaser surgery related to removal of the eye from a living h	uman being.
	(3)	Nonlaser surgery requiring full thickness incision or excision	
	A	sclera other than paracentesis in an emergency situation rec	
		reduction of the pressure inside the eye.	
	<u>(4)</u>	Penetrating keratoplasty (corneal transplant), or lamellar kerat	oplasty.
	(5)	Nonlaser surgery requiring incision of the iris and ciliary bo	
		diathermy or cryotherapy.	
	(6)	Nonlaser surgery requiring incision of the vitreous.	
	(7)	Nonlaser surgery requiring incision of the retina.	
	(8)	Nonlaser surgical extraction of the crystalline lens.	
	(9)	Nonlaser surgical intraocular implants.	
	(10)	Incisional or excisional nonlaser surgery of the extraocular mu	iscles.
	$\overline{(11)}$	Nonlaser surgery of the eyelid for eyelid malignancies	or for incisional
		cosmetic or mechanical repair of blepharochalasis, ptosis, or ta	arsorrhaphy.
	(12)	Nonlaser surgery of the bony orbit, including orbital implants.	
	(13)	Incisional or excisional nonlaser surgery of the lacrimal s	ystem other than
		lacrimal probing or related procedures.	
	(14)	Nonlaser surgery requiring full thickness conjunctivoplasty wi	
	(15)	Any nonlaser surgical procedure that does not provide for t	he correction and
		relief of ocular abnormalities.	
	<u>(16)</u>	Laser or nonlaser injection into the posterior chamber of the	e eye to treat any
		macular or retinal disease.	
	<u>(17)</u>	The administration of general anesthesia.	
	(18)	Procedures performed under general anesthesia."	
	SECT	TION 2. This act becomes effective January 1, 2018.	

NORTH CAROLINA GENERAL ASSEMBLY HOUSE OF REPRESENTATIVES

HEALTH COMMITTEE REPORT

Representative Josh Dobson, Co-Chair Representative Nelson Dollar, Co-Chair Representative Bert Jones, Co-Chair Representative Donny Lambeth, Co-Chair Representative Gregory F. Murphy, MD, Co-Chair

FAVORABLE COM SUB, UNFAVORABLE ORIGINAL BILL

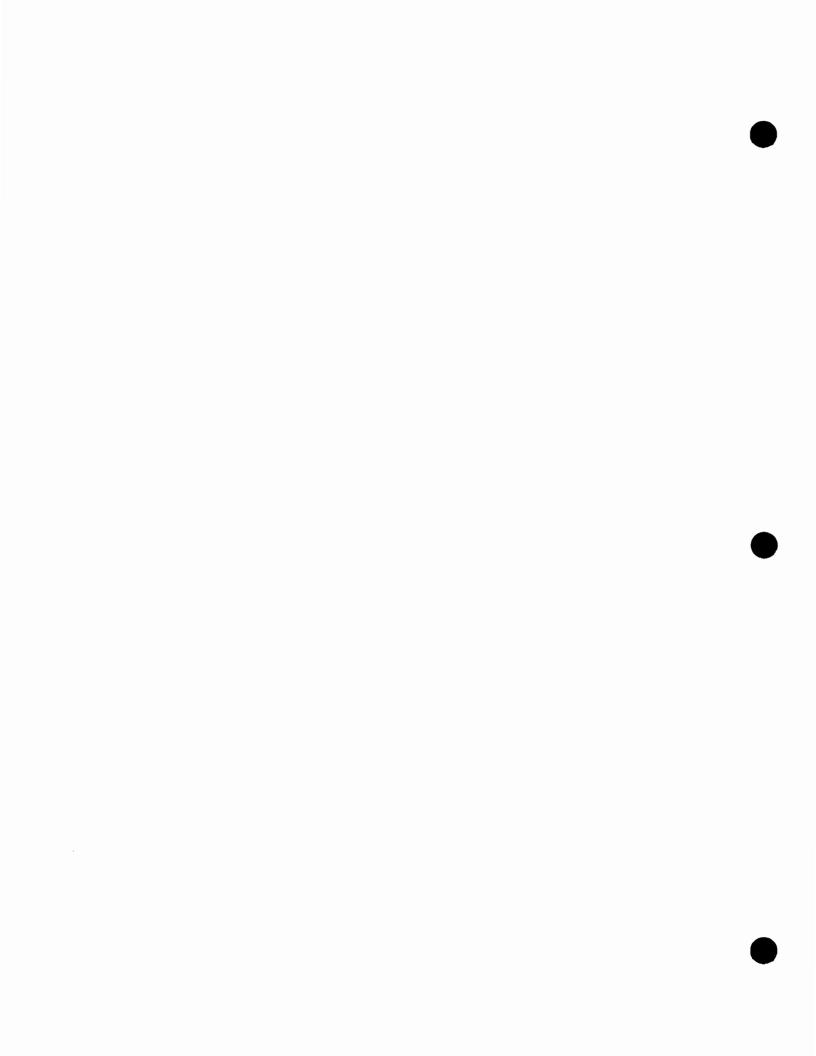
HB **36** Enact Enhanced Access to Eye Care Act.

Draft Number: H36-PCS10343-SH-21

Serial Referral: None Recommended Referral: None Long Title Amended: Yes Floor Manager: Burr

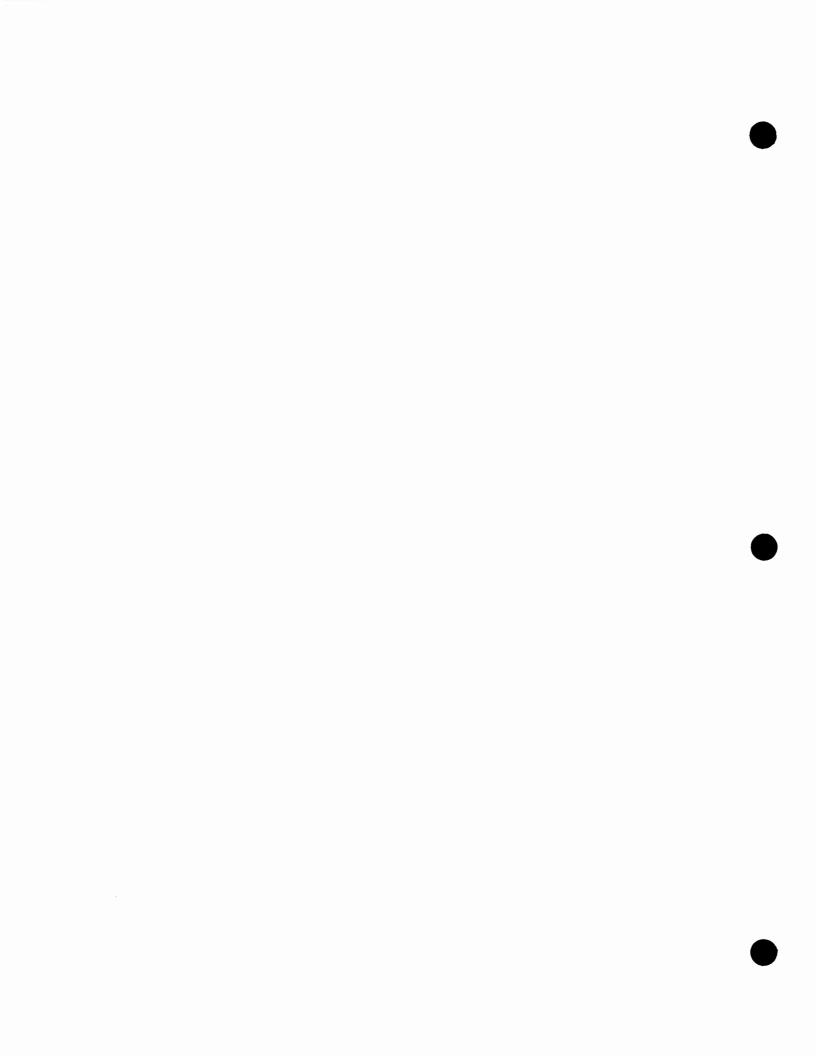
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Committee Sergeants at Arms

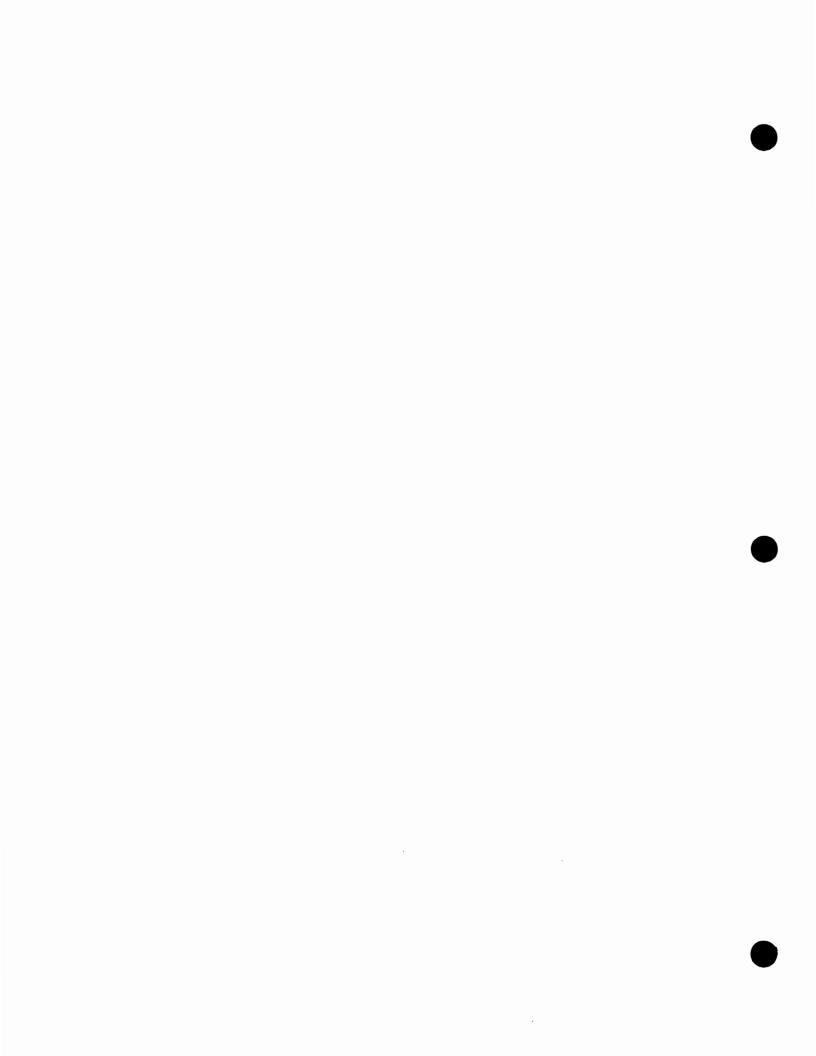
NAME OF COMMITTEE House Comm. on Health	<u>1</u>
DATE: 04/27/17 Room: 643	
House Sgt-At Arms:	
1. Name: Young Bae	
2. Name: Jim Moran	
B. Name: David Linthicum	
s. Name: Dean Marshbourne	
5. Name:	
Senate Sgt-At Arms:	
Name:	
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How Pages Assignments Thursday, April 27, 2017

Session: 10:30 AM

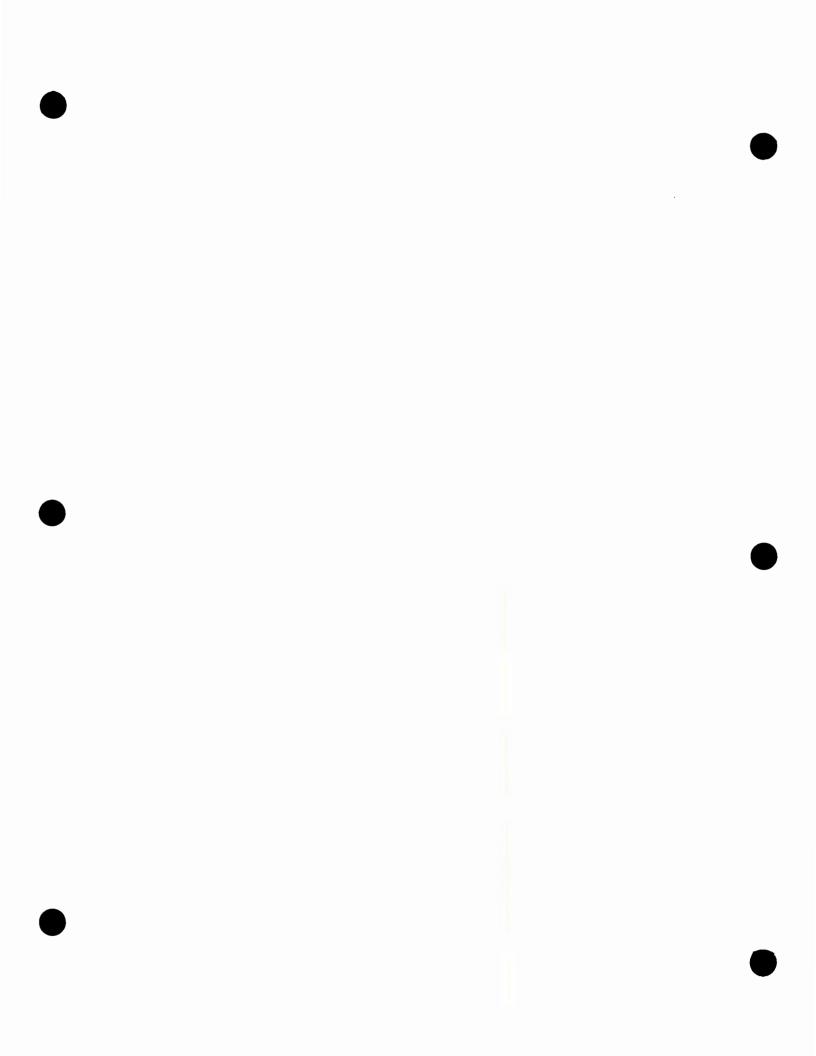
Committee	Room	Time	Staff	Comments	Member
Health	643	9:00 AM	Duncan Mills		Rep. Brian Turner
			Alyssa Scott		Rep. Jimmy Dixon
Rules, Calendar, and Operations of the House		10:00 AM	Claire Morris- Benedict		Rep. Mickey Michaux, Jr.
			Marko Stefanovic		Rep. Speaker Tim Moore



House Comm. on Health

04/27/17

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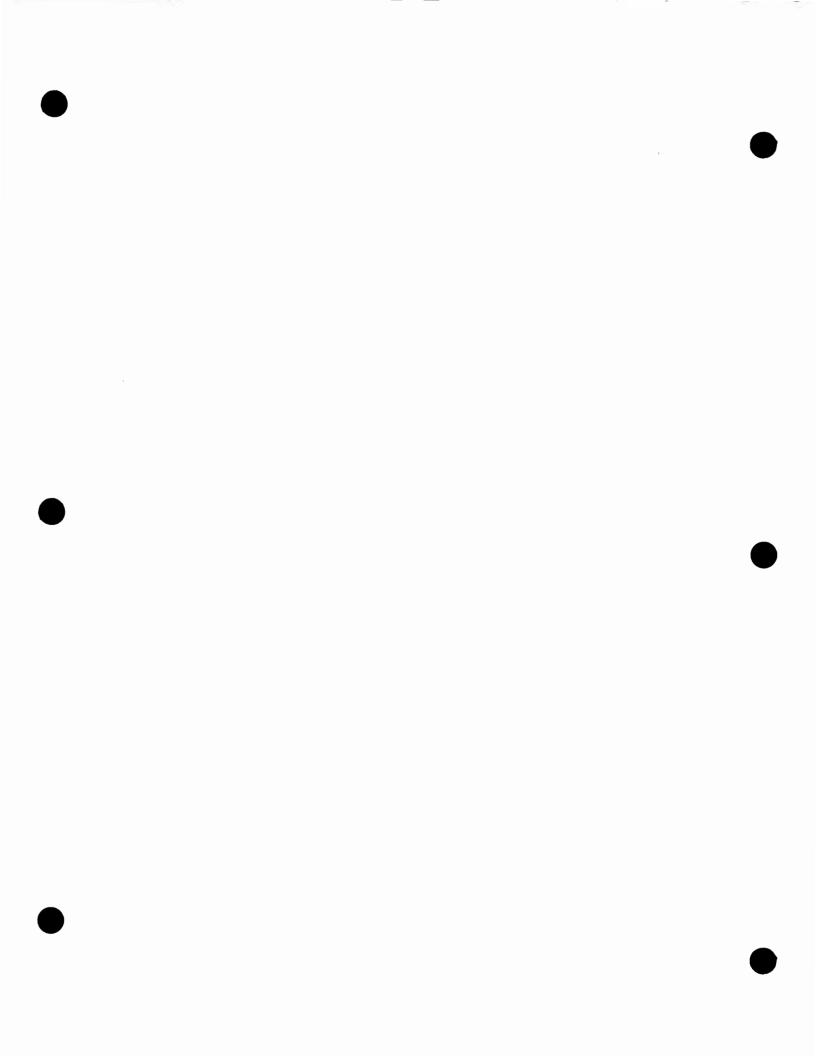
House Comm. on Health

04/27/17

Name of Committee

Date

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Joli Han Q	MTS
Mary Betur	NCCOA
amanda Danovan	KTS
Susanna Birdsorg	· ACUI-NC
Terens	C S S
Mike Hager	HSS
Phoebe Landon	MWC
Kotty Kirg8by	3P .
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All	MWC

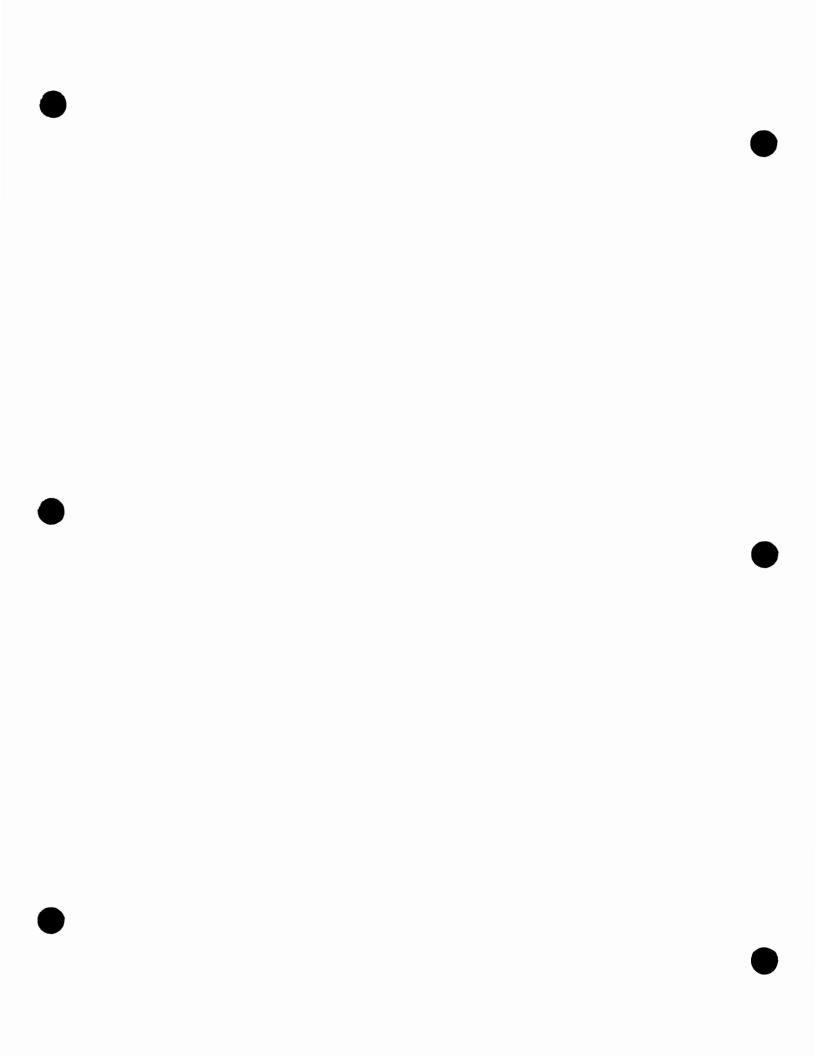


House Comm. on Health 04/27/17

Name of Committee

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Harame rolete	NCOS
Darla Lika	NCOS
Lava Der	.DZS
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Paul Kranze	NCOS.
Dujec Brin	TAMPAUN SIUDRS



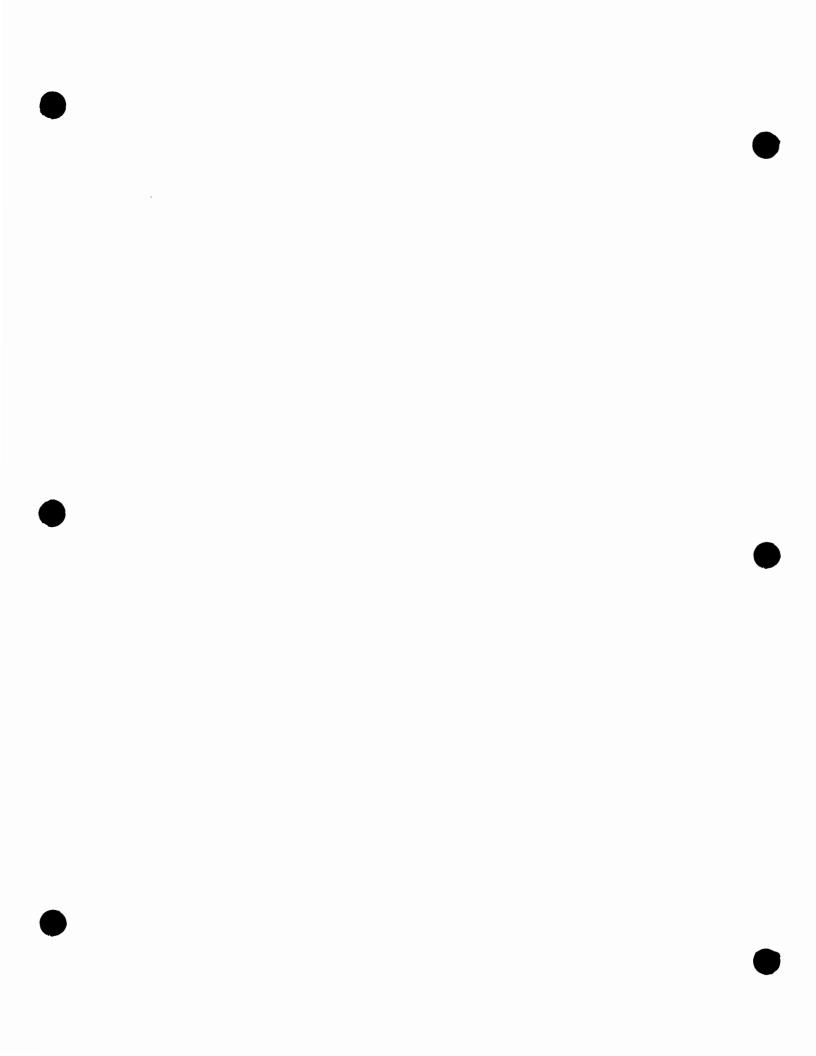
House Comm. on Health

04/27/17

Name of Committee

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Muman Juckson	Providence Aresthesiology
Davidforce	WS
THOM GOOGE	Godfy Grit Relations
Iom Fetzer	FSP
Lindsey Daving	FSP
Alex Scharfetter	FSP.
Dr Jem Bilingh	NC optimetic Society
De Andy Gook	Ne Opt with 500140



House Committee on Health Wednesday, May 10, 2017 at 11:00 AM Room 544 of the Legislative Office Building

MINUTES

The House Committee on Health met at 11:00 AM on May 10, 2017 in Room 544 of the Legislative Office Building. Representatives Adcock, Ball, Blackwell, Boswell, Brisson, Carney, Cunningham, Dobson, Dollar, Dulin, Earle, Farmer-Butterfield, Ford, Howard, Hunter, Jackson, Bert Jones, Lambeth, Lucas, Malone, Murphy, Potts, Rogers, Shepard, Szoka, White, Wray, and Zachary attended.

Representative Gregory F. Murphy, MD, Chair, presided.

The following bills were considered:

HB 357 Modernize Dietetics/Nutrition Practice Act. (Representatives Malone, Murphy, Adcock)

Representative Dollar was recognized for a motion to place the PCS for HB357 before the committee and hearing none Representative Malone was recognized to explain the PCS.

The Proposed Committee Substitute (PCS) to House Bill 357 would amend the Dietetics/Nutrition Practice Act by adding new definitions, changing the composition of the North Carolina Board of Dietetics/Nutrition, modifying the requirements to obtain a license and the acts that are prohibited to unlicensed individuals, permitting tele-practice and enteral nutrition therapy, instituting background checks, and making conforming changes.

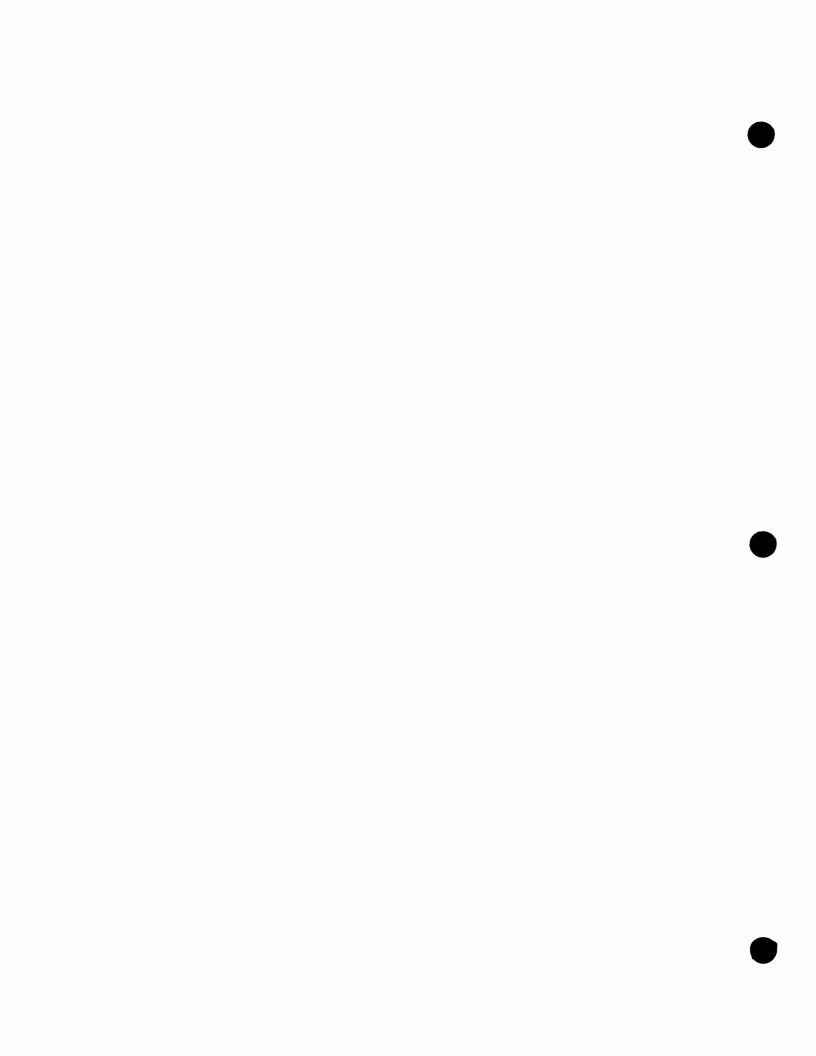
Judy Stone, Board of Certification of Nutrition Specialist provided assistance to the members questions or concerns.

After discussion from the members concluded Representative Bert Jones motioned for a favorable report to the PCS/HB357 unfavorable to the original bill with a Serial referral to Finance. The motion carries.

HB 890 Amend Psychology, Podiatry, Pastoral Counsir. (Representatives Jordan, Zachary, Malone)

Representative Dobson was recognized for a motion to place the PCS for HB890 before the committee and hearing none Representative Jordan was recognized to explain the PCS.

The Proposed Committee Substitute for House Bill 890 amends the Psychology Practice Act to establish an inactive licensure status for licensees, to revise record retention requirements, and to increase various licensing fees; the PCS provides an annual fee increase for podiatrists; and an annual fee increase for pastoral counselors and pastoral counseling associates.



Sandra Panico, Assistant Attorney General, NC Psychology Board Attorney provided assistance with any questions or concerns from the members of the committee.

After discussion from members concluded Representative Dollar motioned for a favorable report to the PCS/HB890 unfavorable to the original bill with a Serial referral to Finance. The motion carries.

HB 461 MH/SA Central Assessment & Navigation Pilot. (Representatives Grange, Murphy, Hardister)

Representative Grange was recognized to explain HB461.

House Bill 461 would create a 2-year pilot program in New Hanover County aimed at reducing the use of hospital emergency departments for mental health and substance use disorder services and appropriate \$250,000 for each of the 2017-18 and 2018-19 fiscal years to fund the program.

Scott Whisnant-Administrator of Community Relations New Hanover Medical Center was in attendance to answer any questions from the members of the committee.

After the discussion from the members concluded Representative Dollar motioned for a favorable report to HB461 with a Serial referral to Appropriations. The motion carries.

HB 477 Behav. Health Crisis EMS Transports/Medicaid. (Representatives Dobson, Malone, Potts, Carney)

Representative Dobson was recognized to explain HB477.

House Bill 477 would require the Department of Health and Human Services (DHHS) to design a plan for adding Medicaid coverage for ambulance transports to behavioral health clinics instead of hospital emergency departments and to report to the General Assembly about the plan, including the expected cost of adding coverage and a timeline for implementation of the plan.

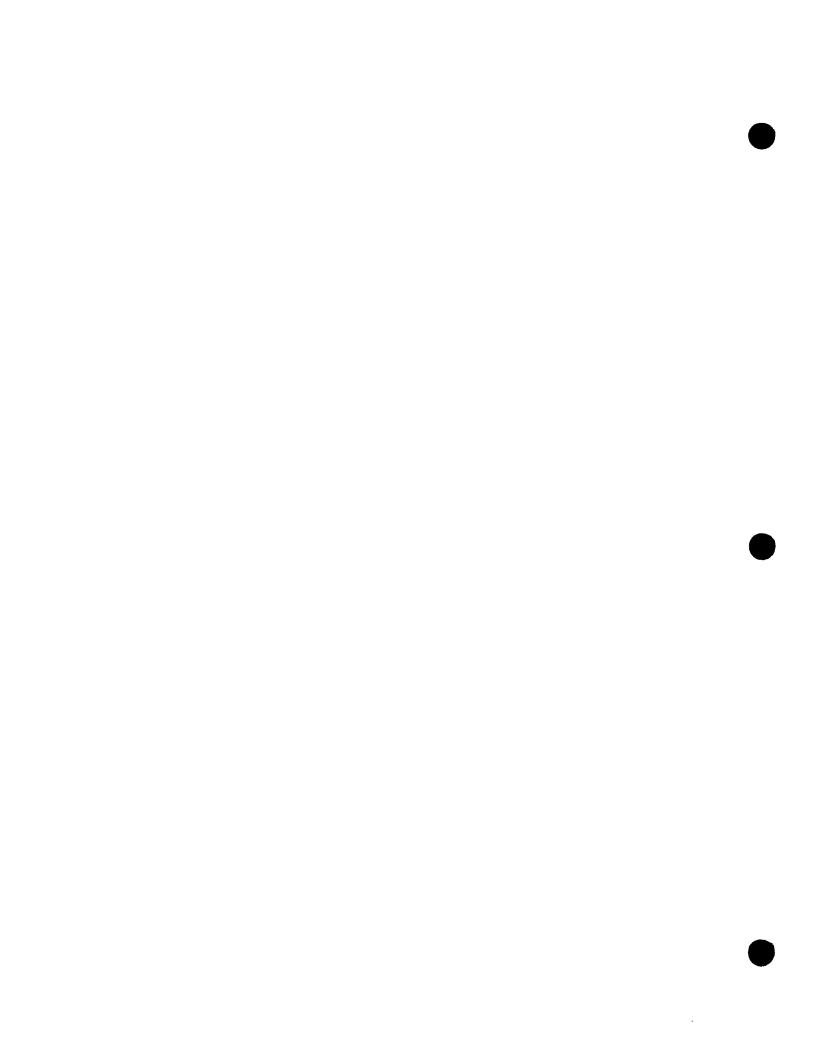
After the discussion from the members concluded Representative Farmer-Butterfield motioned for a favorable report to HB471with a Serial referral to Appropriations. The motion carries.

The meeting adjourned at 11:55.

Representative Gregory F. Murphy, MD, Chair

Presiding

Theresa Lopez, Committee Clerk



NORTH CAROLINA HOUSE OF REPRESENTATIVES COMMITTEE MEETING NOTICE AND BILL SPONSOR NOTIFICATION 2017-2018 SESSION

You are hereby notified that the House Committee on Health will meet as follows:

DAY & DATE: Wednesday, May 10, 2017

TIME: 11:00 AM LOCATION: 643 LOB

The following bills will be considered:

BILL NO. HB 357	SHORT TITLE Modernize Dietetics/Nutrition Practice	\$PONSOR Representative Malone
	Act.	Representative Murphy
		Representative Adcock
<u>HB 890</u>	Amend Psychology Practice Act.	Representative Jordan
		Representative Zachary
		Representative Malone
HB 461	MH/SA Central Assessment &	Representative Grange
	Navigation Pilot.	Representative Murphy
	224	Representative Hardister
<u>HB 477</u>	Behav. Health Crisis EMS	Representative Dobson
	Transports/Medicaid.	Representative Malone
	•	Representative Potts
		Representative Carney

Respectfully,

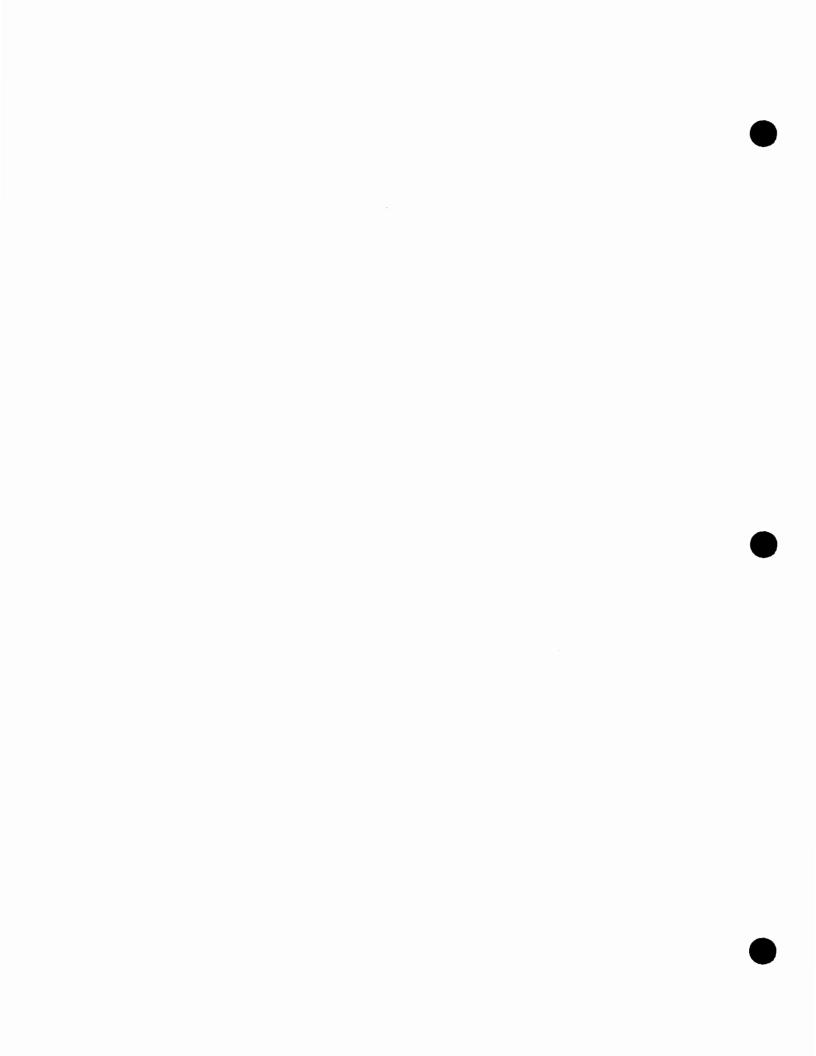
Representative Josh Dobson, Co-Chair Representative Nelson Dollar, Co-Chair Representative Bert Jones, Co-Chair Representative Donny Lambeth, Co-Chair

Representative Gregory F. Murphy, MD, Co-Chair

I hereby certify this notice was filed by the of Thursday, May 04, 2017.	committee assistant at the following offices at 3:05 PM o	n
Principal Clerk		

Brenda Olls (Committee Assistant)

____ Reading Clerk – House Chamber



Corrected #1: ROOM CHANGE

NORTH CAROLINA HOUSE OF REPRESENTATIVES COMMITTEE MEETING NOTICE AND BILL SPONSOR NOTIFICATION 2017-2018 SESSION

You are hereby notified that the House Committee on Health will meet as follows:

DAY & DATE: Wednesday, May 10, 2017

TIME: 11:00 AM LOCATION: 544 LOB

The following bills will be considered:

BILL NO. HB 357	SHORT TITLE Modernize Dietetics/Nutrition Practice	SPONSOR Representative Malone
	Act.	Representative Murphy
		Representative Adcock
HB 890	Amend Psychology Practice Act.	Representative Jordan
		Representative Zachary
		Representative Malone
<u>HB 461</u>	MH/SA Central Assessment &	Representative Grange
	Navigation Pilot.	Representative Murphy
		Representative Hardister
<u>HB 477</u>	Behav. Health Crisis EMS	Representative Dobson
	Transports/Medicaid.	Representative Malone
	•	Representative Potts
		Representative Carney

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Respectfully,

Representative Josh Dobson, Co-Chair Representative Nelson Dollar, Co-Chair Representative Bert Jones, Co-Chair Representative Donny Lambeth, Co-Chair Representative Gregory F. Murphy, MD, Co-Chair

I hereby certify this notice was filed by the committee assistant at the following offices at 3:26 PM on Monday, May 08, 2017.
Principal Clerk Reading Clerk – House Chamber
Brenda Olls (Committee Assistant)

House Committee on Health Wednesday, May 10, 2017, 11:00 AM 544 Legislative Office Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

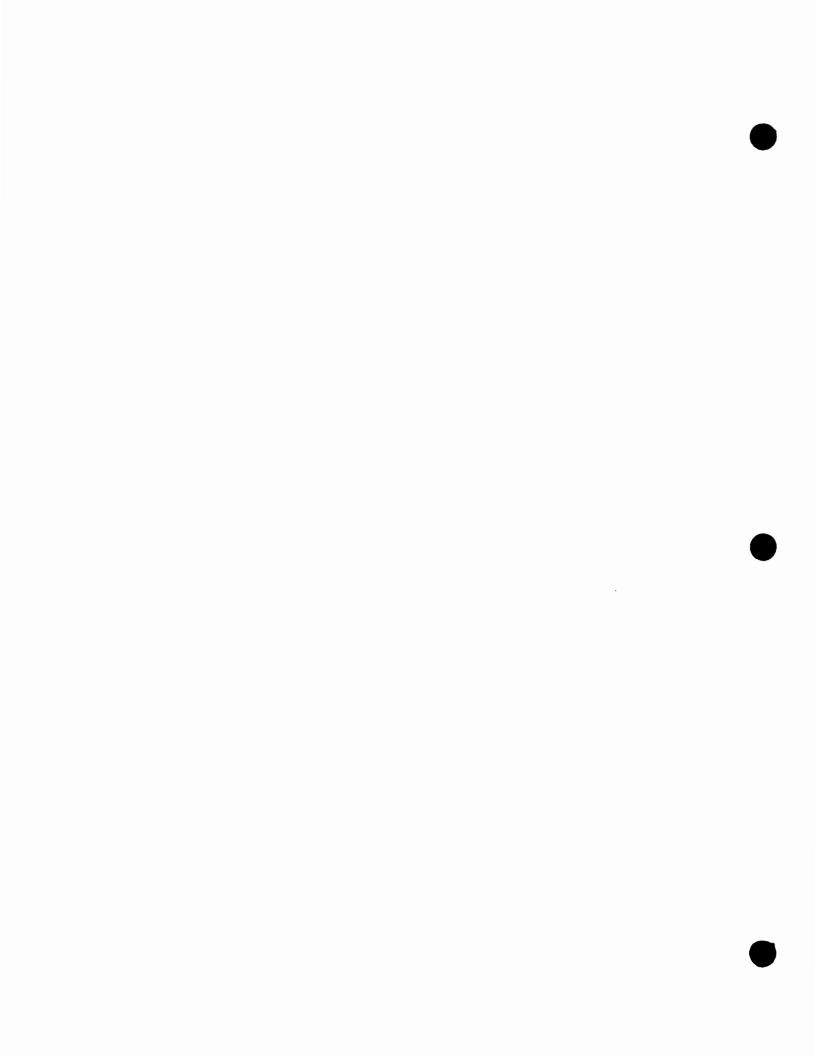
Bills

BILL NO.	SHORT TITLE	SPONSOR
HB 357	Modernize Dietetics/Nutrition Practice	Representative Malone
	Act.	Representative Murphy
		Representative Adcock
HB 890	Amend Psychology Practice Act.	Representative Jordan
		Representative Zachary
		Representative Malone
HB 461	MH/SA Central Assessment &	Representative Grange
	Navigation Pilot.	Representative Murphy
		Representative Hardister
HB 477	Behav. Health Crisis EMS	Representative Dobson
	Transports/Medicaid.	Representative Malone
	-	Representative Potts
		Representative Carney

Presentations

Other Business

Adjournment





HOUSE BILL 357: Modernize Dietetics/Nutrition Practice Act.

2017-2018 General Assembly

Committee:

House Health. If favorable, re-refer to Date:

May 9, 2017

Finance

Introduced by: Reps. Malone, Murphy, Adcock

Prepared by: Jason Moran-Bates

Analysis of:

PCS to First Edition

Staff Attorney

H357-CSBC-24

OVERVIEW: The Proposed Committee Substitute (PCS) to House Bill 357 would amend the Dietetics/Nutrition Practice Act by adding new definitions, changing the composition of the North Carolina Board of Dietetics/Nutrition, modifying the requirements to obtain a license and the acts that are prohibited to unlicensed individuals, permitting telepractice and enteral nutrition therapy, instituting background checks, and making conforming changes.

The PCS adds Section 4.(c) to provide for the staggering of terms for the North Carolina Board of Dietetics/Nutrition

[As introduced, this bill was identical to S297, as introduced by Sen. Brock, which is currently in Senate Rules and Operations of the Senate.]

CURRENT LAW: The Dietetics/Nutrition Practice Act is Article 25 of Chapter 90 of the General Statutes. It regulates the practice of dietetics and nutrition in North Carolina.

BILL ANALYSIS:

Section 1 would make a technical change to G.S. 90-351 to specify that the Dietetics/Nutrition Practice Act applies to individual involved in the practice of dietetics or nutrition.

Section 2 would amend G.S. 90-352 by adding definitions for "ACEND (Accreditation Council for Education in Nutrition and Dietetics)," "Certified Nutrition Specialist," "Diplomate of the American Clinical Board of Nutrition," "Medical nutrition therapy," "Nutrition," "Registered Dietitian Nutritionist," and "Telepractice."

Section 3 would amend G.S. 90-353 to change the composition of the North Carolina Board of Dietetics/Nutrition. The Board would be comprised of three dietitians/nutritionists, two nutritionists, one licensed physician, and one member of the public. Section 3 would also make conforming changes to G.S. 90-353.

Section 4.(a) would amend G.S. 90-354 to change the appointments of Board members. The bill provides that governor would appoint one dietitian/nutritionist, who must be an educator specializing in dietetics or nutrition, the licensed physician, and the member of the public. The General Assembly, on recommendation of the Speaker of the House of Representatives, would appoint one dietitian/nutritionist and one nutritionist. One of those two appointees must have a primary practice of clinical dietetics or nutrition in a hospital. The General Assembly, on recommendation of the President Pro Tempore of the Senate, would appoint one dietitian/nutritionist and one nutritionist. One of those two appointees must have a primary practice consulting in, or the private practice of, nutrition.





Legislative Analysis Division 919-733-2578

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Section 4.(b) would permit existing Board members to serve until their terms expire.

Section 4.(c) would clarify the process for staggering the terms of the new Board.

Section 5 would amend G.S. 90-356 to prohibit the Board from engaging in rule-making until two nutritionists are on the Board. It would also require the Board make public records resulting in disciplinary action taken by the Board and request that the Department of Public Safety conduct background checks on applicants for licensure. In addition, Section 5 makes several conforming changes to G.S. 90-356.

Section 6 would repeal G.S. 90-357, the licensure requirements for dietitians/nutritionists. These requirements would be replaced by new requirements set forth in Section 7 of the bill.

Section 7 would create a new section in Article 25 of Chapter 90 setting out licensure requirements.

Applicants for licensure as a licensed dietitian/nutritionist must either have a current registration from the Commission on Dietetic Registration as a Registered Dietitian Nutritionist, or:

- Obtain at least a bachelor's degree in an accredited program that meets the standards of an ACEND didactic program in dietetics and includes the following courses:
 - o 15 semester hours of clinical or life sciences.
 - o 3 semester hours of behavioral sciences.
 - o 24 semester hours of nutrition.
- Complete at least 1,000 hours of supervised practice experience or internship.
- Successfully complete the registration exam administered by the Commission on Dietetic Registration.

Applicants who applied prior to July 1, 2017, remain eligible for licensure under the requirements in force as of that date.

Applicants for license as a licensed nutritionist must:

- Obtain at least a master's nutrition degree in a relevant major that includes the following courses:
 - 15 semester hours of clinical or life sciences.
 - o 15 semester hours of nutrition and metabolism.
- Complete 1,000 hours of supervised practice experience or internship in nutrition services, which must include:
 - o 200 hours of nutrition intervention.
 - o 200 hours of nutrition monitoring or evaluation.
- Either successfully complete an exam approved by the Board, or have a valid Certified Nutrition Specialist or Diplomate, American Clinical Board of Nutrition designation.

Section 7 would also require applicants to bear the cost of a background check by the Department of Public Safety and permit the Board to refuse licensure to applicants who have been convicted of criminal offenses. Before denying licensure, the Board must consider the following factors related to any conviction: 1) the seriousness, date, and circumstances of the crime; 2) the applicant's age at the time of conviction; 3) the nexus between the crime and the applicant's job duties; and 4) the applicant's criminal and employment history since conviction.

Section 8 would amend G.S. 90-359 to specify which exams are approved by the Board.

Section 9 would amend G.S. 90-360 to permit the Board to grant licensure to individuals who have passed the appropriate exams and who are licensed in another state.

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Sections 10 and 11 would make technical changes to G.S. 90-361 and G.S. 90-363, respectively.

Section 12 would amend G.S. 90-365 to prevent unlicensed individuals from providing medical nutrition therapy, using the words "dietitian/nutritionist" or "nutritionist," or holding themselves out as a dietitian/nutritionist or nutritionist. The use of an earned, trademarked nutrition credential would still be permissible.

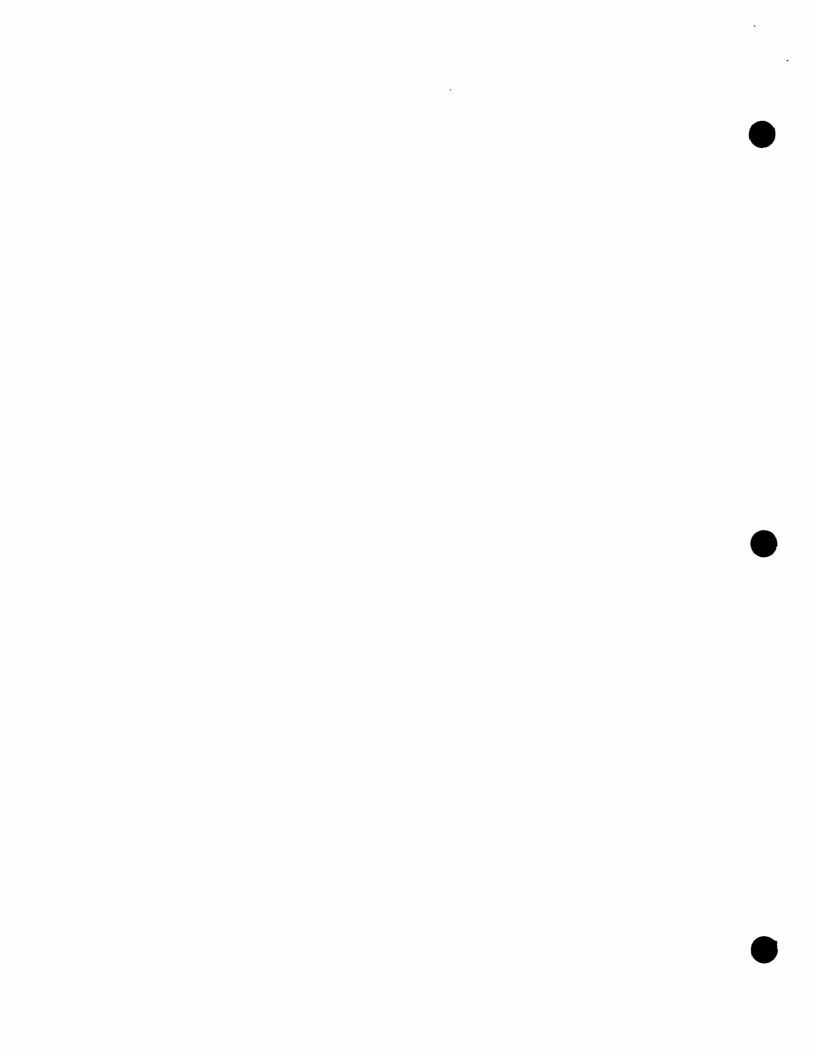
Section 13 would permit telepractice, defined in G.S. 90-355(6) as the "delivery of services . . . by means other than in person, including by telephone, e mail, Internet, or other methods of electronic communication," provided it was appropriate for the individual receiving services and met the care required for that individual. Individuals providing services via telepractice would still be subject to all the provisions of Article 25. Section 13 would also allow individuals deemed qualified by the Board to provide enteral and parenteral nutrition therapy.

Section 14 would clarify that Dietetics/Nutrition Practice Act does not apply to:

- Other medical professionals working within their scopes of practice, provided they do not claim to be licensed dietitians/nutritionists or licensed nutritionists.
- Individuals who provide weight control services, provided their weight control plans are reviewed by, and not subject to modification without approval of, a licensed dietitian/nutritionist, licensed nutritionist, licensed health care provider, or other individual approved by the Board.
- Individuals who provide nutrition services to family members without compensation.
- Individuals who provide nutrition information, guidance, recommendations, and weight control services that do not constitute medical nutrition therapy, provided they do not claim to be licensed dietitians/nutritionists or licensed nutritionists.

Section 15 would allow the Department of Public Safety (DPS) to provide criminal background checks on applicants for licensure to the Board. DPS would be allowed to charge a fee not exceeding the actual cost of conducting the background check.

EFFECTIVE DATE: Section 12 would become effective October 1, 2017, and apply to acts committed on or after that date. The remainder of the bill would become effective July 1, 2017.



GENERAL ASSEMBLY OF NORTH CAROLINA **SESSION 2017**

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HOUSE BILL 357 PROPOSED COMMITTEE SUBSTITUTE H357-CSBC-24 [v.4]

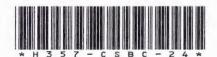
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(Public) Short Title: Modernize Dietetics/Nutrition Practice Act. Sponsors: Referred to:

March 16, 2017

A BILL TO BE ENTITLED 1 2 AN ACT EXPANDING THE ABILITY OF OUALIFIED NUTRITION PROFESSIONALS 3 TO PRACTICE IN THIS STATE AND AMENDING THE DIETETICS/NUTRITION 4 PRACTICE ACT. 5 The General Assembly of North Carolina enacts: 6 SECTION 1. G.S. 90-351 reads as rewritten: 7 "§ 90-351. Purpose. 8 It is the purpose of this Article to safeguard the public health, safety and welfare and to 9 protect the public from being harmed by unqualified persons by providing for the licensure and 10 regulation of persons engaged in the practice of dietetics/nutrition dietetics or nutrition and by the establishment of educational standards for those persons." 11 SECTION 2. G.S. 90-352 reads as rewritten: 12 13 "§ 90-352. Definitions. As used The following definitions apply in this Article, unless the context otherwise 14 15 requires, the term:requires: 16 "Board" means the ACEND. - The Accreditation Council for Education in (1) Nutrition and Dietetics, which is the Academy of Nutrition and Dietetics 17 accrediting agency for education programs preparing students for careers as 18 Registered Dietitian Nutritionists or Nutrition and Dietetic Technicians, 19 20 Registered. 21 Board. - The North Carolina Board of Dietetics/Nutrition. (1a)Certified Nutrition Specialist. - An individual certified by the Board for 22 (1b)23 Certification of Nutrition Specialists. "Dietetics/nutrition" means the Dietetics. - The integration and application 24 (2) 25 of principles derived from the science of nutrition, biochemistry, physiology, food, and management and from behavioral and social sciences to achieve 26 27 and maintain a healthy status. The primary function of dietetic/nutrition 28 practice-dietetics is the provision of medical nutrition eare services.therapy. 29 Diplomate of the American Clinical Board of Nutrition. - An individual (2a)certified by the American Clinical Board of Nutrition. 30 "Licensed dietitian/nutritionist" means an Licensed dietitian/nutritionist or 31 (3) licensed nutritionist. - An individual licensed in good standing to practice 32 dietetics/nutrition.dietetics, nutrition, or both. 33 Medical nutrition therapy. - The provision of nutrition care services for the



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- G.S. 90-353(a1)(1) and one licensed nutritionist as described in G.S. 90-353(a1)(2), both in accordance with G.S. 120-121, one of whom shall be a nutritionist with a masters or higher degree in a nutrition-related discipline. G.S. 120-121. One of these appointees shall be a dietician/nutritionist or a nutritionist whose primary practice is consulting in, or the private practice of, dietetics or nutrition.
- (b) Members of the Board shall take office on the first day of July immediately following the expired term of that office and shall serve for a term of three years and until their successors are appointed and qualified.
 - (c) No member shall serve on the Board for more than two consecutive terms.
- (d) The Governor may remove members of the Board, after notice and opportunity for hearing, for: for any of the following reasons:
 - (1) Incompetence: Incompetence.
 - (2) Neglect of duty; Neglect of duty.
 - (3) Unprofessional conduct; Unprofessional conduct.
 - (4) Conviction of any felony; Conviction of any felony.
 - (5) Failure to meet the qualifications of this Article; or Failure to meet the qualifications of this Article.
 - (6) Committing any act prohibited by this Article. Committing any act prohibited by this Article.
- (e) Any vacancy shall be filled by the appointing authority originally filling that position, except that any vacancy in appointments by the General Assembly shall be filled in accordance with G.S. 120-122.
- (f) Members of the Board shall receive no compensation for their services, but shall be entitled to travel, per diem, and other expenses authorized by G.S. 93B-5."

SECTION 4.(b) Members of the Board appointed prior to July 1, 2017, shall continue to serve until their terms expire, so long as, beginning July 1, 2017, two members of the Board are licensed nutritionists that meet the qualifications described in G.S. 90-357.5(c), as enacted by this act.

SECTION 4.(c) The staggering of terms and new Board composition shall be as follows. The Board member appointed pursuant to G.S. 90-353(a)(6), whose term expires on June 30, 2017, shall be succeeded by a licensed physician appointed by the Governor, pursuant to G.S. 90-353(a1)(3) and G.S. 90-354(a)(1)b. The Board member appointed pursuant to G.S. 90-353(a)(6) whose term expires on June 30, 2019, shall be succeeded by a member of the public appointed by the governor, pursuant to G.S. 90-353(a1)(4) and G.S. 90-354(a)(1)c. The Board member appointed pursuant to G.S. 90-353(a)(5) shall be succeeded by a licensed dietitian/nutritionist appointed by the Governor, pursuant to G.S. 90-353(a1)(1) and G.S. 90-354(a)(1)a. The Board member appointed pursuant to G.S. 90-353(a)(4) shall be succeeded by a licensed dietitian/nutritionist appointed by the General Assembly upon recommendation of the Speaker of the House, pursuant to G.S. 90-353(a1)(1) and G.S. 90-354(a)(2). The Board member appointed pursuant to G.S. 90-353(a)(3) shall be succeeded by a licensed nutritionist appointed by the General Assembly upon recommendation of the President Pro Tempore of the Senate, pursuant to G.S. 90-353(a1)(2) and G.S. 90-354(a)(3). The Board member appointed pursuant to G.S. 90-353(a)(2) shall be succeeded by a licensed dietitian/nutritionist appointed by the General Assembly upon recommendation of the President Pro Tempore of the Senate, pursuant to G.S. 90-353(a1)(1) and G.S. 90-354(a)(3). The Board member appointed pursuant to G.S. 90-353(a)(1) shall be succeeded by licensed nutritionist appointed by the General Assembly upon recommendation of the Speaker of the House, pursuant to G.S. 90-353(a1)(2) and G.S. 90-354(a)(2). Individuals who are Board members as of July 1, 2017, may be reappointed under the provisions of this subsection, provided they are otherwise eligible for reappointment.

SECTION 5. G.S. 90-356 reads as rewritten:

"§ 90-356. Power and responsibility of Board.

The Board shall:

- (1) Determine the qualifications and fitness of applicants for licenses, renewal of licenses, and reciprocal licenses; licenses.
- (2) Adopt rules necessary to conduct its business, carry out its duties, and administer this Article; provided, however, that as of July 1, 2017, no rule making shall be performed by the Board until two licensed nutritionists have been appointed to the Board.
- (3) Adopt and publish a code of ethics; ethics.
- (4) Deny, issue, suspend, revoke, and renew licenses in accordance with this Article; Article.
- (5) Conduct investigations, subpoena individuals and records, and do all other things necessary and proper to discipline persons licensed under this Article and to enforce this Article: Article.
- (6) Employ professional, clerical, investigative or special personnel necessary to carry out the provisions of this Article, and purchase or rent office space, equipment and supplies; supplies.
- (7) Adopt a seal by which it shall authenticate its proceedings, official records, and licenses; licenses.
- (8) Conduct administrative hearings in accordance with Article 3A of Chapter 150B of the General Statutes when a "contested case" as defined in G.S. 150B-2(2) arises under this Article; Article.
- (9) Establish reasonable fees for applications for examination; initial, provisional, and renewal licenses; and other services provided by the Board; Board.
- (10) Submit an annual report to the Governor and General Assembly of all its official actions during the preceding year, together with any recommendations and findings regarding improvements of the practice of dietetics/nutrition; dietetics or nutrition.
- (11) Publish and make available upon request the licensure standards prescribed under this Article and all rules adopted by the Board; Board.
- (12) Request and receive the assistance of State educational institutions or other State agencies; agencies.
- (13) Approve educational curricula, clinical practice and and evaluate continuing education requirements for persons seeking to renew licensure under this Article.
- (14) Publish, and make available to the public, records of any Board action resulting in any disciplinary action taken by the Board or criminal action taken by the State for any violation of this Article.
- (15) Request that the Department of Public Safety conduct criminal history record checks of applicants for licensure pursuant to G.S. 143B-966."

SECTION 6. G.S. 90-357 is repealed.

SECTION 7. Article 25 of Chapter 90 of the General Statutes is amended by adding new sections to read:

"§ 90-357.5. License Requirements.

- (a) Each applicant for a license as a licensed dietitian/nutritionist shall submit a completed application as required by the Board, submit any fees as required by the Board, and meet one of the following criteria:
 - (1) The applicant shall submit proof of completion for the following educational, supervised practice experience and examination requirements:

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- The applicant has received a baccalaureate degree, master's, or doctoral degree or validated foreign equivalent with a major in human nutrition, foods and nutrition, dietetics, food systems management, community nutrition, public health nutrition, nutrition education, nutrition, nutrition science, clinical nutrition, applied clinical nutrition, nutrition counseling, nutrition and functional medicine, nutritional biochemistry, nutrition and integrative health, or an equivalent course of study, from a college or university accredited at the time of graduation from the appropriate regional accrediting agency recognized by the Council on Higher Education Accreditation and the United States Department of Education and that, as approved by the Board, meets the competency requirements of an ACEND accredited didactic program in dietetics that shall, at a minimum, include the following courses:
 - 1. Fifteen semester hours of clinical or life sciences. These hours must include human anatomy and physiology or the equivalent, microbiology or the equivalent, organic chemistry, and biochemistry.
 - Three semester hours of behavioral sciences, such as psychology, sociology, cultural anthropology, counseling, or educational psychology.
 - 3. Twenty-four semester hours of food and nutrition. At least three semester hours must have been received in each of the following categories:
 - Diet therapy, medical dietetics, clinical nutrition, or the equivalent.
 - II. Nutrition through life cycle, applied human nutrition, advanced human nutrition, or the equivalent.
 - III. Foods, food science, food composition and menu planning, food service management, or the equivalent.
 - The applicant has completed a Board-approved internship or documented, supervised practice experience that meets the competency requirements of an ACEND accredited, supervised practice experience and is not less than 1,000 hours under the supervision of a Certified Nutrition Specialist, a Diplomate of the American Clinical Board of Nutrition, a Registered Dietitian Nutritionist, a licensed dietitian/nutritionist, a licensed nutritionist, a State-licensed health care practitioner whose licensed scope of practice includes dietetics or nutrition, or an individual with a doctoral degree conferred by a United States regionally accredited college or university with a major course of study in human nutrition, foods and nutrition, dietetics, food systems management, community nutrition, public health nutrition, nutrition education, nutrition, nutrition science, clinical nutrition, applied clinical nutrition, nutrition counseling, nutrition and functional medicine, nutritional biochemistry, nutrition and integrative health, or an equivalent course of study, with a reasonable threshold of academic credits in nutrition and nutrition sciences as described in sub-subdivision a. of this subdivision. Supervisors who obtained their doctoral degree outside of the United States and its territories must have their degrees

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validated by the Board as equivalent to the doctoral degree conferred by a United States regionally accredited college or university.

- c. The applicant has successfully completed the registration examination for dietitian nutritionists administered by the Commission on Dietetic Registration.
- (2) The applicant has a valid current registration with the Commission on Dietetic Registration that gives the applicant the right to use the term "Registered Dietitian Nutritionist" or "RDN."
- (b) All persons licensed or who have submitted an application for licensure as a dietitian/nutritionist prior to July 1, 2017, shall remain licensed, eligible for reactivation, or eligible for licensure under the requirements in place at the time of licensure or application, so long as the applicant or licensee remains in good standing and maintains an active or inactive license if obtained or once it is obtained.
- (c) Each applicant for a license as a licensed nutritionist shall submit a completed application as required by the Board, submit any fees as required by the Board, and shall submit proof of the completion of all of the following educational, supervised practice experience and examination requirements:
 - (1) The applicant has received any of the following from a college or university accredited at the time of graduation from the appropriate regional accrediting agency recognized by the Council on Higher Education, or a validated foreign equivalent: a master's or doctoral nutrition degree with a major in human nutrition, foods and nutrition, dietetics, community nutrition, public health nutrition, nutrition education, nutrition, nutrition science, clinical nutrition, applied clinical nutrition, nutrition counseling, nutrition and functional medicine, nutritional biochemistry, nutrition and integrative health, or an equivalent course of study or a master's or doctoral degree in a field of clinical health care. Regardless of the course of study, an applicant shall have completed coursework from a regionally accredited college or university in medical nutrition therapy that shall consist of the following courses:
 - a. Fifteen semester hours of clinical or life sciences, including such courses as chemistry, organic chemistry, biology, molecular biology, biotechnology, botany, genetics, genomics, neuroscience, experimental science, immunotherapy, pathology, pharmacology, toxicology, research methods, applied statistics, biostatistics, epidemiology, oxidative/reductive dynamics, energy production, molecular pathways, hormone and transmitter regulations and imbalance, biotransformation pathways and imbalances, and pathophysiologic basis of disease. At least three semester hours must be in human anatomy and physiology or the equivalent.
 - b. Fifteen semester hours of nutrition and metabolism, including such courses as nutrition assessment, developmental nutrition, nutritional aspects of disease, human nutrition, macronutrients, micronutrients, vitamins and minerals, functional medicine nutrition, molecular metabolism, clinical nutrition, nutritional biochemistry, nutrition and digestive health, and public health nutrition. At least six semester hours must be in biochemistry.
 - (2) The applicant must have completed a Board-approved internship or a documented, supervised practice experience in nutrition services of not less than 1,000 hours involving at least 200 hours of nutrition assessment, 200 hours of nutrition intervention, education, counseling, or management, and

200 hours of nutrition monitoring or evaluation under the supervision of a Certified Nutrition Specialist, a Diplomate of the American Clinical Board of Nutrition, a Registered Dietitian Nutritionist, a licensed dietitian/nutritionist, a licensed nutritionist, a State-licensed health care practitioner whose licensed scope of practice includes dietetics or nutrition, or an individual with a doctoral degree conferred by a United States regionally accredited college or university with a major course of study in human nutrition, foods and nutrition, dietetics, nutrition education, nutrition, nutrition science, clinical nutrition, applied clinical nutrition, nutrition counseling, nutrition and functional medicine, nutritional biochemistry, nutrition and integrative health, or an equivalent course of study, with a reasonable threshold of academic credits in nutrition and nutrition sciences as described in subdivision (1) of this subsection. Supervisors who obtained their doctoral degree outside of the United States and its territories must have their degrees validated by the Board as equivalent to the doctoral degree conferred by a United States regionally accredited college or university.

(3)

(3) The applicant meets one of the following criteria:

a. The applicant has successfully completed either the examination administered by the Board for Certification of Nutrition Specialists, the examination administered by the American Clinical Board of Nutrition, or another examination approved by the Board and meeting the requirements defined in G.S. 90-359.

b. The applicant has either a valid current certification with the Board for Certification of Nutrition Specialists that gives the applicant the right to use the term "Certified Nutrition Specialist" or "CNS" or a valid current certification with the American Clinical Board of Nutrition that gives the applicant the right to use the term "Diplomate, American Clinical Board of Nutrition" or "DACBN."

"§ 90-357.6. Criminal history record checks of applicants for licensure.

(a) All applicants for licensure shall consent to a criminal history record check. The Board may request a criminal history record check of applicants returning to active status as a licensed dietitian/nutritionist or a licensed nutritionist. Refusal to consent to a criminal history record check may constitute grounds for the Board to deny licensure to an applicant. The Board shall ensure that the State and national criminal history of each applicant is checked. The Board shall be responsible for providing to the North Carolina Department of Public Safety the fingerprints of the applicant to be checked, a form signed by the applicant consenting to the criminal history record check and the use of fingerprints and other identifying information required by the State or National Repositories, the fee required by the Department of Public Safety for providing this service, and any additional information required by the Department of Public Safety. The Board shall keep all information obtained pursuant to this section confidential.

(b) The cost of the criminal history record check and the fingerprinting shall be borne by the applicant. The Board shall collect any fees required by the Department of Public Safety and shall remit the fees to the Department of Public Safety for expenses associated with conducting the criminal history record check.

(c) If an applicant's criminal history record check reveals one or more convictions, the conviction shall not automatically bar issuance of a license by the Board to the applicant. The Board shall consider all of the following factors regarding the conviction:

- (1) The level of seriousness of the crime.
- (2) The date of the crime.

- (3) The age of the person at the time of the conviction.
- (4) The circumstances surrounding the commission of the crime, if known.
- (5) The nexus between the criminal conduct of the person and the job duties of the position to be filled.
- (6) The person's prison, jail, probation, parole, rehabilitation, and employment records since the date the crime was committed.

(7) Any subsequent commission of a crime by the applicant.

If, after reviewing the factors, the Board determines that the grounds set forth in G.S. 90-363 exist, the Board may deny licensure of the applicant. The Board may disclose to the applicant information contained in the criminal history record check that is relevant to the denial. The Board shall not provide a copy of the criminal history record check to the applicant. The applicant shall have the right to appear before the Board to appeal the Board's decision. However, an appearance before the full Board shall constitute an exhaustion of administrative remedies in accordance with Chapter 150B of the General Statutes.

(d) The Board, its officers and employees, acting in good faith and in compliance with this section, shall be immune from civil liability for denying licensure to an applicant based on information provided in the applicant's criminal history record check."

SECTION 8. G.S. 90-359 reads as rewritten:

"§ 90-359. Examinations.

Competency examinations shall be administered at least twice each year to qualified applicants for licensing. The examinations may be administered by a national testing service. The Board examinations shall prescribe or develop the examinations which may include an examination the RDN Examination given by the Commission on Dietetic Registration of the American Dietetic Association or any other examination Registration, the CNS Examination given by the Board for Certification of Nutrition Specialists and the DACBN Examination given by the American Clinical Board of Nutrition. The Board may include other nutrition therapy-focused examinations accredited by the National Commission for Certifying Agencies for graduates with a baccalaureate degree or higher from a college or university accredited at the time from the appropriate regional accrediting agency recognized by the Council on Health Education Accreditation and the United States Department of Education that are approved by two-thirds vote of the entire Board."

SECTION 9. G.S. 90-360 reads as rewritten:

"§ 90-360. Granting license without examination.

The Board may grant, upon application and payment of proper fees, a license without examination as a licensed dietitian/nutritionist or a licensed nutritionist to a person who has met the examination requirements under G.S. 90-359 at the time of application and holds a valid license or certification as a licensed dietitian/nutritionist dietitian/nutritionist, dietitian, or nutritionist issued by another state or any political territory or jurisdiction acceptable to the Board if in the Board's opinion the requirements for that license or certification are substantially the same as the requirements of this Article."

SECTION 10. G.S. 90-361 reads as rewritten:

"§ 90-361. Provisional licenses.

The Board may grant a provisional license for a period not exceeding 12 months to any individual who has successfully completed the educational and clinical practice requirements and has made application to take one of the examination examinations required under G.S. 90-357. G.S. 90-359. A provisional license shall allow the individual to practice as a dietitian/nutritionist or nutritionist under the supervision of a dietitian/nutritionist or nutritionist licensed in this State and shall be valid until revoked by the Board."

SECTION 11. G.S. 90-363(a) reads as rewritten:

"§ 90-363. Suspension, revocation and refusal to renew license.

An individual certified by the Board of Certification of Nutrition Specialists (2) has the right to use the title "Certified Nutrition Specialist" and the designation "CNS."

An individual certified by the American Clinical Board of Nutrition has the (3) right to use the title "Diplomate, American Clinical Board of Nutrition" and the designation "DACBN.""

SECTION 13. Article 25 of Chapter 90 of the General Statutes is amended by adding new sections to read:

"§ 90-365.5. Telepractice.

Telepractice as defined in G.S. 90-352 is not prohibited under this Article so long as (i) it is appropriate for the individual receiving the services and (ii) the level of care provided meets the required level of care for that individual. An individual providing services regulated by this

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General Assembly Of North Carolina Article via telepractice shall comply with, and shall be subject to, all the licensing and 1 2 disciplinary provisions of this Article. 3 "§ 90-365.6. Enteral and parenteral nutrition therapy. 4 Enteral and parenteral nutrition therapy shall consist of enteral feedings or 5 specialized intravenous solutions and shall only be ordered by an individual licensed under this 6 Article who meets one of the following criteria: 7 The individual is a Registered Dietitian Nutritionist registered with the (1)8 Commission on Dietetic Registration. 9 The individual is a Certified Nutrition Support Clinician certified by the (2) National Board of Nutrition Support Certification. 10 The individual meets the requirements set forth in rules adopted by the 11 (3) 12 13 Nothing in this Article shall be construed to limit the ability of any other licensed (b) 14 health care practitioner in this State to order therapeutic diets, so long as the ordering of 15 SECTION 14. G.S. 90-368 reads as rewritten: 16 17 "§ 90-368. Persons and practices not affected. 18 The requirements of this Article shall not apply to: 19 20 21 22 23 (2) 24 25 26 27

therapeutic diets falls within the scope of the license held by the health care practitioner."

- A health care professional duly licensed in accordance with Chapter 90 of the General Statutes. Statutes who is acting within the scope of the individual's licensed profession, provided that the individual does not use the titles licensed dietitian/nutritionist or licensed nutritionist.
- A student or trainee, working under the direct supervision of a licensed dietitian/nutritionist an individual who meets the criteria outlined in G.S. 90-357.5(a)(1)b. or G.S. 90-357.5(c)(2) while fulfilling an experience requirement or pursuing a course of study to meet requirements for licensure, for a limited period of time as determined by the Board.
- (3) A dietitian/nutritionist or nutritionist serving in the Armed Forces or the Public Health Service of the United States or employed by the Veterans Administration when performing duties associated with that service or employment.
- **(4)** A person aiding the practice of dietetics/nutrition dietetics or nutrition if the person works under the direct supervision of a licensed dietitian/nutritionist and-dietitian/nutritionist, licensed nutritionist, or other licensed health care practitioner whose licensed scope of practice includes the practice of dietetics or nutrition and the person performs only support activities that do not require formal academic training in the basic food, nutrition, chemical, biological, behavioral, and social sciences that are used in the practice of dietetics.dietetics or nutrition.
- (5) An employee of the State, a local political subdivision, or a local school administrative unit or a person that contracts with the State, a local political subdivision, or a local school administrative unit while engaged in the practice of dietetics/nutrition dietetics or nutrition within the scope of that employment.
- A retailer who does not hold himself out to be a dietitian or nutritionist when (6)that retailer furnishes nutrition information to customers on food, food materials, dietary supplements and other goods sold at his retail establishment in connection with the marketing and distribution of those goods at his retail establishment.
- A person who provides weight control services; provided the program has (7) been reviewed by, consultation is available from, and no program change

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1		can be initiated without prior approval of: of one of the following
2		individuals:
3		a. A licensed dietitian/nutritionist; North Carolina licensed
4		dietitian/nutritionist, nutritionist, or other health care practitioner
5		whose licensed scope of practice includes the practice of dietetics or
6		nutrition.
7		b. A dietitian/nutritionist dietitian/nutritionist, nutritionist, or other
8		health care practitioner licensed or certified in another state that has
9		licensure or certification requirements that are at least as stringent as
10		under this Article; or Article, and other relevant sections of this
11		Chapter, and whose licensed or certified scope of practice includes
12		the practice of dietetics or nutrition.
13		c. A <u>dietitian dietitian/nutritionist or nutritionist</u> registered by the
14		Commission on Dietetic Registration of the American Dietetic
15		Association. Registration, the Board for Certification of Nutrition
16		Specialists, or the American Clinical Board of Nutrition.
17	(8)	Employees or independent contractors of a hospital or health care facility
18	(0)	licensed under Article 5 or Part A of Article 6 of Chapter 131E or Article 2
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	(0)	of Chapter 122C of the General Statutes.
20	(9)	A person who does not hold himself or herself out to be a dietitian or
21		nutritionist when that person furnishes nutrition information on food, food
22		materials, or dietary supplements. This Article does not prohibit that person
23		from making explanations to customers about foods or food products in
24	(10)	connection with the marketing and distribution of these products.
21 22 23 24 25 26	(10)	An herbalist or other person who does not hold himself or herself out to be a
20		dietitian or nutritionist when the person furnishes nonfraudulent specific
27		nutritional information and counseling about the reported or historical use of
28		herbs, vitamins, minerals, amino acids, carbohydrates, sugars, enzymes, food
29	(4.4)	concentrates, or other foods.
30	(11)	Any individual who provides nutrition services without remuneration to
31	(4.5)	family members.
32	(12)	Any individual who provides nutrition information, guidance,
33		encouragement, individualized nutrition recommendations, or weight control
34		services that do not constitute medical nutrition therapy as defined in
35		G.S. 90-352, provided that the individual (i) does not hold himself or herself
36		out as a licensed dietitian/nutritionist or a licensed nutritionist as prohibited
37		under G.S. 90-365 and (ii) does not seek to provide medical nutrition therapy
38		as defined in G.S. 90-352."
39		FION 15. Article 13 of Chapter 143B of the General Statutes is amended by
10	adding a new sec	
11		riminal record checks of applicants for licensure as dietitian/nutritionists
12		tritionists.
13		ment of Public Safety may provide to the North Carolina Board of
14		on a criminal history record from the State and National Repositories of
15		es for applicants for licensure by the Board. Along with a request for criminal
16		he Board shall provide to the Department of Public Safety the fingerprints of
17		subject, a form signed by the applicant consenting to the criminal history
18		d use of the fingerprints and other identifying information required by the
19	Repositories, and	any additional information required by the Department. The fingerprints shall
0	be forwarded to	the State Bureau of Investigation for a search of the State's criminal history
51	record file, and	the State Bureau of Investigation shall forward a set of fingerprints to the

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Federal Bureau of Investigation for a national criminal history record check. The Board shall keep all information obtained pursuant to this section confidential. The Department of Public Safety may charge a fee to offset the cost incurred by the Department of Public Safety to conduct a criminal history record check under this section, but the fee shall not exceed the actual cost of locating, editing, researching, and retrieving the information."

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SECTION 16. Section 12 of this act becomes effective October 1, 2017, and applies to acts committed on or after that date. The remainder of this act becomes effective July 1, 2017.

GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2017

H

HOUSE BILL 357

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Short Title: Modernize Dietetics/Nutrition Practice Act. (Public)

Sponsors: Representatives Malone, Murphy, and Adcock (Primary Sponsors).

For a complete list of sponsors, refer to the North Carolina General Assembly web site.

Referred to: Health, if favorable, Finance

March 16, 2017

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A BILL TO BE ENTITLED

AN ACT EXPANDING THE ABILITY OF QUALIFIED NUTRITION PROFESSIONALS TO PRACTICE IN THIS STATE AND AMENDING THE DIETETICS/NUTRITION PRACTICE ACT.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-351 reads as rewritten:

"§ 90-351. Purpose.

It is the purpose of this Article to safeguard the public health, safety and welfare and to protect the public from being harmed by unqualified persons by providing for the licensure and regulation of persons engaged in the practice of dietetics/nutrition_dietetics or nutrition and by the establishment of educational standards for those persons."

SECTION 2. G.S. 90-352 reads as rewritten:

"§ 90-352. Definitions.

As used The following definitions apply in this Article, unless the context otherwise requires; the term:requires:

- (1) "Board" means the ACEND. The Accreditation Council for Education in Nutrition and Dietetics, which is the Academy of Nutrition and Dietetics accrediting agency for education programs preparing students for careers as Registered Dietitian Nutritionists or Nutrition and Dietetic Technicians, Registered.
- (1a) Board. The North Carolina Board of Dietetics/Nutrition.
- (1b) Certified Nutrition Specialist. An individual certified by the Board for Certification of Nutrition Specialists.
- "Dietetics/nutrition" means the <u>Dietetics</u>. The integration and application of principles derived from the science of nutrition, biochemistry, physiology, food, and management and from behavioral and social sciences to achieve and maintain a healthy status. The primary function of <u>dietetic/nutrition practice_dietetics</u> is the provision of <u>medical nutrition care services.therapy</u>.
- (2a) Diplomate of the American Clinical Board of Nutrition. An individual certified by the American Clinical Board of Nutrition.
- (3) "Licensed dietitian/nutritionist" means an Licensed dietitian/nutritionist or licensed nutritionist. An individual licensed in good standing to practice dietetics/nutrition.dietetics, nutrition, or both.
- (3a) Medical nutrition therapy. The provision of nutrition care services for the purpose of managing or treating a medical condition.



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least five years; and three years.

- (3) Be licensed under this Article, except that initial appointees shall be licensed under this Article no later than March 31, 1992. the first appointed licensed nutritionists are not required to be licensed under this Article or to have practiced for three years at the time of their appointment to a first term on the Board; provided, however, that each appointed licensed nutritionist must meet all of the following criteria:
 - a. Possess the qualifications necessary for licensure under this Article.
 - b. Apply for licensure under this Article within six months of its availability.
- (b1) The licensed physician member of the Board shall be a citizen of the United States and a resident of this State.
- (c) The <u>members_member</u> of the Board appointed from the public at large shall be <u>eitizens_a citizen</u> of the United States and <u>residents_a resident</u> of this State and shall not be any of the following:
 - (1) A dietician/nutritionist.dietician/nutritionist or nutritionist.
 - (2) An agent or employee of a person engaged in the profession of dietetics/nutrition.dietetics or nutrition.
 - (3) A licensed health care professional or enrolled in a program to become prepared to be a licensed health care professional.
 - (4) An agent or employee of a health care institution, a health care insurer, or a health care professional school.
 - (5) A member of any allied health profession or enrolled in a program to become prepared to be a member of an allied health profession.
 - (6) The spouse of an individual who may not is not eligible to serve as a public member of the Board."

SECTION 4.(a) G.S. 90-354 reads as rewritten:

"§ 90-354. Appointments and removal of Board members, terms and compensation.

- (a) The members of the Board shall be appointed as follows:
 - (1) The Governor shall appoint the professional member following members:
 - a. One licensed dietitian/nutritionist as described in G.S. 90-353(a)(5) and the two-G.S. 90-353(a1)(1), who shall be an educator on the faculty of a college or university accredited at the time from the appropriate regional accrediting agency recognized by the Council on Higher Education Accreditation and the United States Department of Education, specializing in the field of dietetics or nutrition.
 - b. The licensed physician as described in G.S. 90-353(a1)(3).
 - c. The public members member as described in G.S. 90-353(a)(6);G.S. 90-353(a1)(4).
 - The General Assembly upon the recommendation of the Speaker of the House of Representatives shall appoint the professional members one licensed dietitian/nutritionist as described in G.S. 90-353(a)(1) and G.S. 90-353(a)(2)—G.S. 90-353(a1)(1) and one licensed nutritionist as described in G.S. 90-353(a1)(2), both in accordance with G.S. 120-121, one of whom G.S. 120-121. One of these appointees shall be a dietician/nutritionist or a nutritionist with a masters or higher degree in a nutrition related discipline; and whose primary practice is clinical dietetics or nutrition in a hospital or long-term care institution regulated under Article 5 or Part 1 of Article 6 of Chapter 131E of the General Statutes.
 - (3) The General Assembly upon the recommendation of the President Pro Tempore of the Senate shall appoint the professional members one licensed dietitian/nutritionist as described in G.S. 90-353(a)(3) and G.S. 90-353(a)(4)

1		G.S. 90-353(a1)(1) and one licensed nutritionist as described in G.S
2		90-353(a1)(2), both in accordance with G.S. 120-121, one of whom shall be
3		a nutritionist with a masters or higher degree in a nutrition-related
4		discipline.G.S. 120-121. One of these appointees shall be a
5		dietician/nutritionist or a nutritionist whose primary practice is consulting in
6		or the private practice of, dietetics or nutrition.
7	(b) Men	bers of the Board shall take office on the first day of July immediately
8	' /	spired term of that office and shall serve for a term of three years and until their
9	_	ppointed and qualified.
10		nember shall serve on the Board for more than two consecutive terms.
11		Governor may remove members of the Board, after notice and opportunity for
12	hearing, for:	Governor may remove memoers of the Board, after notice and opportunity to
13		Incompetence;
	(1)	Neglect of duty;
14	(2)	
15	(3)	Unprofessional conduct;
16	(4)	Conviction of any felony;
17	(5)	Failure to meet the qualifications of this Article; or
18	(6)	Committing any act prohibited by this Article.
19		vacancy shall be filled by the appointing authority originally filling tha
20		t that any vacancy in appointments by the General Assembly shall be filled in
21	accordance with	
22		bers of the Board shall receive no compensation for their services, but shall be
23		l, per diem, and other expenses authorized by G.S. 93B-5."
24		TION 4.(b) Members of the Board appointed prior to July 1, 2017, shall
25		ve until their terms expire, and they are not reappointed, so long as, beginning
26		vo members of the Board are licensed nutritionists that meet the qualifications
27		S. 90-357.5(c), as enacted by this act.
28		TION 5. G.S. 90-356 reads as rewritten:
29	"§ 90-356. Pov	ver and responsibility of Board.
30	The Board s	
31	(1)	Determine the qualifications and fitness of applicants for licenses, renewa
32		of licenses, and reciprocal licenses; licenses.
33	(2)	Adopt rules necessary to conduct its business, carry out its duties, and
34		administer this Article; provided, however, that as of July 1, 2017, no rule
35		making shall be performed by the Board until two licensed nutritionists have
36		been appointed to the Board.
37	(3)	Adopt and publish a code of ethics; ethics.
38	(4)	Deny, issue, suspend, revoke, and renew licenses in accordance with this
39	,	Article; Article.
40	(5)	Conduct investigations, subpoena individuals and records, and do all other
11	,	things necessary and proper to discipline persons licensed under this Article
12		and to enforce this Article; Article.
13	(6)	Employ professional, clerical, investigative or special personnel necessary to
14	. /	carry out the provisions of this Article, and purchase or rent office space
45		equipment and supplies; supplies.
16	(7)	Adopt a seal by which it shall authenticate its proceedings, official records

Conduct administrative hearings in accordance with Article 3A of Chapter

150B of the General Statutes when a "contested case" as defined in

G.S. 150B-2(2) arises under this Article; Article.

and licenses; licenses.

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educational psychology.

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- 3. Twenty-four semester hours of food and nutrition. At least three semester hours must have been received in each of the following categories:
 - I. <u>Diet therapy, medical dietetics, clinical nutrition, or the equivalent.</u>
 - II. Nutrition through life cycle, applied human nutrition, advanced human nutrition, or the equivalent.
 - III. Foods, food science, food composition and menu planning, food service management, or the equivalent.
- The applicant has completed a Board-approved internship or documented, supervised practice experience that meets the competency requirements of an ACEND accredited, supervised practice experience and is not less than 1,000 hours under the supervision of a Certified Nutrition Specialist, a Diplomate of the American Clinical Board of Nutrition, a Registered Dietitian Nutritionist, a licensed dietitian/nutritionist, a licensed nutritionist, a State-licensed health care practitioner whose licensed scope of practice includes dietetics or nutrition, or an individual with a doctoral degree conferred by a United States regionally accredited college or university with a major course of study in human nutrition, foods and nutrition, dietetics, food systems management, community nutrition, public health nutrition, nutrition education, nutrition, nutrition science, clinical nutrition, applied clinical nutrition, nutrition counseling, nutrition and functional medicine, nutritional biochemistry, nutrition and integrative health, or an equivalent course of study, with a reasonable threshold of academic credits in nutrition and nutrition sciences as described in sub-subdivision a. of this subdivision. Supervisors who obtained their doctoral degree outside of the United States and its territories must have their degrees validated by the Board as equivalent to the doctoral degree conferred by a United States regionally accredited college or university.
- c. The applicant has successfully completed the registration examination for dietitian nutritionists administered by the Commission on Dietetic Registration.
- (2) The applicant has a valid current registration with the Commission on Dietetic Registration that gives the applicant the right to use the term "Registered Dietitian Nutritionist" or "RDN."
- (b) All persons licensed or who have submitted an application for licensure as a dietitian/nutritionist prior to July 1, 2017, shall remain licensed, eligible for reactivation, or eligible for licensure under the requirements in place at the time of licensure or application, so long as the applicant or licensee remains in good standing and maintains an active or inactive license if obtained or once it is obtained.
- (c) Each applicant for a license as a licensed nutritionist shall submit a completed application as required by the Board, submit any fees as required by the Board, and shall submit proof of the completion of all of the following educational, supervised practice experience and examination requirements:
 - (1) The applicant has received any of the following from a college or university accredited at the time of graduation from the appropriate regional accrediting agency recognized by the Council on Higher Education, or a validated foreign equivalent: a master's or doctoral nutrition degree with a major in human nutrition, foods and nutrition, dietetics, community nutrition, public

health nutrition, nutrition education, nutrition, nutrition science, clinical nutrition, applied clinical nutrition, nutrition counseling, nutrition and functional medicine, nutritional biochemistry, nutrition and integrative health, or an equivalent course of study or a master's or doctoral degree in a field of clinical health care. Regardless of the course of study, an applicant shall have completed coursework from a regionally accredited college or university in medical nutrition therapy that shall consist of the following courses:

- a. Fifteen semester hours of clinical or life sciences, including such courses as chemistry, organic chemistry, biology, molecular biology, biotechnology, botany, genetics, genomics, neuroscience, experimental science, immunotherapy, pathology, pharmacology, toxicology, research methods, applied statistics, biostatistics, epidemiology, oxidative/reductive dynamics, energy production, molecular pathways, hormone and transmitter regulations and imbalance, biotransformation pathways and imbalances, and pathophysiologic basis of disease. At least three semester hours must be in human anatomy and physiology or the equivalent.
- b. Fifteen semester hours of nutrition and metabolism, including such courses as nutrition assessment, developmental nutrition, nutritional aspects of disease, human nutrition, macronutrients, micronutrients, vitamins and minerals, functional medicine nutrition, molecular metabolism, clinical nutrition, nutritional biochemistry, nutrition and digestive health, and public health nutrition. At least six semester hours must be in biochemistry.
- (2) The applicant must have completed a Board-approved internship or a documented, supervised practice experience in nutrition services of not less than 1,000 hours involving at least 200 hours of nutrition assessment, 200 hours of nutrition intervention, education, counseling, or management, and 200 hours of nutrition monitoring or evaluation under the supervision of a Certified Nutrition Specialist, a Diplomate of the American Clinical Board Nutrition, a Registered Dietitian Nutritionist, a licensed dietitian/nutritionist, a licensed nutritionist, a State-licensed health care practitioner whose licensed scope of practice includes dietetics or nutrition, or an individual with a doctoral degree conferred by a United States regionally accredited college or university with a major course of study in human nutrition, foods and nutrition, dietetics, nutrition education, nutrition, nutrition science, clinical nutrition, applied clinical nutrition, nutrition counseling, nutrition and functional medicine, nutritional biochemistry, nutrition and integrative health, or an equivalent course of study, with a reasonable threshold of academic credits in nutrition and nutrition sciences as described in subdivision (1) of this subsection. Supervisors who obtained their doctoral degree outside of the United States and its territories must have their degrees validated by the Board as equivalent to the doctoral degree conferred by a United States regionally accredited college or university.
- (3) The applicant meets one of the following criteria:
 - a. The applicant has successfully completed either the examination administered by the Board for Certification of Nutrition Specialists, the examination administered by the American Clinical Board of

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 Nutrition, or another examination approved by the Board and meeting the requirements defined in G.S. 90-359.

 The applicant has either a valid current certification with the Board for Certification of Nutrition Specialists that gives the applicant the right to use the term "Certified Nutrition Specialist" or "CNS" or a valid current certification with the American Clinical Board of Nutrition that gives the applicant the right to use the term "Diplomate, American Clinical Board of Nutrition" or "DACBN."

"§ 90-357.6. Criminal history record checks of applicants for licensure.

- (a) All applicants for licensure shall consent to a criminal history record check. The Board may request a criminal history record check of applicants returning to active status as a licensed dietitian/nutritionist or a licensed nutritionist. Refusal to consent to a criminal history record check may constitute grounds for the Board to deny licensure to an applicant. The Board shall ensure that the State and national criminal history of each applicant is checked. The Board shall be responsible for providing to the North Carolina Department of Public Safety the fingerprints of the applicant to be checked, a form signed by the applicant consenting to the criminal history record check and the use of fingerprints and other identifying information required by the State or National Repositories, the fee required by the Department of Public Safety for providing this service, and any additional information required by the Department of Public Safety. The Board shall keep all information obtained pursuant to this section confidential.
- (b) The cost of the criminal history record check and the fingerprinting shall be borne by the applicant. The Board shall collect any fees required by the Department of Public Safety and shall remit the fees to the Department of Public Safety for expenses associated with conducting the criminal history record check.
- (c) If an applicant's criminal history record check reveals one or more convictions, the conviction shall not automatically bar issuance of a license by the Board to the applicant. The Board shall consider all of the following factors regarding the conviction:
 - (1) The level of seriousness of the crime.
 - (2) The date of the crime.
 - (3) The age of the person at the time of the conviction.
 - (4) The circumstances surrounding the commission of the crime, if known.
 - (5) The nexus between the criminal conduct of the person and the job duties of the position to be filled.
 - (6) The person's prison, jail, probation, parole, rehabilitation, and employment records since the date the crime was committed.
 - (7) Any subsequent commission of a crime by the applicant.

If, after reviewing the factors, the Board determines that the grounds set forth in G.S. 90-363 exist, the Board may deny licensure of the applicant. The Board may disclose to the applicant information contained in the criminal history record check that is relevant to the denial. The Board shall not provide a copy of the criminal history record check to the applicant. The applicant shall have the right to appear before the Board to appeal the Board's decision. However, an appearance before the full Board shall constitute an exhaustion of administrative remedies in accordance with Chapter 150B of the General Statutes.

(d) The Board, its officers and employees, acting in good faith and in compliance with this section, shall be immune from civil liability for denying licensure to an applicant based on information provided in the applicant's criminal history record check."

SECTION 8. G.S. 90-359 reads as rewritten:

"§ 90-359. Examinations.

Competency examinations shall be administered at least twice each year to qualified applicants for licensing. The examinations may be administered by a national testing service.

 The Board examinations shall prescribe or develop the examinations which may include an examination the RDN Examination given by the Commission on Dietetic Registration of the American Dietetic Association or any other examination Registration, the CNS Examination given by the Board for Certification of Nutrition Specialists and the DACBN Examination given by the American Clinical Board of Nutrition. The Board may include other nutrition therapy-focused examinations accredited by the National Commission for Certifying Agencies for graduates with a baccalaureate degree or higher from a college or university accredited at the time from the appropriate regional accrediting agency recognized by the Council on Health Education Accreditation and the United States Department of Education that are approved by two-thirds vote of the entire Board."

SECTION 9. G.S. 90-360 reads as rewritten:

"§ 90-360. Granting license without examination.

The Board may grant, upon application and payment of proper fees, a license without examination as a licensed dietitian/nutritionist or a licensed nutritionist to a person who has met the examination requirements under G.S. 90-359 at the time of application and holds a valid license or certification as a licensed dietitian/nutritionist dietitian/nutritionist, dietitian, or nutritionist issued by another state or any political territory or jurisdiction acceptable to the Board if in the Board's opinion the requirements for that license or certification are substantially the same as the requirements of this Article."

SECTION 10. G.S. 90-361 reads as rewritten:

"§ 90-361. Provisional licenses.

The Board may grant a provisional license for a period not exceeding 12 months to any individual who has successfully completed the educational and clinical practice requirements and has made application to take <u>one of the examination examinations</u> required under G.S. 90-357. G.S. 90-359. A provisional license shall allow the individual to practice as a dietitian/nutritionist <u>or nutritionist</u> under the supervision of a dietitian/nutritionist <u>or nutritionist</u> licensed in this State and shall be valid until revoked by the Board."

SECTION 11. G.S. 90-363(a) reads as rewritten:

"§ 90-363. Suspension, revocation and refusal to renew license.

- (a) The Board may deny or refuse to renew a license, may suspend or revoke a license, or may impose probationary conditions on a license if the licensee or applicant for licensure has engaged in any of the following conduct:
 - (1) Employment of fraud, deceit or misrepresentation in obtaining or attempting to obtain a license, or the renewal of a license; license.
 - (2) Committing an act or acts of malpractice, gross negligence or incompetence in the practice of dietetics/nutrition; dietetics or nutrition.
 - (3) Practicing as a licensed dietitian/nutritionist <u>or a licensed nutritionist</u> without a current <u>license</u>; <u>license</u>.
 - (4) Engaging in conduct that could result in harm or injury to the public; public.
 - (5) Conviction of or a plea of guilty or nolo contendere to any crime involving moral turpitude; turpitude.
 - (6) Adjudication of insanity or incompetency, until proof of recovery from the condition can be established; established.
 - (7) Engaging in any act or practice violative in violation of any of the provisions of this Article or any rule adopted by the Board, or aiding, abetting or assisting any person in such a violation."

SECTION 12. G.S. 90-365 reads as rewritten:

"§ 90-365. Requirement of license.

- (a) After March 31, 1992, it It shall be unlawful for any person who is not currently licensed under this Article to do any of the following:
 - (1) Engage in the practice of dietetics/nutrition.

- Use the title "dietitian/nutritionist". "dietitian/nutritionist" or "nutritionist."
- Use the words "dietitian," "nutritionist," "licensed nutritionist," or "licensed dietitian/nutritionist" alone or in combination.or hold oneself out as a dietitian or nutritionist unless licensed under this Article.
- Use the letters "LD," "LN," or "LDN," or any facsimile or combination in
- To imply orally or in writing or indicate in any way that the person is a licensed dietitian/nutritionist.dietitian/nutritionist or licensed nutritionist.
- Use of an earned, trademarked nutrition credential is not prohibited, but such use does not give the right to practice dietetics or nutrition or use the general titles of "dietitian/nutritionist" or "nutritionist" unless an individual is also licensed under this Article. Notwithstanding any law to the contrary, all of the following are permissible:
 - An individual registered with the Commission on Dietetic Registration has the right to use the title "Registered Dietitian" and "Registered Dietitian Nutritionist" and the designation "RD" or "RDN."
 - An individual certified by the Board of Certification of Nutrition Specialists has the right to use the title "Certified Nutrition Specialist" and the
 - An individual certified by the American Clinical Board of Nutrition has the right to use the title "Diplomate, American Clinical Board of Nutrition" and

SECTION 13. Article 25 of Chapter 90 of the General Statutes is amended by adding new sections to read:

"§ 90-365.5. Telepractice.

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Telepractice as defined in G.S. 90-352 is not prohibited under this Article so long as (i) it is appropriate for the individual receiving the services and (ii) the level of care provided meets the required level of care for that individual. An individual providing services regulated by this Article via telepractice shall comply with, and shall be subject to, all the licensing and disciplinary provisions of this Article.

"§ 90-365.6. Enteral and parenteral nutrition therapy.

- Enteral and parenteral nutrition therapy shall consist of enteral feedings or specialized intravenous solutions and shall only be ordered by an individual licensed under this Article who meets one of the following criteria:
 - The individual is a Registered Dietitian Nutritionist registered with the (1)Commission on Dietetic Registration.
 - The individual is a Certified Nutrition Support Clinician certified by the (2)National Board of Nutrition Support Certification.
 - (3)The individual meets the requirements set forth in rules adopted by the Board.
- Nothing in this Article shall be construed to limit the ability of any other licensed health care practitioner in this State to order therapeutic diets, so long as the ordering of therapeutic diets falls within the scope of the license held by the health care practitioner."

SECTION 14. G.S. 90-368 reads as rewritten:

"§ 90-368. Persons and practices not affected.

The requirements of this Article shall not apply to:

A health care professional duly licensed in accordance with Chapter 90 of the General Statutes. Statutes who is acting within the scope of the individual's licensed profession, provided that the individual does not use the titles licensed dietitian/nutritionist or licensed nutritionist.

materials, or dietary supplements. This Article does not prohibit that person

- from making explanations to customers about foods or food products in connection with the marketing and distribution of these products.
 - (10) An herbalist or other person who does not hold himself or herself out to be a dietitian or nutritionist when the person furnishes nonfraudulent specific nutritional information and counseling about the reported or historical use of herbs, vitamins, minerals, amino acids, carbohydrates, sugars, enzymes, food concentrates, or other foods.
 - (11) Any individual who provides nutrition services without remuneration to family members.
 - Any individual who provides nutrition information, guidance, encouragement, individualized nutrition recommendations, or weight control services that do not constitute medical nutrition therapy as defined in G.S. 90-352, provided that the individual (i) does not hold himself or herself out as a licensed dietitian/nutritionist or a licensed nutritionist as prohibited under G.S. 90-365 and (ii) does not seek to provide medical nutrition therapy as defined in G.S. 90-352."

SECTION 15. Article 13 of Chapter 143B of the General Statutes is amended by adding a new section to read:

"§ 143B-966. Criminal record checks of applicants for licensure as dietitian/nutritionists or nutritionists.

The Department of Public Safety may provide to the North Carolina Board of Dietetics/Nutrition a criminal history record from the State and National Repositories of Criminal Histories for applicants for licensure by the Board. Along with a request for criminal history records, the Board shall provide to the Department of Public Safety the fingerprints of the applicant or subject, a form signed by the applicant consenting to the criminal history record check and use of the fingerprints and other identifying information required by the Repositories, and any additional information required by the Department. The fingerprints shall be forwarded to the State Bureau of Investigation for a search of the State's criminal history record file, and the State Bureau of Investigation shall forward a set of fingerprints to the Federal Bureau of Investigation for a national criminal history record check. The Board shall keep all information obtained pursuant to this section confidential. The Department of Public Safety may charge a fee to offset the cost incurred by the Department of Public Safety to conduct a criminal history record check under this section, but the fee shall not exceed the actual cost of locating, editing, researching, and retrieving the information."

SECTION 16. Section 12 of this act becomes effective October 1, 2017, and applies to acts committed on or after that date. The remainder of this act becomes effective July 1, 2017.



HOUSE BILL 890: Amend Psychology, Podiatry, Pastoral Counsir.

2017-2018 General Assembly

Committee: House Health. If favorable, re-refer to Date: May 9, 2017

Finance

Introduced by: Reps. Jordan, Zachary, Malone Prepared by: Theresa Matula

Analysis of: PCS to First Edition Committee Staff

H890-CSSH-22

OVERVIEW: The Proposed Committee Substitute for House Bill 890 amends the Psychology Practice Act to establish an inactive licensure status for licensees, to revise record retention requirements, and to increase various licensing fees; the PCS provides an annual fee increase for podiatrists; and an annual fee increase for pastoral counselors and pastoral counseling associates.

CURRENT LAW:

Article 18A of Chapter 90 provides for the Psychology Practice Act.

Article 12A of Chapter 90 pertains to podiatrists.

Article 26 of Chapter 90 pertains for fee-based practicing pastoral counselors.

BILL ANALYSIS:

Section 1 would add a new section to the Psychology Practice Act pertaining to inactive status. The new section, G.S. 90-270.14A, would allow a licensee to request the North Carolina Psychology Board (Board) to place him or her on inactive status. A licensee on inactive status would be required to pay a fee at every renewal period and would not be allowed to practice psychology without holding a current active license. A licensee on inactive status may reactivate a license by completing the application for reactivation; paying a reactivation fee; and completing other reactivation requirements which may include a criminal history record check, continuing education, fitness to practice evaluation, examination, and supervision.

Section 2 would amend G.S. 90-270.15 pertaining to disciplinary actions; and denial, suspension and revocation of licenses to specifically allow the Board to act upon proof that a licensee has had a license or certification for any mental health profession in the State suspended or revoked, or who has been disciplined by a licensing or certification board in this State. This section would also remove the language in the Code of Conduct that authorizes the Board to act on a psychologist failing to securely and confidentially retain the case record for three years from the date of the attainment of majority age by the patient or client or for at least seven years from the date of the last provision of psychological services, whichever is longer. The requirement that a psychologist securely and confidentially retain a complete case record for at least seven years from the date of the last provision of psychological services, except when prevented from doing so by circumstances beyond the psychologist's control, remains in place.





Legislative Analysis Division 919-733-2578

House PCS 890

Page 2

<u>Section 3</u> would amend G.S. 90-270.18(b) which authorizes the fees that may be charged by the Board for various activities. Below are the fee increases the bill would authorize.

- The *application fee* for licensed psychologists and licensed psychological associations is increased from \$100 to the cost of application as set by the vendor, if applicable, plus an additional fee not to exceed \$300. Additionally, the Board is authorized to require applicants to pay the fee directly to the vendor.
- The fee for *license renewal* is being increased from a ceiling of \$250 to a ceiling of \$400 per biennium.
- The *late fee for license renewal* is being increased from \$25 to \$75.
- The fee to reinstate a license is being increased from a ceiling of \$100 to a ceiling of \$200.
- The fee for a *duplicate license* is being increased from \$25 to \$75.
- The fee for a *temporary license* is being increased from \$35 to \$50.
- The fee for a health services provider certification is being increased from \$50 to \$100.
- A \$100 fee for each renewal period to place a *license on inactive status*, corresponding to Section 1 of the bill, is being added.
- A \$300 fee for reactivating an inactive status license is also being added.

<u>Section 4</u> conforms to Section 1 by amending G.S. 90-270.22 pertaining to criminal history record checks. The amendments would authorize the Board to request an applicant for reactivation of a license to consent to a criminal history record check.

<u>Section 5</u> amends G.S. 90-202.10 which authorizes the annual fee for podiatrists engaged in the practice of podiatry. The PCS increases the fee from \$200 to \$350 per year.

<u>Section 6</u> amends G.S. 90-389 pertaining to the renewal certificates for fee-based pastoral counselors and fee-based pastoral counseling associates. The PCS increases the annual fee from \$100 to \$300 per year.

EFFECTIVE DATE: The PCS for House Bill 890 would become effective October 1, 2017.

BACKGROUND:

Most Recent Fee Increases:

- The last fee increase authorized by the General Assembly for the Psychology Practice Act was in 1993. S.L. 1993-375 authorized the fees currently contained in G.S. 90-270.18(b)(1)-(9).
- The last annual fee increase for the pastoral counselors and associates was in 1991 (S.L.1991-670).
- The last annual fee increase for podiatrists was in 1991 (S.L. 1991-457).

Inactive Status:

There are a number of healthcare-related licensure boards that are authorized to allow a licensee to go on inactive status, including, but not limited to: Physicians (G.S. 90-13.2(d)), Nurses (G.S. 90-171.36), Marriage and Family Therapists (G.S. 90-270.58B), Acupuncturist (G.S. 90-455), Recreational Therapists (G.S. 90C-31).

GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2017

H

HOUSE BILL 890 PROPOSED COMMITTEE SUBSTITUTE H890-PCS10346-SH-22

Short Title:	Amend Psychology, Podiatry, Pastoral Counslr.	(Public)
Sponsors:		
Referred to:		
		<u> </u>

April 26, 2017

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH INACTIVE LICENSURE STATUS, TO REVISE RECORD

RETENTION REQUIREMENTS, AND TO INCREASE FEES UNDER THE
PSYCHOLOGY PRACTICE ACT; TO INCREASE THE ANNUAL FEE FOR
PODIATRISTS; AND TO INCREASE THE ANNUAL FEE FOR PASTORAL
COUNSELORS AND PASTORAL COUNSELING ASSOCIATES.

The General Assembly of North Carolina enacts:

SECTION 1. Article 18A of Chapter 90 of the General Statutes is amended by adding a new section to read:

"§ 90-270.14A. Inactive status.

- (a) The Board shall place a license on inactive status upon request of a licensee and payment of the inactive status fee prescribed in G.S. 90-270.18(b)(10). No person shall practice psychology in North Carolina unless that person holds a current active license. The Board may investigate complaints and take disciplinary action against an inactive status licensee. An inactive status license shall only be issued to a person who has previously been issued a license to practice psychology in North Carolina. Licensees on inactive status shall not hold themselves out to the public as licensed by the Board.
- (b) In order to maintain inactive status, the inactive status fee prescribed in G.S. 90-270.18(b)(10) shall be paid at every renewal period. The inactive status licensee is exempt from continuing education requirements set forth in G.S. 90-270.14(a)(2).
- (c) A licensee on inactive status may reactivate licensure by completing an application for reactivation, paying the reactivation fee prescribed in G.S. 90-270.18(b)(11), and completing any other reactivation requirements set forth by Board rules, which may include a criminal history record check, continuing education, fitness to practice evaluation, examination, and supervision."

SECTION 2. G.S. 90-270.15(a) reads as rewritten:

- "§ 90-270.15. Denial, suspension, or revocation of licenses and health services provider certification, and other disciplinary and remedial actions for violations of the Code of Conduct; relinquishing of license.
- (a) Any applicant for licensure or health services provider certification and any person licensed or certified under this Article shall have behaved in conformity with the ethical and professional standards specified in this Code of Conduct and in the rules of the Board. The Board may deny, suspend, or revoke licensure and certification, and may discipline, place on probation, limit practice, and require examination, remediation, and rehabilitation, or any combination thereof, all as provided for in subsection (b) below. The Board shall act upon



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proof that the applicant or licensee engaged in illegal, immoral, dishonorable, unprofessional, or unethical conduct by violating any of the provisions of the Code of Conduct as follows:

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(6) Has had a license or certification for the practice of psychology or other mental health profession in this State or in any other jurisdiction suspended or revoked, or has been disciplined by the a licensing or certification board in this State or in any other jurisdiction for conduct which would subject him or her to discipline under this Article;

(18) Except when prevented from doing so by circumstances beyond the psychologist's control, has failed to retain securely and confidentially the complete case record for at least seven years from the date of the last provision of psychological services; or, except when prevented from doing so by circumstances beyond the psychologist's control, has failed to retain securely and confidentially the complete case record for three years from the date of the attainment of majority age by the patient or client or for at least seven years from the date of the last provision of psychological services, whichever is longer; services; or, except when prevented from doing so by circumstances beyond the psychologist's control, has failed to retain securely and confidentially the complete case record indefinitely if there are pending legal or ethical matters or if there is any other compelling circumstance;

SECTION 3. G.S. 90-270.18(b) reads as rewritten:

"(b) Fees for activities specified by this Article are as follows:

 (1) Application fees for licensed psychologists and licensed psychological associates per G.S. 90-270.11(a) and (b)(1), or G.S. 90-270.13, shall not exceed one hundred dollars (\$100.00). be the cost of application as set by the vendor, if applicable, plus an additional fee not to exceed three hundred dollars (\$300.00). The Board may require applicants to pay the fee directly to the vendor.

(2) Fees for the national written examination shall be the cost of the examination as set by the vendor plus an additional fee not to exceed fifty dollars (\$50.00). The Board may require applicants to pay the fee directly to the vendor.

(3) Fees for additional examinations shall be as prescribed by the Board.

(4) Fees for the renewal of licenses, per G.S. 90-270.14(a)(1), shall not exceed two hundred fifty dollars (\$250.00) four hundred dollars (\$400.00) per biennium. This fee may not be prorated.

(5) Late fees for license renewal, per G.S. 90-270.14(a)(1), shall be twenty-five dollars (\$25.00).seventy-five dollars (\$75.00).

(6) Fees for the reinstatement of a license, per G.S. 90-270.15(f), shall not exceed one hundred dollars (\$100.00).two hundred dollars (\$200.00).

(7) Fees for a duplicate license, per G.S. 90-270.14(b), shall be twenty-five dollars (\$25.00).seventy-five dollars (\$75.00).

(8) Fees for a temporary license, per G.S. 90-270.5(f) and 90-270.5(g), shall be thirty five dollars (\$35.00). fifty dollars (\$50.00).

(9) Application fees for a health services provider certificate, per G.S. 90-270.20, shall be fifty dollars (\$50.00).one hundred dollars (\$100.00).

(10) Fees to place a license on inactive status, per G.S. 90-270.14A, shall not exceed one hundred dollars (\$100.00) for every renewal period.

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(11) Fees for reactivation of an inactive status license, per G.S. 90-270.14A(c), shall not exceed three hundred dollars (\$300.00)."

SECTION 4. G.S. 90-270.22(a) reads as rewritten:

"§ 90-270.22. Criminal history record checks of applicants for licensure and licensees.

(a) The Board may request that an applicant for licensure or reinstatement of a license licensure, reinstatement, or reactivation of a license, or that a licensed psychologist or psychological associate currently under investigation by the Board for allegedly violating this Article Article, consent to a criminal history record check. Refusal to consent to a criminal history record check may constitute grounds for the Board to deny licensure or reinstatement licensure, reinstatement, or reactivation of a license to an applicant or take disciplinary action against a licensee, including revocation of a license. The Board shall be responsible for providing to the North Carolina Department of Public Safety the fingerprints of the applicant or licensee to be checked, a form signed by the applicant or licensee consenting to the criminal record check and the use of fingerprints and other identifying information required by the State or National Repositories, and any additional information required by the Department of Public Safety. The Board shall keep all information obtained pursuant to this section confidential.

The Board shall collect any fees required by the Department of Public Safety and shall remit the fees to the Department of Public Safety for the cost of conducting the criminal history record check."

SECTION 5. G.S. 90-202.10 reads as rewritten:

"§ 90-202.10. Annual fee; cancellation or renewal of license.

On or before the first day of July of each year every podiatrist engaged in the practice of podiatry in this State shall transmit to the secretary-treasurer of the said North Carolina State Board of Podiatry Examiners his signature and post-office address, the date and year of his or her certificate, together with a fee to be set by the Board of Podiatry Examiners not to exceed two hundred dollars (\$200.00) three hundred fifty dollars (\$350.00) and receive therefor a renewal certificate. Any license or certificate granted by said Board under or by virtue of this section shall automatically be cancelled and annulled if the holder thereof fails to secure the renewal herein provided for within a period of 30 days after the first day of July of each year, and such delinquent podiatrist shall pay a penalty for reinstatement of twenty-five dollars (\$25.00) for each succeeding month of delinquency until a six-month period of delinquency exists. After a six-month period of delinquency exists or after January 1 following the July 1 deadline, the said podiatrist must appear before the North Carolina Board of Podiatry Examiners and take a new examination before being allowed to practice podiatry in the State of North Carolina."

SECTION 6. G.S. 90-389 reads as rewritten:

"§ 90-389. Renewal of certificate.

A certificate issued under this Article must be renewed annually on or before the first day of January of each year. Each application for renewal must be accompanied by a renewal fee set by the Board of not more than one hundred dollars (\$100.00).three hundred dollars (\$300.00). If a certificate is not renewed on or before the first day of January of each year, an additional fee of not more than twenty-five dollars (\$25.00) as set by the Board shall be charged for late renewal. The Board may establish requirements for continuing education for pastoral counselors and pastoral counseling associates certified in this State as an additional condition for renewal."

SECTION 7. This act becomes effective October 1, 2017.

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GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2017

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HOUSE BILL 890

(Public) Short Title: Amend Psychology Practice Act. Sponsors: Representatives Jordan, Zachary, and Malone (Primary Sponsors). For a complete list of sponsors, refer to the North Carolina General Assembly web site. Referred to: Health, if favorable, Finance

April 26, 2017

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A BILL TO BE ENTITLED

AN ACT TO ESTABLISH INACTIVE LICENSURE STATUS, TO REVISE RECORD RETENTION REQUIREMENTS, AND TO INCREASE FEES UNDER THE PSYCHOLOGY PRACTICE ACT.

The General Assembly of North Carolina enacts:

SECTION 1. Article 18A of Chapter 90 of the General Statutes is amended by adding a new section to read:

"§ 90-270.14A. Inactive status.

- The Board shall place a license on inactive status upon request of a licensee and (a) payment of the inactive status fee prescribed in G.S. 90-270.18(b)(10). No person shall practice psychology in North Carolina unless that person holds a current active license. The Board may investigate complaints and take disciplinary action against an inactive status licensee. An inactive status license shall only be issued to a person who has previously been issued a license to practice psychology in North Carolina. Licensees on inactive status shall not hold themselves out to the public as licensed by the Board.
- (b) In order to maintain inactive status, the inactive status fee prescribed in G.S. 90-270.18(b)(10) shall be paid at every renewal period. The inactive status licensee is exempt from continuing education requirements set forth in G.S. 90-270.14(a)(2).
- A licensee on inactive status may reactivate licensure by completing an application for reactivation, paying the reactivation fee prescribed in G.S. 90-270.18(b)(11), and completing any other reactivation requirements set forth by Board rules, which may include a criminal history record check, continuing education, fitness to practice evaluation, examination, and supervision."

SECTION 2. G.S. 90-270.15(a) reads as rewritten:

- "§ 90-270.15. Denial, suspension, or revocation of licenses and health services provider certification, and other disciplinary and remedial actions for violations of the Code of Conduct; relinquishing of license.
- Any applicant for licensure or health services provider certification and any person licensed or certified under this Article shall have behaved in conformity with the ethical and professional standards specified in this Code of Conduct and in the rules of the Board. The Board may deny, suspend, or revoke licensure and certification, and may discipline, place on probation, limit practice, and require examination, remediation, and rehabilitation, or any combination thereof, all as provided for in subsection (b) below. The Board shall act upon proof that the applicant or licensee engaged in illegal, immoral, dishonorable, unprofessional, or unethical conduct by violating any of the provisions of the Code of Conduct as follows:



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(6) Has had a license or certification for the practice of psychology or other mental health profession in this State or in any other jurisdiction suspended or revoked, or has been disciplined by the a licensing or certification board in this State or in any other jurisdiction for conduct which would subject him or her to discipline under this Article;

(18) Except when prevented from doing so by circumstances beyond the psychologist's control, has failed to retain securely and confidentially the complete case record for at least seven years from the date of the last provision of psychological services; or, except when prevented from doing so by circumstances beyond the psychologist's control, has failed to retain securely and confidentially the complete case record for three years from the date of the attainment of majority age by the patient or client or for at least seven years from the date of the last provision of psychological services, whichever is longer; services; or, except when prevented from doing so by circumstances beyond the psychologist's control, has failed to retain securely and confidentially the complete case record indefinitely if there are pending legal or ethical matters or if there is any other compelling circumstance;

SECTION 3. G.S. 90-270.18(b) reads as rewritten:

- "(b) Fees for activities specified by this Article are as follows:
 - (1) Application fees for licensed psychologists and licensed psychological associates per G.S. 90-270.11(a) and (b)(1), or G.S. 90-270.13, shall not exceed one hundred dollars (\$100.00). be the cost of application as set by the vendor, if applicable, plus an additional fee not to exceed three hundred dollars (\$300.00). The Board may require applicants to pay the fee directly to the vendor.
 - (2) Fees for the national written examination shall be the cost of the examination as set by the vendor plus an additional fee not to exceed fifty dollars (\$50.00). The Board may require applicants to pay the fee directly to the vendor.
 - (3) Fees for additional examinations shall be as prescribed by the Board.
 - (4) Fees for the renewal of licenses, per G.S. 90-270.14(a)(1), shall not exceed two hundred fifty dollars (\$250.00) four hundred dollars (\$400.00) per biennium. This fee may not be prorated.
 - (5) Late fees for license renewal, per G.S. 90-270.14(a)(1), shall be twenty-five dollars (\$25.00).seventy-five dollars (\$75.00).
 - (6) Fees for the reinstatement of a license, per G.S. 90-270.15(f), shall not exceed one hundred dollars (\$100.00).two hundred dollars (\$200.00).
 - (7) Fees for a duplicate license, per G.S. 90-270.14(b), shall be twenty-five dollars (\$25.00).seventy-five dollars (\$75.00).
 - (8) Fees for a temporary license, per G.S. 90-270.5(f) and 90-270.5(g), shall be thirty-five dollars (\$35.00). fifty dollars (\$50.00).
 - (9) Application fees for a health services provider certificate, per G.S. 90-270.20, shall be fifty dollars (\$50.00).one hundred dollars (\$100.00).
 - (10) Fees to place a license on inactive status, per G.S. 90-270.14A, shall not exceed one hundred dollars (\$100.00) for every renewal period.
 - (11) Fees for reactivation of an inactive status license, per G.S. 90-270.14A(c), shall not exceed three hundred dollars (\$300.00)."

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SECTION 4. G.S. 90-270.22(a) reads as rewritten:

"§ 90-270.22. Criminal history record checks of applicants for licensure and licensees.

(a) The Board may request that an applicant for licensure or reinstatement of a license licensure, reinstatement, or reactivation of a license, or that a licensed psychologist or psychological associate currently under investigation by the Board for allegedly violating this Article—Article, consent to a criminal history record check. Refusal to consent to a criminal history record check may constitute grounds for the Board to deny licensure or reinstatement licensure, reinstatement, or reactivation of a license to an applicant or take disciplinary action against a licensee, including revocation of a license. The Board shall be responsible for providing to the North Carolina Department of Public Safety the fingerprints of the applicant or licensee to be checked, a form signed by the applicant or licensee consenting to the criminal record check and the use of fingerprints and other identifying information required by the State or National Repositories, and any additional information required by the Department of Public Safety. The Board shall keep all information obtained pursuant to this section confidential.

The Board shall collect any fees required by the Department of Public Safety and shall remit the fees to the Department of Public Safety for the cost of conducting the criminal history record check."

SECTION 5. This act becomes effective October 1, 2017.





HOUSE BILL 461: MH/SA Central Assessment & Navigation Pilot.

2017-2018 General Assembly

Committee: House Health. If favorable, re-refer to Date: May 10, 2017

Appropriations

Introduced by: Reps. Grange, Murphy, Hardister Prepared by: Augustus D. Willis

Analysis of: First Edition Committee Counsel

OVERVIEW: House Bill 461 would create a 2-year pilot program in New Hanover County aimed at reducing the use of hospital emergency departments for mental health and substance use disorder services and appropriate \$250,000 for each of the 2017-18 and 2018-19 fiscal years to fund the program.

[As introduced, this bill was identical to S334, as introduced by Sens. Lee, Rabon, which is currently in Senate Health Care.]

CURRENT LAW:

BILL ANALYSIS: House Bill 461 would require the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services within DHHS, in consultation with the LME/MCO for New Hanover County (currently Trillium), to oversee a 2-year program in New Hanover County focusing on assessing and navigating individuals seeking mental health or substance use disorder services, or both, to appropriate community-based services or other community resources in order to reduce the utilization of hospital emergency department services for mental health and substance use disorder services.

The pilot program would be conducted at New Hanover Regional Medical Center and at Wellness City, operated by Recovery Innovations, Inc.by a three-person centralized team consisting of the following:

- A master's level fully licensed clinician to perform comprehensive clinical assessments of NHRMC patients and other New Hanover County residents exhibiting symptoms of mental illness or substance use disorder who are referred to the pilot program.
- A qualified professional to assist patients with identifying and accessing appropriate community-based services or other community resources.
- A North Carolina certified peer support specialist, with specialized training and personal experience in successfully managing his/her own serious mental illness or substance use disorder, to provide peer support services.

The LME/MCO would be required to, in collaboration with NHRMC and Recovery Innovations, Inc., make an interim report to DHHS, Division of MH/DD/SAS and the Fiscal Research Division on the effectiveness of the program by July 1, 2018. The Division of MH/DD/SAS would then be required to report to the Joint Legislative Oversight Committee on Health and Human Services by October 1, 2018 on the effectiveness of the program and costs associated with administering the program. The LME/MCO would have to make a final report on the program to the Division of MH/DD/SAS by July 1, 2019, and the Division would be required to make its final report to the Joint Legislative Oversight





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House Bill 461

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Committee on Health and Human Services and the Fiscal Research Division by October 1, 2019, on the effectiveness of the program and any recommendations for sustaining or expanding the program.

The bill includes an appropriation of \$250,000 for each of the 2017-18 and 2018-29 fiscal years from the General Fund to DHHS, Division of MA/DD/SAS to fund the pilot program.

EFFECTIVE DATE: House Bill 461 would become effective July 1, 2017.

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GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2017

HOUSE BILL 461*

Short Title:	MH/SA Central Assessment & Navigation Pilot.	(Public)
Sponsors:	Representatives Grange, Murphy, and Hardister (Primary Sponsors). For a complete list of sponsors, refer to the North Carolina General Assembly w	eb site.
Referred to:	Health, if favorable, Appropriations	

March 27, 2017

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A BILL TO BE ENTITLED

AN ACT ESTABLISHING A CENTRAL ASSESSMENT AND NAVIGATION SYSTEM PILOT PROGRAM IN NEW HANOVER COUNTY TO REDUCE THE NUMBER OF INDIVIDUALS UTILIZING HOSPITAL EMERGENCY DEPARTMENTS FOR MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1.(a) Pilot Program Created. – The Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, in consultation with the local management entity/managed care organization (LME/MCO) responsible for the management and provision of mental health, developmental disabilities, and substance use disorder services in New Hanover County under the 1915(b)/(c) Medicaid Waiver, shall oversee the establishment of a two-year pilot program in New Hanover County to focus on assessing and navigating individuals seeking mental health or substance use disorder services, or both, to appropriate community-based services or other community resources in order to reduce the utilization of hospital emergency department services for mental health and substance use disorder services.

SECTION 1.(b) Program Design and Location. – The pilot program shall be conducted at New Hanover Regional Medical Center (NHRMC) and at Wellness City, operated by Recovery Innovations, Inc., by a three-person centralized team. The three-person team shall consist of the following individuals:

- (1) A master's level, fully licensed clinician to perform comprehensive clinical assessments of NHRMC patients and other New Hanover County residents exhibiting symptoms of mental illness or substance use disorder who are referred to the pilot program.
- (2) A qualified professional to assist patients, particularly those with a completed comprehensive clinical assessment, with identifying and accessing appropriate community-based services or other community resources.
- (3) A North Carolina certified peer support specialist, with specialized training and personal experience in successfully managing his or her own serious mental illness or substance use disorder, to provide peer support services, including encouraging patients to take personal responsibility for managing their condition, assisting patients in establishing meaningful roles in society, and providing patients with transportation to and from appointments.



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SECTION 1.(c) Reports. – The LME/MCO responsible for the management and provision of mental health, developmental disabilities, and substance abuse services in New Hanover County, in collaboration with New Hanover Regional Medical Center and Recovery Innovations, Inc., shall make an interim report to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, and the Fiscal Research Division on the effectiveness of the pilot program by July 1, 2018. The Division shall then make an interim report to the Joint Legislative Oversight Committee on Health and Human Services by October 1, 2018, on the effectiveness of the program and the costs associated with administering the program. By July 1, 2019, the LME/MCO responsible for the management and provision of mental health, developmental disabilities, and substance abuse services in New Hanover County, in collaboration with New Hanover Regional Medical Center and Recovery Innovations, Inc., shall make a final report to the Division on the effectiveness of the program. The Division shall make a final report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division by October 1, 2019, on the effectiveness of the program, along with any recommendations for sustaining or expanding the program.

SECTION 2. There is appropriated from the General Fund to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, the sum of two hundred fifty thousand dollars (\$250,000) for the 2017-2018 fiscal year and the sum of two hundred fifty thousand dollars (\$250,000) for the 2018-2019 fiscal year to fund the central assessment and navigation system pilot program established under Section 1 of this act.

SECTION 3. This act becomes effective July 1, 2017.



HOUSE BILL 477: Behav. Health Crisis EMS Transports/Medicaid.

2017-2018 General Assembly

Committee: House Health. If favorable, re-refer to Date: May 10, 2017

Appropriations

Introduced by: Reps. Dobson, Malone, Potts, Carney Prepared by: Augustus D. Willis

Analysis of: First Edition Jennifer Hillman

Committee Co-Counsel

OVERVIEW: House Bill 477 would require the Department of Health and Human Services (DHHS) to design a plan for adding Medicaid coverage for ambulance transports to behavioral health clinics instead of hospital emergency departments and to report to the General Assembly about the plan, including the expected cost of adding coverage and a timeline for implementation of the plan.

CURRENT LAW / BACKGROUND: Medicaid Clinical Coverage Policy 15 sets forth the criteria for Medicaid coverage of ambulance transports. Currently Medicaid covers ambulance transports only to specified destinations and does not cover transports to behavioral health clinics.

Section 12H.32 of the 2014 Budget Act, S.L. 2014-100, required DHHS to study the practice of reimbursing for ambulance transports that divert individuals in mental health crisis from hospital emergency departments to alternative appropriate locations for care and to propose necessary Medicaid policy changes. In a March 1, 2015, legislative report entitled "Ambulance Transports to Crisis Centers," DHHS reported the results of this study and proposed an option to seek to add Medicaid coverage for ambulance transports to alternative locations by requesting federal approval of a Medicaid State Plan amendment.

At the time the March 2015 report was submitted, G.S. 108A-54.1A(b) limited DHHS's authority to submit State Plan amendments for federal approval unless directed to do so by the General Assembly. In September 2015, Medicaid Transformation legislation, S.L. 2015-245, as amended by S.L. 2016-121, repealed G.S. 108A-54.1A(b) and gave DHHS the authority under G.S. 108A-54(e) to administer and operate the Medicaid program, including establishing and adjusting all program components except for eligibility, within the budget for the Medicaid program set by the General Assembly. Pursuant to the authority granted under G.S. 108A-54(e), DHHS can add Medicaid coverage for services, such as ambulance transports, as long as adding the coverage will not cause the Medicaid program to exceed the budget set by the General Assembly.

BILL ANALYSIS:

Section 1 would state the General Assembly's intent to provide opportunities to divert individuals in behavioral health crisis from hospital emergency departments to behavioral health clinics and direct DHHS to evaluate the financial impact of adding Medicaid coverage for ambulance transports to behavioral health clinics. DHHS would have to ensure that the Emergency Medical Services (EMS) Systems that receive reimbursement utilize EMS providers who have received appropriate education related to individuals in behavioral health crisis and have partnerships with facilities that can offer appropriate care. EMS Systems would have to report on patient experiences and outcomes in their EMS System Plan.





Legislative Analysis Division 919-733-2578

House Bill 477

Page 2

<u>Section 2</u> would require DHHS to report to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice by December 1, 2017, on the evaluation of the financial impact for adding this coverage. The report would have to include a plan of implementation of the plan and a timeline for submission of any State Plan amendments or waivers necessary for implementation.

<u>Section 3</u> would require DHHS to submit for federal approval any State Plan amendments or any waivers necessary to establish this plan and would specify that the plan shall not be implemented until CMS approves the necessary State Plan amendments or waivers.

<u>Section 4</u> would state the General Assembly's intent to provide funding to add Medicaid coverage for ambulance transports of Medicaid recipients in behavioral health crisis to behavioral health clinics if federal approval of the coverage is obtained but DHHS could not implement the coverage under its authority to manage the Medicaid program within the budget set by the General Assembly.

EFFECTIVE DATE: The bill would be effective when it becomes law.

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GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2017

HOUSE BILL 477*

Short Title: Behav. Health Crisis EMS Transports/Medicaid. (Public)

Sponsors: Representatives Dobson, Malone, Potts, and Carney (Primary Sponsors).

For a complete list of sponsors, refer to the North Carolina General Assembly web site.

Referred to: Health, if favorable, Appropriations

March 27, 2017

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH MEDICAID REIMBURSEMENT FOR AMBULANCE TRANSPORTS OF MEDICAID RECIPIENTS IN BEHAVIORAL HEALTH CRISIS TO BEHAVIORAL HEALTH CLINICS OR ALTERNATIVE APPROPRIATE CARE LOCATIONS.

The General Assembly of North Carolina enacts:

SECTION 1. It is the intent of the General Assembly to provide opportunities to divert individuals in behavioral health crisis from hospital emergency departments to alternative appropriate care locations. Consistent with Option 1 outlined in the Department of Health and Human Services' (DHHS) March 1, 2015, report entitled "Ambulance Transports to Crisis Centers," DHHS shall evaluate the financial impact, including any anticipated cost to the Medicaid program, of establishing Medicaid reimbursement for ambulance transports of Medicaid recipients in behavioral health crisis to behavioral health clinics or other alternative appropriate care locations. Any reimbursement shall be contingent upon an Emergency Medical Services (EMS) System's ability to demonstrate its EMS providers have received appropriate education in caring for individuals in behavioral health crisis and that it has at least one partnership with a receiving facility that is able to provide care appropriate for those individuals. Additionally, an EMS System shall be required to include in its EMS System Plan a report on patient experiences and outcomes. Rules regarding the EMS System Plan requirements shall be adopted by the Department of Health and Human Services, Division of Health Regulation, Office of Emergency Medical Services.

SECTION 2. No later than December 1, 2017, the Department of Health and Human Services, Division of Medical Assistance, shall report to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice on the evaluation of the financial impact of establishing Medicaid reimbursement for ambulance transports of Medicaid recipients in behavioral health crisis to behavioral health clinics or other alternative appropriate care locations. The report shall also include a plan of implementation and a time line for submission of any State Plan amendments or any waivers necessary for implementation.

SECTION 3. The Department of Health and Human Services, Division of Medical Assistance, shall submit any State Plan amendments or any waivers necessary to establish Medicaid reimbursement for ambulance transports of Medicaid recipients in behavioral health crisis to behavioral health clinics or other alternative appropriate care locations to the Centers for Medicaid Services (CMS). Medicaid reimbursement for ambulance transports of Medicaid recipients in behavioral health crisis to behavioral health clinics or other



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alternative appropriate care locations shall not be implemented until CMS approval of any submitted State Plan amendments or waivers has been received. recipients in behavioral health crisis cannot be implemented under the authority granted to the

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Medicare and Medicaid Services.

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

Department of Health and Human Services under G.S. 108A-54(e), then it is the intent of the

General Assembly to appropriate any funds necessary to cover the costs of implementation

upon the approval of any submitted State Plan amendments or waivers by the Centers for

SECTION 4. If Medicaid reimbursement for ambulance transports of Medicaid

House Bill 477*-First Edition

NORTH CAROLINA GENERAL ASSEMBLY HOUSE OF REPRESENTATIVES

HEALTH COMMITTEE REPORT

Representative Josh Dobson, Co-Chair Representative Nelson Dollar, Co-Chair Representative Bert Jones, Co-Chair Representative Donny Lambeth, Co-Chair Representative Gregory F. Murphy, MD, Co-Chair

FAVORABLE AND RE-REFERRED

HB 461 MH/SA Central Assessment & Navigation Pilot.

Draft Number: None

Serial Referral: APPROPRIATIONS

Recommended Referral: None Long Title Amended: No Floor Manager: Grange

HB 477 Behav. Health Crisis EMS Transports/Medicaid.

Draft Number: None

Serial Referral: APPROPRIATIONS

Recommended Referral: None
Long Title Amended: No
Floor Manager: Dobson

FAVORABLE COM SUB, UNFAVORABLE ORIGINAL BILL AND RE-REFERRED

HB 357 Modernize Dietetics/Nutrition Practice Act.

Draft Number: H357-PCS10347-BC-24

Recommended Referral: None
Long Title Amended: No
Floor Manager: Malone

TOTAL REPORTED: 3



NORTH CAROLINA GENERAL ASSEMBLY HOUSE OF REPRESENTATIVES

HEALTH COMMITTEE REPORT

Representative Josh Dobson, Co-Chair Representative Nelson Dollar, Co-Chair Representative Bert Jones, Co-Chair Representative Donny Lambeth, Co-Chair Representative Gregory F. Murphy, MD, Co-Chair

FAVORABLE COM SUB, UNFAVORABLE ORIGINAL BILL AND RE-REFERRED

HB **890** Amend Psychology Practice Act.

Draft Number: H890-PCS10346-SH-22

Serial Referral: FINANCE
Recommended Referral: None
Long Title Amended: Yes
Floor Manager: Jordan

TOTAL REPORTED: 1



North Carolina Psychology Board



Robert W. Hill, Ph.D., ABPP Chairperson Daniel P. Collins Executive Director

Why Does the NC Psychology Board Need a Fee Increase?

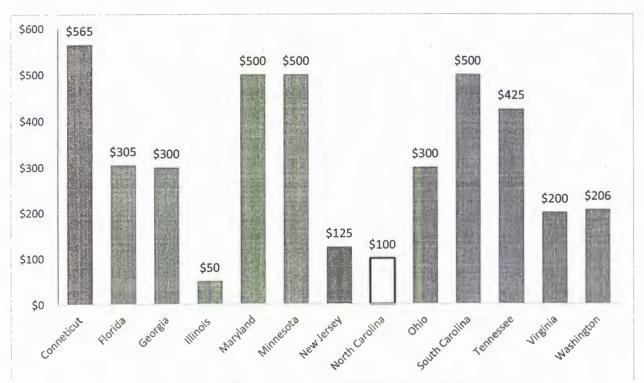
The Psychology Board is self-funded through the fees it collects. It receives no tax payer revenue. The majority of the Board's fees (including application and license renewal fees, which are the Board's primary sources of income) have been statutorily capped since 1996. Without a change in the statute, the Board cannot continue to sufficiently serve and protect North Carolina's citizens at the level they deserve.

Adequately funding the Psychology Board ensures that the staff have the necessary resources to properly address claims of unqualified, incompetent and dangerous practice in order to protect the public, who may not have a voice or understanding of the ramifications of such practice.

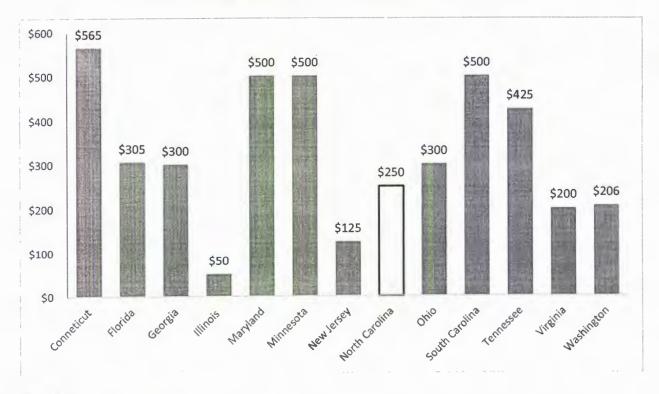
The funds provided through an increase in fees would primarily be spent to:

- Hire another Investigator/Credentials Reviewer to decrease the length of time to investigate complaints and to more quickly review licensure applications.
- Replace the Board's DOS-based database system, which was originally installed in 1983, which would substantially improve access to information about licensees and provide improved services for licensees and applicants.
- Develop an online application process to reduce processing time by Board staff and to provide applicants with improved up-to-date status of their applications.
- Develop a new online state licensure exam to better evaluate applicants' knowledge of their legal and ethical requirements.
- Replace the Board's aging computer servers (which are near the end of their service life) to improve the security of the Board's computer network.
- Develop an online system for submission of supervision contracts and reports
 which would provide a less time consuming method for licensees to submit the
 information and for quicker identification of possible supervision problems in
 order to better protect the public.
- Upgrade online license and corporation renewal systems to allow licensees to more quickly and easily renew licenses and corporate registrations.

NC Psychology Board Current Application Fee Comparison



NC Psychology Board Current Renewal Fee Comparison



Contact:
Daniel P. Collins
Executive Director
North Carolina Psychology Board
(828) 262-2258
dcollins@ncpsychologyboard.org

North Carolina Psychology Board



Robert W. Hill, Ph.D., ABPP Chairperson

Daniel P. Collins Executive Director

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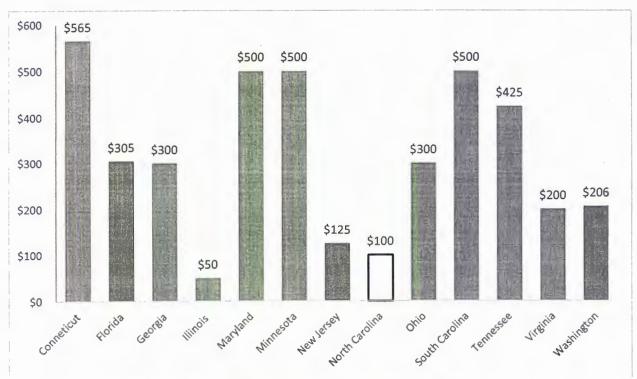
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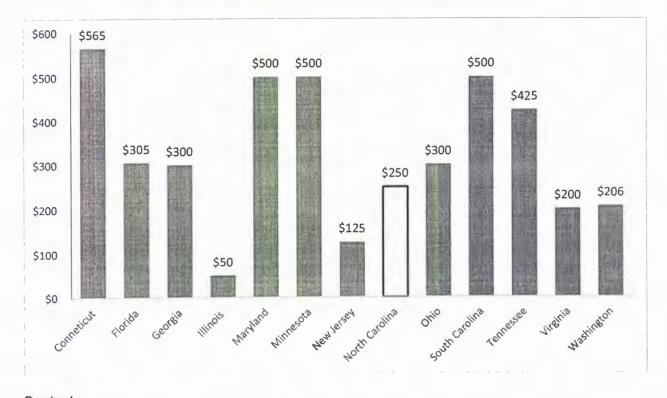
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Robert W. Hill, Ph.D., ABPP Chairperson Daniel P. Collins Executive Director

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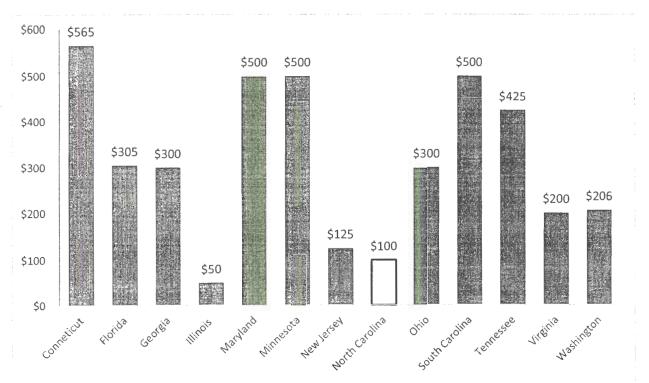
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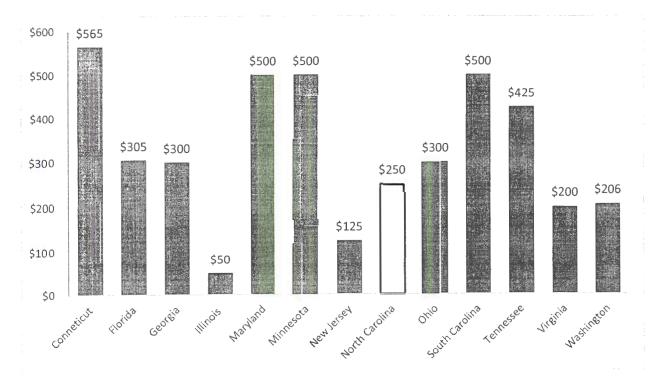
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Robert W. Hill, Ph.D., ABPP Chairperson Daniel P. Collins Executive Director

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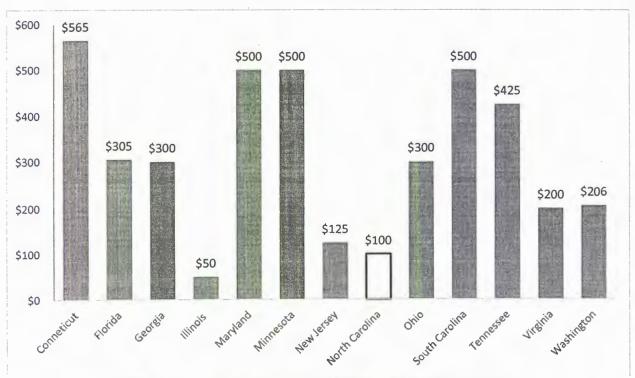
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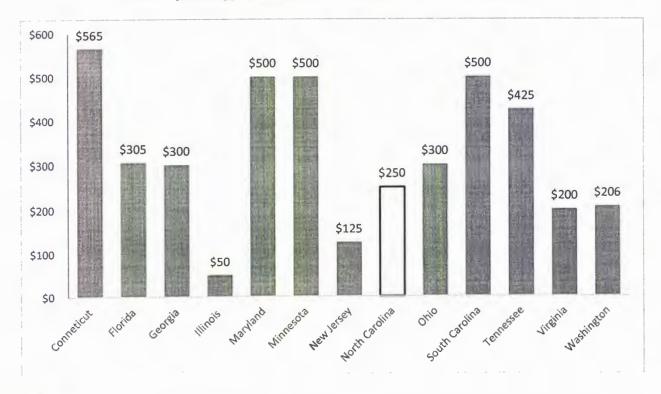
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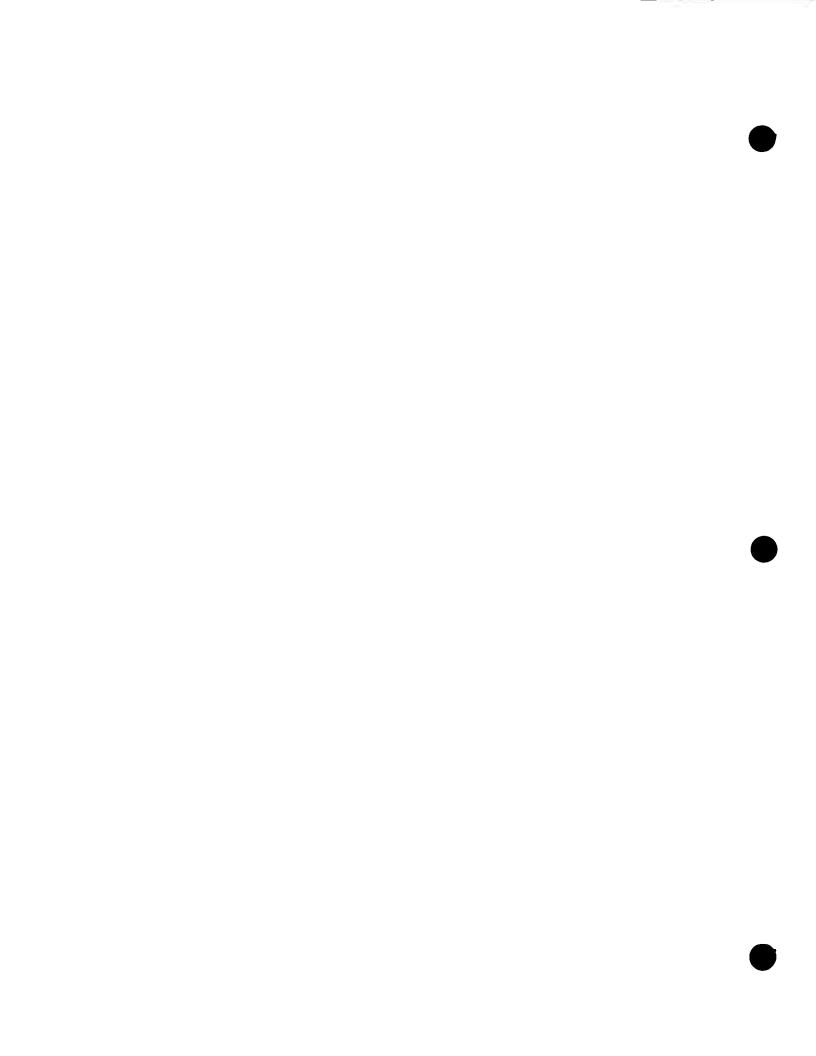
NC Psychology Board Current Renewal Fee Comparison



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dcollins@ncpsychologyboard.org

Committee Sergeants at Arms

NAME OF COMMITTEE HEALTH			
DATE: _	5-10-17	Room: 544	
		House Sgt-At Arms:	
1. Name:	REGGIE SILLS		_
	MARVIN LEE		
		REY COOKE	_
4. Name:	THOMAS TERRY		-
5. Name: _			
		Senate Sgt-At Arms:	
. Name:			•
%. Name:			
. Name: _			
. Name: _			
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House Pages Assignments Wednesday, May 10, 2017

Session: 3:00 PM

Committee	Room	Time	Staff	Comments	Member
State and Local Government	544	10:00 AM	Marc-Alain Bertoni		Rep. Debra Conrad
			Joshua Cartret		Rep. Brenden Jones
Health	544	11:00 AM	Daniel Ma		Rep. Nelson Dollar
			Mary Beth Rhyne		Rep. Rena Turner
Regulatory Reform	1228/1327	11:00 AM	Trey Blackwood		Rep. Hugh Blackwell
Judiciary I	415	12:00 PM	Marc-Alain Bertoni		Rep. Debra Conrad
			Mary Beth Rhyne		Rep. Rena Turner
Energy Policy Commission, Jt. Leg.	544	1:00 PM	Daniel Ma		Rep. Nelson Dollar
Judiciary I	415	1:00 PM	Trey Blackwood		Rep. Hugh Blackwell
			Joshua Cartret		Rep. Brenden Jones

VISITOR REGISTRATION SHEET

Health Name of Committee

Date 5/10/2017

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
TRACY COLVAR	1 AHBE
HOWAR OCHUS	sen Md LABS.
Stre Stonecyphen	Shipavisht Healthous Grays
mol Eh	R. Wasser.
SallyCamera	NE Prychological Assoc
Sonda Panico	NC Psychology Boad
Soft Whim	+ New Humon Region Wellief Courte
THOM GOOTH	Godge God Relitaris
Joen Michals	OrthoCoolina
Salut	776
Julia Adams Schuric	Loan Cy GR
Reanna Hankins	Nutrition of Dietetics Student @ NCCU
Thom Mansfield	WWE

VISITOR REGISTRATION SHEET

Name of Committee

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME

FIRM OR AGENCY AND ADDRESS

Jennifer Mahan	ASNC
Stephen Kurba	KMA
Andy Chase	KMA
Ropan South Brown	NC Dieteric Assoc.
Kin Iles	NC Dietetic Assoc.
Jon Alger	BCIUS
Susan Dalton	OBGYN Resident Prysician UNC
Kaitham Cine	OBGYN fesibent Quake Forest
Timbaly Base	Wake Forest OBGYN
Kathleen Ferry	WakeForest OBGYN
Katherine Hines	Wake Forest OBGYN
ReBLamme	REA

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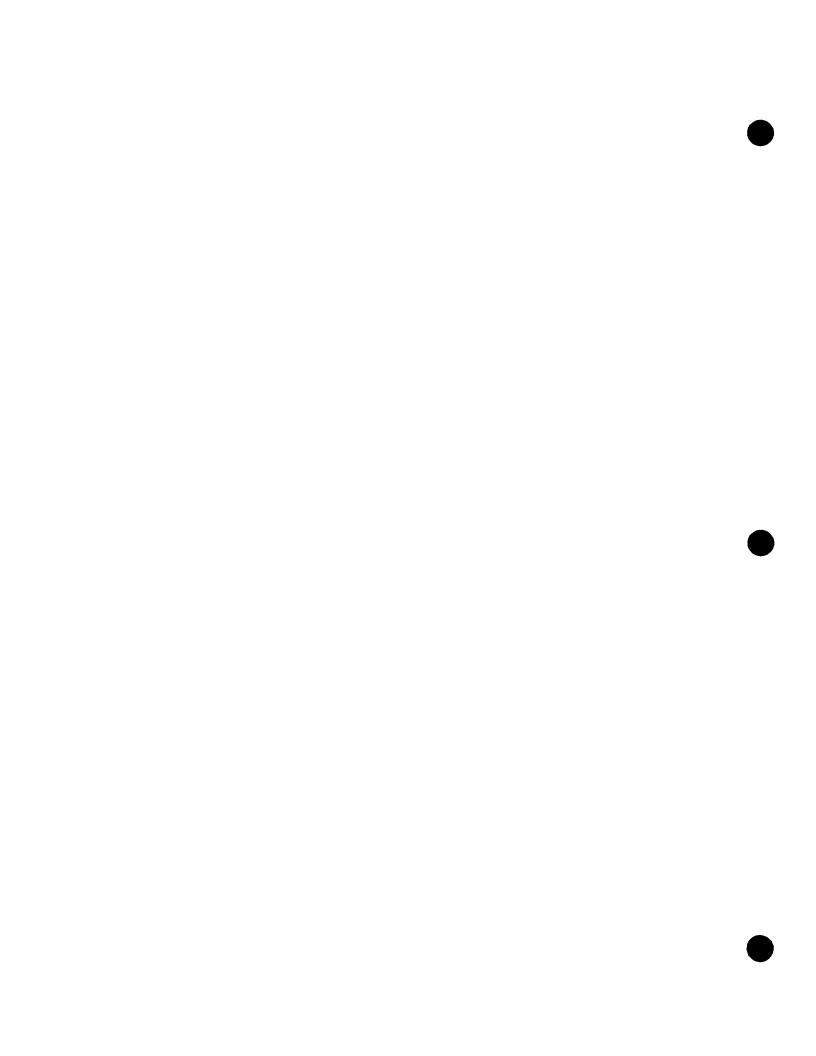
VISITOR REGISTRATION SHEET

Health
Name of Committee

Date 5/10/2017

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
ARTHUR APOLINARIO MD MDH FAAFP	Chylon Modical Chinic 40 3 Fairview 78328
RyanBlacklulge	Cone Heuth
Lanier Hodgion	UNC HCS
Matthaden M'Consell	Carolinastratular System
Jean U. Kirk	NC Food Ankle Society
or. Mike Kerzner	Duke Orthopaedics
r. Denek Pargial	Ne Four à Anton Society
Dr. Phillip Ward	NC Foot + ANX 10 Socialy
Dep yary	NOSP
x. Millicent Brown	NC Foot and Ankle Society
Dr. N'Tuma Jah	Mc Foot and Ankle Occioty
Andy Minny	MVA



VISITOR REGISTRATION SHEET

Health Name of Committee	Date 5/10/2017
VISITORS: PLEASE SIGN I	N BELOW AND RETURN TO COMMITTEE CLERK
NAME	FIRM OR AGENCY AND ADDRESS
DEKARLOS MIDIAL	NC FOOT AND ANKLE SOCIETY (IMMEDIATE PAST PRESIDENT)
Kick Woelffer	. //
Jacob Panici	NCFAS / Piedmont Foot + Andele Cory NC FLOT and Ande Society
Hartha Ailoung	NC Foot and Ande Society
Tel Titene	TAG Advocacy,
Need formthe	Atty
Kenthers	AH
Pavid M. Franzen	President, NC Association of President, NC Association of
JAMES F Black MD	Wake Forest Brotist Health Gynecology Le
Kate Menord	NC OBGYN Society
Mr Bonz	Nems
Don Martin	Forsyth G. Commissioner

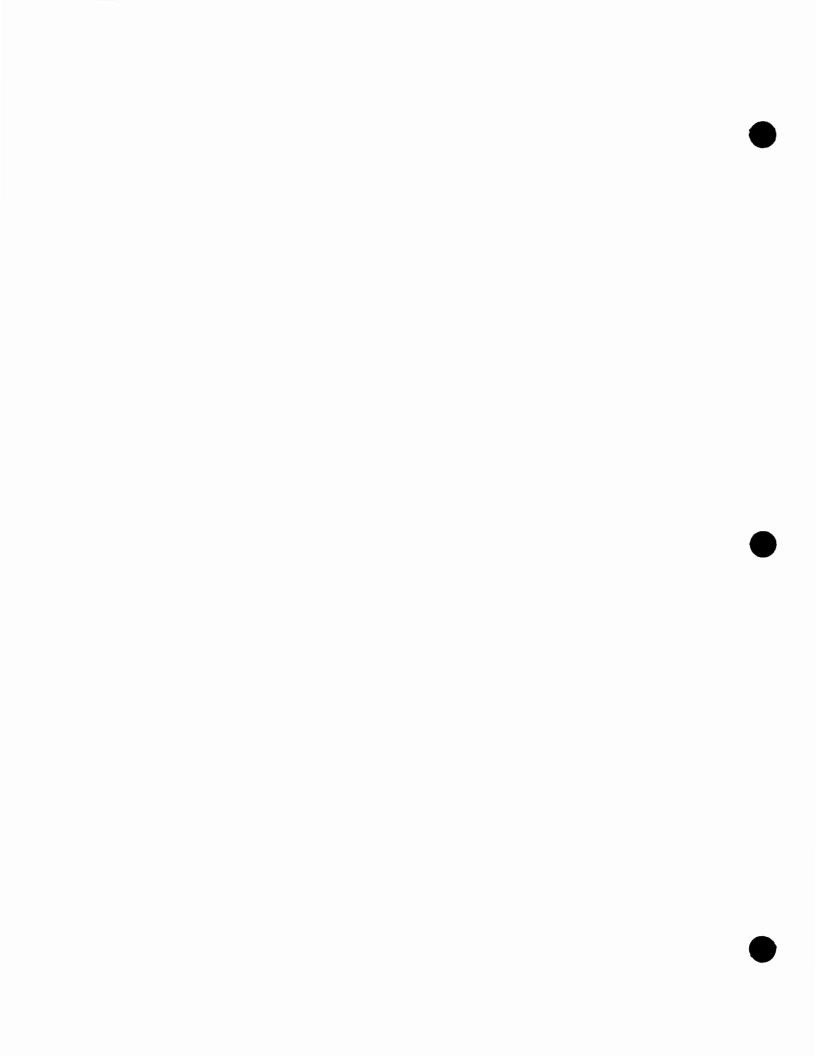
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VISITOR REGISTRATION SHEET

Name of Committee

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
& JEFF MANNEY	NC FOOT & ANKLO SOCIETY
DR WILLIAM O'NEIL	NIC FORTH AMILLE SOCIETY.
Dr. Shalonda Davidson	NC Fout Ankle Society
Pero Buff	50G
Ma Wien.	(61
Breeden FlAckwel	CEUMC.
Copy HAM	NICHA
Evelyn Contre	NC Medica (Board
Dr. DON POGLOCK	NC Foot & ANKle Society
5-01	
Ken Molton	KM.A
Ford Do	Bon: ASSO



VISITOR REGISTRATION SHEET

Name of Committee

VISTOR REGISTRATION STEEL

5/10/10

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME

FIRM OR AGENCY AND ADDRESS

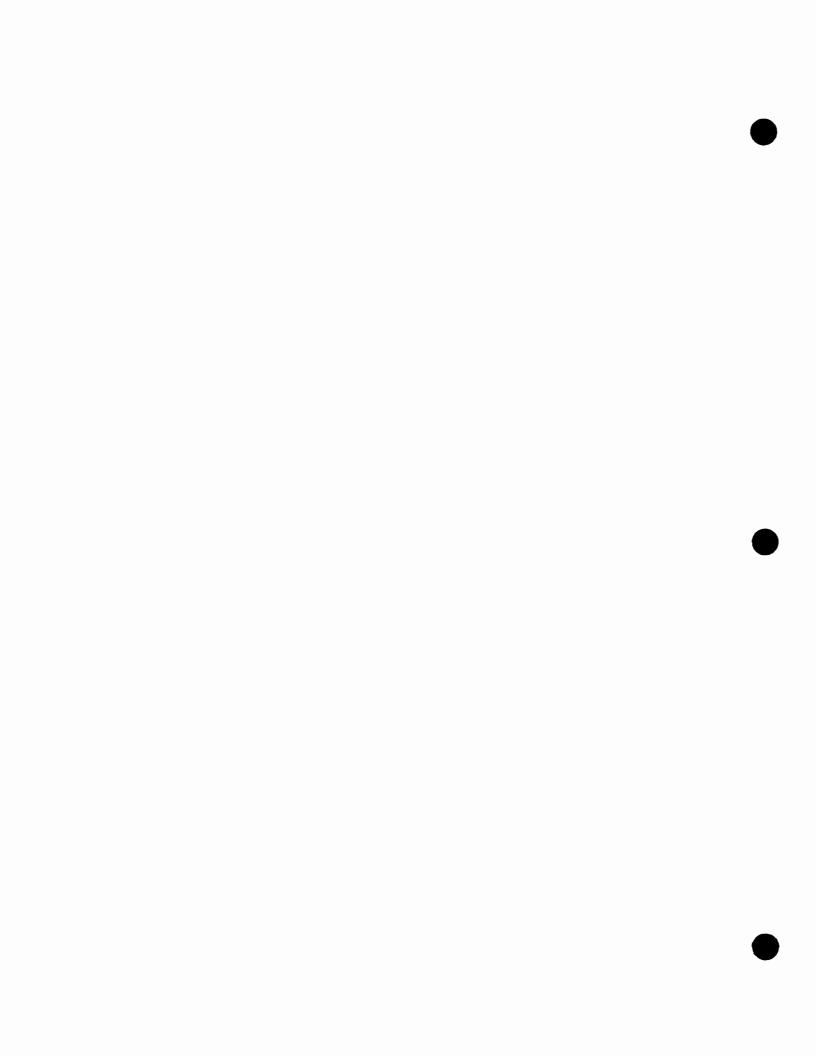
Both Grose	Nutritional Thorapy Association
Susan Greco	Nutritional Therapy Association BCNS
JONI Alger	Board for Certification of Mator tion Theraps
Jill Hinton	NCCounal on Deu DISAMHUS
Brian Perkins	Alience Stic
Sava Wilson	Alliance BMC
Judy Stone	Board for Certification of Jutition Specialists
Thursall Celle	Nutritional Therapy Association (Self) Apex, NC
Bre dagger	CaroMont
Dodle Renfer	CCR
	No 6-12
	NCOR6S

Elizabeth hivingson

NCOB6S

Jennifer Ozkurt

NCDPS



House Committee on Health Wednesday, June 21, 2017 at 11:00 AM Room 643 of the Legislative Office Building

MINUTES

The House Committee on Health met at 11:00 AM on June 21, 2017 in Room 643 of the Legislative Office Building. Representatives Adcock, Ball, Blackwell, Boswell, Brisson, Carney, Cunningham, Dobson, Dollar, Dulin, Earle, Farmer-Butterfield, Ford, Howard, Hunter, Insko, Bert Jones, Lambeth, Murphy, Potts, Rogers, Shepard, White, Wray, Yarborough, and Zachary attended.

Representative Nelson Dollar, Chair, presided.

The following bills were considered:

HB 192 Rec. and Music Therapy Licensure. (Representatives Warren, Blackwell, Corbin, Williams)

Representative Dollar motioned for the PCS for the bill to be brought before the committee. Representative Warren explained the bill. Discussion followed. Martine Bullard, MT-BC, spoke of her 20 years of practicing musical therapy and its benefit for Alzheimer's disease patients. She added that degrees in musical therapy are offered at ECU, Queens College, and Appalachian State University. Rep. Bert Jones motioned for an Unfavorable to the original bill, favorable to the PCS. All in favor, HB 192 passed, with a serial referral to Finance.

SB 350 LME/MCO Claims Reporting/Mental Health Amdts. (Senators Britt, Tucker, J. Jackson)

Representative Bert Jones assumed the position of Chair, while Representative Dollar explained the PCS for the bill. Discussion followed. Rep. Dollar motioned for an Unfavorable to the original bill, favorable to the PCS. All in favor, SB 350 passed.

The meeting adjourned at 11:45.

Representative Nelson Dollar, Chair

Presiding

Brenda Olls, Committee Clerk

Corrected #1: Add SB350

NORTH CAROLINA HOUSE OF REPRESENTATIVES COMMITTEE MEETING NOTICE AND BILL SPONSOR NOTIFICATION 2017-2018 SESSION

You are hereby notified that the House Committee on Health will meet as follows:

DAY & DATE: Wednesday, June 21, 2017

TIME: 11:00 AM LOCATION: 643 LOB

DILL NO CHODE ETEL D

The following bills will be considered:

RILL NO.	SHORTTILLE	SPUNSUR
<u>HB 192</u>	Establish Music Therapy Practice Act.	Representative Warren
		Representative Blackwell
		Representative Corbin
		Representative Williams
SB 350	Amend Drug Laws/Ellison v.	Senator Britt
	Treadway.	Senator Tucker
		Senator J. Jackson

Respectfully,

CDONCOD

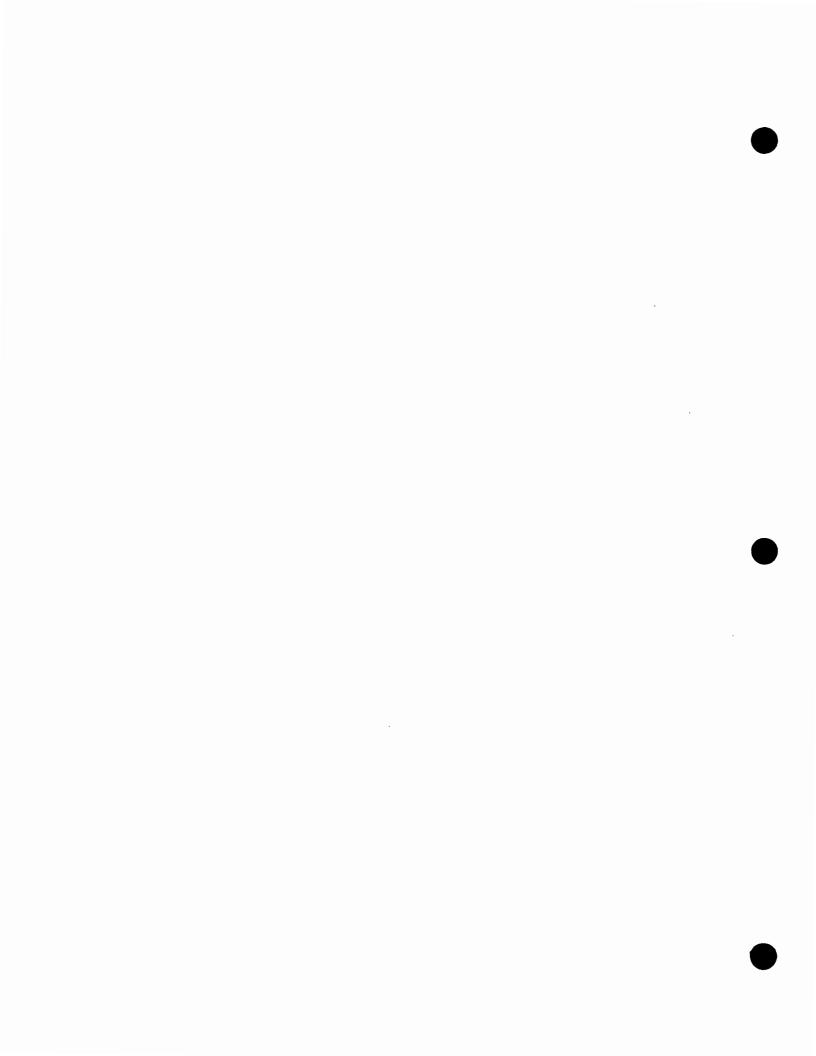
Representative Josh Dobson, Co-Chair Representative Nelson Dollar, Co-Chair Representative Bert Jones, Co-Chair Representative Donny Lambeth, Co-Chair Representative Gregory F. Murphy, MD, Co-Chair

I hereby certify this notice was filed by the committee assistant at the following offices at 9:38 AM on Wednesday, June 21, 2017.

____ Principal Clerk

Brenda Olls (Committee Assistant)

Reading Clerk – House Chamber

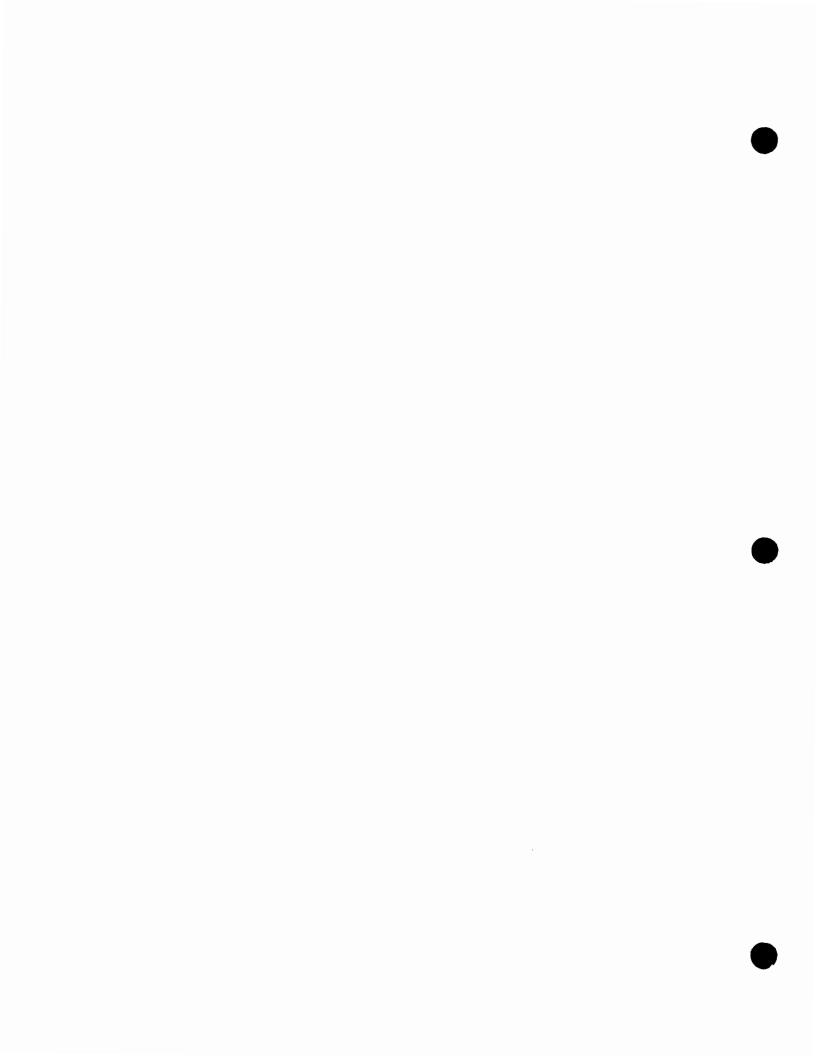


NORTH CAROLINA HOUSE OF REPRESENTATIVES COMMITTEE MEETING NOTICE AND BILL SPONSOR NOTIFICATION 2017-2018 SESSION

You are hereby notified that the House Committee on Health will meet as follows:

Brenda Olls (Committee Assistant)

DAY & DAY TIME: LOCATION		Wednesday, June 21, 2017 11:00 AM 643 LOB		
The following	ng bill	ls will be considered:		
BILL NO. HB 192		ORT TITLE ablish Music Therapy Practice A	Act.	SPONSOR Representative Warren Representative Blackwell Representative Corbin Representative Williams
		Re	espectfu	lly,
		Re Re Re	epresent epresent epresent	ative Josh Dobson, Co-Chair ative Nelson Dollar, Co-Chair ative Bert Jones, Co-Chair ative Donny Lambeth, Co-Chair ative Gregory F. Murphy, MD, Co-Chair
I hereby cert Tuesday, Jur			nittee as:	sistant at the following offices at 3:02 PM on
		Principal Clerk Reading Clerk – House Chambo	er	



House Committee on Health Wednesday, June 21, 2017, 11:00 AM 643 Legislative Office Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

BILL NO.	SHORT TITLE	SPONSOR ·
HB 192	Establish Music Therapy Practice Act.	Representative Warren
		Representative Blackwell
		Representative Corbin
		Representative Williams
SB 350	Amend Drug Laws/Ellison v.	Senator Britt
	Treadway.	Senator Tucker
		Senator J. Jackson

Presentations

Other Business

Adjournment

		_



HOUSE BILL 192: Rec. and Music Therapy Licensure.

2017-2018 General Assembly

Committee: House Health. If favorable, re-refer to Date: June 21, 2017

Finance

Introduced by: Reps. Warren, Blackwell, Corbin, Williams Prepared by: Jason Moran-Bates

Analysis of: PCS to First Edition Committee Co-Counsel

H192-CSBCf-30

OVERVIEW: The Proposed Committee Substitute (PCS) to House Bill 192 would amend the North Carolina Recreational Therapy Licensure Act (Chapter 90C of the General Statutes) to add provisions for licensing the practice of Music Therapy.

CURRENT LAW: Under current law, Chapter 90C of the General Statutes regulates the licensing of recreational therapists. Music therapists are not regulated under current law.

BILL ANALYSIS: The PCS would change the name of the North Carolina Recreational Therapy Licensure Board to the "North Carolina Recreational and Music Therapy Licensure Board." It would make changes throughout Chapter 90C to conform to the new name. The PCS would add a definition of music therapy to G.S. 90C-22, add two music therapists to the Board, require the Board to license as a "Licensed Music Therapist" any individual who meets the educational, clinical training, and experience requirements set by the Board and who passes a test established by the Board or a national accrediting agency, and permit the Board to discipline individuals who practice music therapy without a license or who have a license revoked or suspended in another state. Finally, the PCS would make conforming changes throughout Chapter 90C to reflect that Board would regulate music therapists in addition to recreational therapists.

EFFECTIVE DATE: The bill would become effective January 1, 2018.

BACKGROUND: Music Therapy is an established health profession in which music is used within a therapeutic relationship to address physical, emotional, cognitive, and social needs of individuals. Currently 10 states require the registration, certification, or licensure of music therapists.

Karen Cochrane-Brown
Director



Legislative Analysis Division 919-733-2578

GENERAL ASSEMBLY OF NORTH CAROLINA **SESSION 2017**

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HOUSE BILL 192 PROPOSED COMMITTEE SUBSTITUTE H192-CSBCf-30 [v.3] 06/20/2017 5:14:53 PM

Rec. and Music Therapy Licensure. Short Title:

(Public)

Sponsors:

Referred to:

February 27, 2017

AN ACT PROVIDING FOR THE LICENSURE OF MUSIC THERAPISTS BY THE NORTH CAROLINA RECREATIONAL AND MUSIC THERAPY LICENSURE BOARD.

A BILL TO BE ENTITLED

The General Assembly of North Carolina enacts:

SECTION 1. Chapter 90C of the General Statutes reads as rewritten:

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"Chapter 90C.

7 8 "North Carolina Recreational and Music Therapy Licensure Act.

9 10 "§§ 90C-1 through 90C-19: Repealed by Session Laws 2005-378, s. 1, effective October 5, 2005.

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"Chapter 90C.

"North Carolina Recreational and Music Therapy Licensure Act.

12 13 "\$ 90C-20. Short title.

> This Chapter shall be known as the "North Carolina Recreational and Music Therapy Licensure Act".

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"§ 90C-21. Purpose.

It is the purpose and intent of the Recreational and Music Therapy Licensure Act to safeguard the health and safety of the public and to protect the public from harm by unqualified persons by establishing a minimum level of education, experience, and competence to assure the highest degree of professional care and conduct on the part of licensed recreational therapists and licensed recreational therapy assistants therapists, licensed recreational therapy assistants, and licensed music therapists.

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"§ 90C-22. Definitions.

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

- Board. The North Carolina Board of Recreational Therapy Licensure.Recreational and Music Therapy Licensure Board.
- Licensed music therapist A person licensed to practice music therapy (1a)under this Chapter.
- Licensed recreational therapist. A person who holds a license pursuant to (2) this Chapter as a recreational therapist. A person licensed as a "Recreational Therapist" under this Chapter may practice in clinical, residential, educational, and community settings and may:
 - Conduct an individualized patient or client assessment for the purpose of collecting systematic, comprehensive, and accurate data



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documentation of the client's response to treatment.
 Person. - Any individual, corporation, partnership, association, unit of government, or other legal entity.
 Recreational therapy. - A treatment service designed to restore, remediate,

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Recreational therapy. – A treatment service designed to restore, remediate, or rehabilitate a patient or client's level of functioning and independence in life activities, as well as reduce or eliminate the activity limitations and restrictions to participation in life situations caused by an illness or disabling condition.

through music, and movement to music; and (iii) evaluation and

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- (6) Recreational therapy aide. Any nonlicensed person who aids in the provision of recreational therapy services under the provisions of this Chapter, and who acts under the direction and on-site supervision of a licensed recreational therapist or licensed recreational therapy assistant. A recreational therapy aide may perform recreational therapy related duties and functions which are assigned and are commensurate with an aide's training and competency. An aide's work shall not include responding to a physician's orders; designing, conducting, or interpreting individualized recreational therapy patient assessment; determining or modifying recreational therapy treatment plans or interventions; or any independent practice or performance of recreational therapy services.
 - (7) Scope of recreational therapy. The practice of recreational therapy includes all direct patient or client services of assessment, planning, design, implementation, evaluation, and documentation of specific interventions, management, consultation, research, and education for either individuals or groups that require specific therapeutic recreation or recreational therapy intervention representing the process and knowledge base delineated in the most recent National Council for Therapeutic Recreation Certification (NCTRC) Job Analysis Study and professional standards of practice. Scope is inclusive of professional and preprofessional education and training in recreational therapy, therapeutic recreation, and related research.
- (8) Therapeutic recreation. The provision of treatment services and the provision of recreation services to persons with illnesses or disabling conditions. The primary purposes of treatment services, which are often referred to as recreational therapy, are to restore, remediate, or rehabilitate in order to improve functioning and independence as well as reduce or eliminate the effects of illness or disability. The primary purposes of recreation services are to provide recreation resources and opportunities in order to improve health and well-being. Therapeutic recreation is provided by professionals who are trained and certified, registered, or licensed to provided therapeutic recreation.

"§ 90C-23. North Carolina Recreational and Music Therapy Licensure Board is created.

- (a) The North Carolina Recreational and Music Therapy Licensure Board is created.
- (b) Composition. The Board shall consist of eight ten members appointed as follows:
 - (1) Three practicing recreational therapists, one of whom shall be appointed by the Governor, one of whom shall be appointed by the General Assembly upon the recommendation of the President Pro Tempore of the Senate, and one of whom shall be appointed by the General Assembly upon the recommendation of the Speaker of the House of Representatives.
 - (2) One licensed practicing recreational therapy assistant appointed by the Governor.
 - (3) One licensed practicing recreational therapist who is engaged primarily in providing education or training for recreational therapists or recreational therapy assistants appointed by the Governor.
 - (4) One physician licensed pursuant to Article 1 of Chapter 90 of the General Statutes appointed by the Governor.
 - (5) Two public members, one of whom shall be appointed by the General Assembly upon the recommendation of the President Pro Tempore of the Senate and one of whom shall be appointed by the General Assembly upon the recommendation of the Speaker of the House of Representatives.

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Two practicing music therapists, one of whom shall be appointed by the (6)General Assembly upon the recommendation of the President Pro tempore of the Senate, and one of whom shall be appointed by the General Assembly upon the recommendation of the Speaker of the House of Representatives. Notwithstanding the provisions of subsection (d) of this section, the initial music therapist Board member appointed by the General Assembly upon the recommendation of the Speaker of the House of Representatives shall serve a term of two years. Each subsequent music therapist Board member appointed by the General Assembly upon the recommendation of the Speaker of the House of Representatives shall serve a term in accordance with subsection (d) of this section.

The Governor shall make appointments after consultation with the North Carolina Recreational and Music Therapy Licensure Board and other interested persons.

Qualifications. - The nonpublic recreational therapist or recreational therapy assistant members of the Board shall hold a current license. Each nonpublic recreational therapist or recreational therapy assistant member of the Board, at the time of his or her appointment and for at least two years before, shall have been actively engaged in North Carolina in the practice of recreational therapy or therapeutic recreation, in the education and training of graduate or undergraduate students of recreational therapy or therapeutic recreation, or in recreational therapy or therapeutic recreation research.

Initial music therapist Board members do not have to be licensed upon appointment. However, once licensure requirements are established, those initial Board members shall satisfy the applicable requirements for licensure pursuant to this Chapter.

One public member shall not be a licensed health care professional or an agent or employee of any health care institution, health care insurer, health care professional school, or a member of any allied health profession. One public member shall have received recreational therapy or therapeutic recreation services, therapy, therapeutic recreation services, music therapy, or music therapy services. For purposes of this subsection, a person enrolled in a program to prepare him or her to be a licensed health care professional or an allied health professional shall not be eligible to serve as a public member of the Board. The spouse of any person who would be prohibited by this subsection from serving on the Board as a public member shall not serve as a public member of the Board. Public members shall reasonably reflect the population of this State.

- Term. Members of the Board shall serve three-year staggered terms and shall serve until a successor is appointed and qualified. No member shall serve more than two consecutive full terms.
- Vacancies. The Governor shall fill vacancies to the Board positions for which the Governor is the appointing authority within 30 days after a position is vacated. The General Assembly shall fill vacancies for which it is the appointing authority in accordance with G.S. 120-122. Appointees shall serve the remainder of the unexpired term and until their successors have been appointed and qualified.
- Removal. The Board may remove any of its members for gross neglect of duty. incompetence, or unprofessional conduct. A member subject to disciplinary proceedings shall be disqualified from Board business until the charges are resolved. The Governor may also remove any member for gross neglect of duty, incompetence, or unprofessional conduct.
- (g) Compensation. - Each member of the Board shall receive such per diem compensation and reimbursement for travel and subsistence as shall be set for licensing Board members generally, as provided in G.S. 93B-5.
- Officers. The officers of the Board shall be a chairman, a vice-chairman, and other (h) officers deemed necessary by the Board to carry out the purposes of this Chapter. All officers

shall be elected annually by the Board for one-year terms and shall serve until their successors are elected and qualified.

- (i) Meetings. The Board shall hold at least two meetings each year to conduct business and shall adopt rules governing the calling, holding, and conducting of regular and special meetings. A majority of the Board members shall constitute a quorum.
- (j) Employees. The Board may employ necessary personnel for the performance of its functions and fix their compensation within the limits of the funds available to the Board.
- (k) The total expense of the administration of this Chapter shall not exceed the total income from fees collected pursuant to this Chapter. None of the expenses of the Board, or the compensation or expenses of any officer or any employee of the Board, shall be paid or payable out of the General Fund. Neither the Board nor any of its officers or employees may incur any expense, debt, or other financial obligation binding upon the State.

"§ 90C-24. Powers of the Board.

- (a) The Board shall have the following general powers and duties:
 - (1) To administer this Chapter.
 - (2) To issue interpretations of this Chapter.
 - (3) To adopt, amend, or repeal rules and regulations in the manner prescribed by Chapter 150B of the General Statutes, as may be necessary to carry out the provisions of this Chapter.
 - (4) To establish qualifications of, employ, and set the compensation of the Executive Director who shall not be a member of the Board.
 - (5) To employ and fix the compensation of the personnel that the Board determines are necessary to carry out the provisions of this Chapter and to incur other expenses necessary to effectuate this Chapter.
 - (6) To determine the qualifications of persons who are licensed pursuant to this Chapter.
 - (7) To issue, renew, deny, suspend, or revoke licenses and carry out any of the other actions authorized by this Chapter.
 - (8) To conduct investigations for the purpose of determining whether violations of this Chapter are grounds for revoking, denying, suspending, or refusing to renew the licenses of persons licensed pursuant to this Chapter.
 - (9) To maintain a record of all proceedings and make available to persons who hold a license and other concerned parties an annual report of all Board action.
 - (10) To set fees for licensure, license renewal, and other services deemed necessary to carry out the purpose of this Chapter.
 - (11) To adopt a seal containing the name of the Board to be used on licenses and official reports it issues.
 - (12) To issue annually a list stating the names of persons currently licensed under the privilege of this Chapter.
 - (13) To establish or approve, as defined by rule, reasonable competency requirements for licensure, including the power to adopt or use examination materials, study or training courses, and standards of recognized accrediting and credentialing agencies and professional associations and the power to establish or approve, as defined by rule, reasonable standards for renewal of licensure, including requirements for continuing recreational therapy or therapeutic recreation education. therapy, therapeutic recreation, or music therapy education.

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The powers and duties enumerated above are granted for the purpose of enabling the Board to protect the public from misrepresentation of licensure status as provided in this Chapter and shall be liberally construed to accomplish this objective.

"8 90C-25. Executive Director.

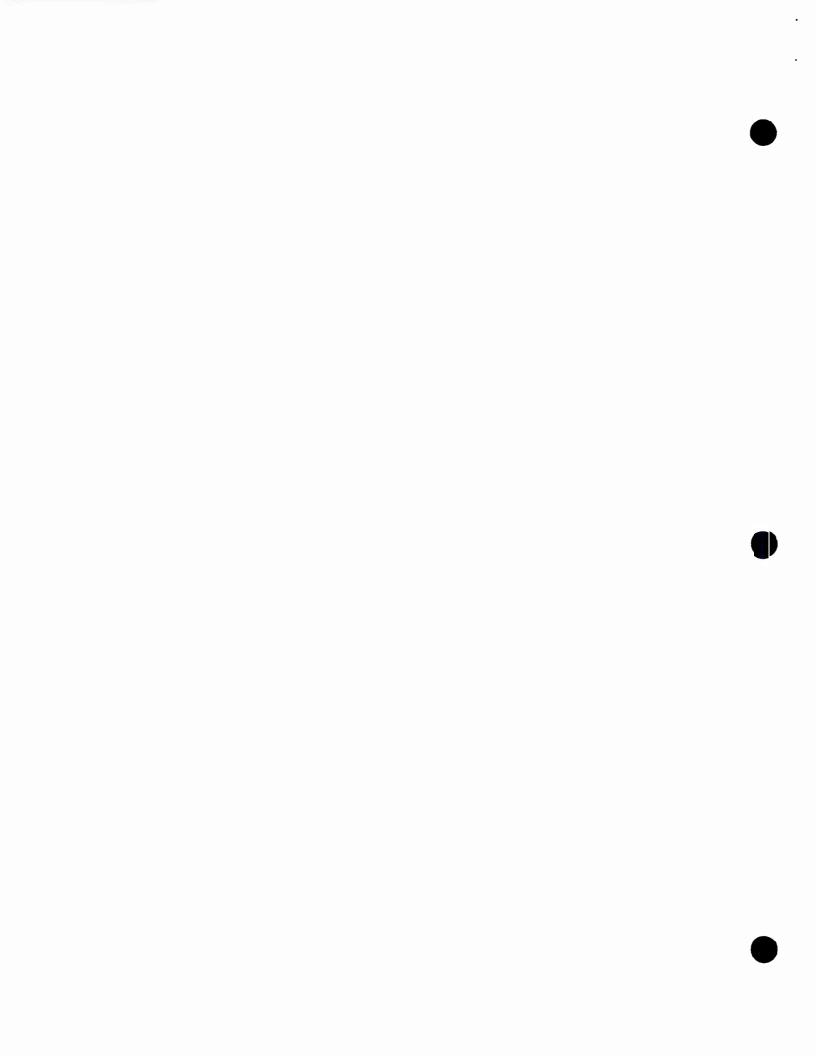
The Executive Director shall deposit all fees payable to the Board in financial institutions designated by the Board as official depositories. The funds shall be deposited in the name of the Board and shall be used to pay all expenses incurred by the Board in carrying out the purposes of this Chapter.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

"§ 90C-26. The Board may accept contributions, etc.

The Board may accept grants, contributions, devises, and gifts that shall be kept in a separate fund and shall be used by it to publicize the licensure program and its protective benefits to the public.

"§ 90C-27. Requirements for licensure.

- The Board shall license any person as a "Licensed Recreational Therapist" who meets the following education, credential, and experience requirements:
 - Passage of an appropriate examination as a therapeutic recreation specialist (1) or a recreational therapist by the North Carolina Recreational and Music Therapy Licensure Board or current certification as a "Certified Therapeutic Recreation Specialist" by the National Council for Therapeutic Recreation Certification.
 - A minimum level of education or experience, as defined by rules of the (2) Board, inclusive of practice competency standards or guidelines promulgated by professional associations and credentialing and accrediting organizations.
 - (3) For purposes of this subsection, an academic major or specialization shall be defined by rules of the Board and shall be inclusive of information gathered through surveys of educational institutions in the State having a bachelors or masters degree with a specialization in recreational therapy or therapeutic recreation.
- The Board shall license any person as a "Licensed Recreational Therapy Assistant" who meets the following education and experience requirements:
 - A minimum level of education or experience, as defined by rules of the Board, inclusive of practice competency standards or guidelines promulgated by professional associations and credentialing and accrediting organizations as deemed appropriate by the Board.
 - For purposes of this section, an academic major or specialization shall be (2)defined by rules of the Board and shall be inclusive of information gathered through surveys of educational institutions in the State having associate degree curricula in recreational therapy or therapeutic recreation.
- The Board shall license any person as a "Licensed Music Therapist" who meets the (c) following requirements:
 - A minimum level of education, clinical training, and experience, as defined (1) by the rules of the Board, inclusive of practice competency standards or guidelines promulgated by professional associations and credentialing and accrediting organizations.
 - Passage of an appropriate examination as a music therapist offered by the (2)North Carolina Recreational and Music Therapy Licensure Board or current



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certification as a Music Therapist-Board Certified (MT-BC) from the Certification Board for Music Therapists.

"§ 90C-28. Licensure fees.

Applications for licensure shall be made on forms prescribed and furnished by the Board. The Board may establish fees for the actual cost of duplication services, materials, and returned bank items. All fees derived from services provided by the Board under the provisions of this Chapter shall be nonrefundable. The Board shall establish the amount of fees as defined by rule not to exceed the following amounts:

(1)	Initial application for licensure fee	\$200.00
(2)	Licensure renewal fee	\$200.00
(3)	Record maintenance fee	\$100.00
(4)	Inactive fee	\$ 50.00.

"§ 90C-29. License renewal.

Every license issued pursuant to this Chapter shall be renewable every two years. Within 30 days before the expiration date, a person who desires to continue to be licensed in the field of therapeutic recreation or recreational therapyrecreation, recreational therapy, or music therapy shall apply for license renewal on forms furnished by the Board. The applicant shall meet criteria for renewal, including continuing education, established by the Board as defined by rule and shall pay the required fee established by the Board pursuant to this Chapter. Failure to renew the license before the expiration date shall result in automatic forfeiture of any license issued pursuant to this Chapter.

The Executive Director shall notify, in writing, every person at his or her last known address of the expiration of his or her license and the amount that is required for its two-year renewal.

"§ 90C-30. Reinstatement.

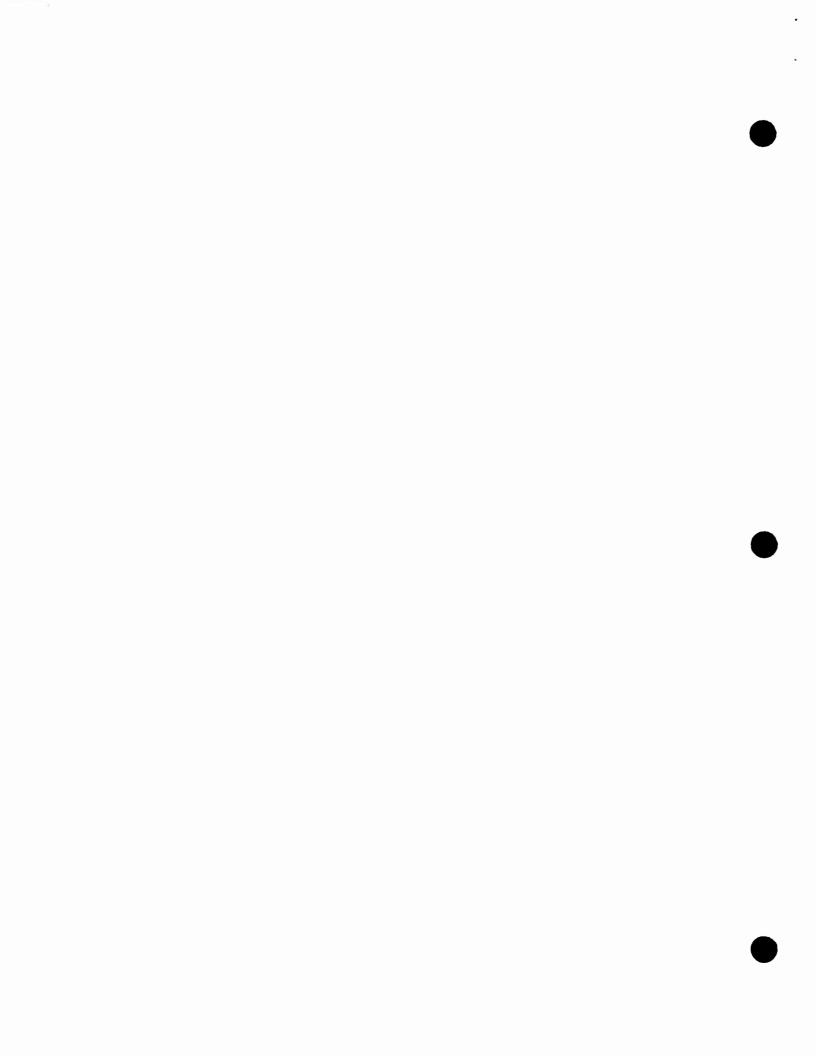
A person who has allowed his or her license to lapse by failure to renew it pursuant to this Chapter must apply for licensure on a reinstatement form provided by the Board. The Board shall require the applicant to return the completed reinstatement licensure form including renewal requirements established by the Board as defined by rule. If the license has lapsed for more than two years, the Board shall require the applicant to successfully demonstrate competency as defined by rules established by the Board. If the Board determines that the license should be reinstated, it shall issue a license renewal to the applicant.

"§ 90C-31. Inactive list.

When a person licensed by the Board submits a request for inactive status and pays the inactive fee, the Board shall issue to the person a statement of inactive status and shall place the person's name on the "Inactive Status" list. While on that list, the person shall not hold himself or herself out as licensed pursuant to this Chapter. When that person desires to be removed from the inactive list and returned to an active list, an application shall be submitted to the Board on a form furnished by the Board, and the fee shall be paid for license renewal. The Board shall require evidence of competency as defined by rule to resume practice before returning the applicant to the active status.

"§ 90C-32. Revocation, suspension, or denial of licensure.

The Board may require remedial education, issue of a letter of reprimand, restrict, revoke, or suspend any license issued pursuant to this Chapter or deny any application for licensure if the Board determines that the licensee or applicant has done any of the following:



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therapy at an accredited college or university that meets the minimum academic requirements for a major or specialization in recreational therapy as defined by the rules and regulations of the Board.

- Any person fulfilling the supervised fieldwork experience required for a (4) degree and for licensure, as defined by the rules of the Board, if the person is designated by a title that clearly indicates his or her status as a student.
- (5) Expired.

"§ 90C-35. Reports; immunity from suit.

Any person who has reasonable cause to suspect malpractice, misconduct, or incapacity of a person who is licensed pursuant to this Chapter or who has reasonable cause to suspect that any person is in violation of this Chapter should report the relevant facts to the Board. Upon receipt of a charge or upon its own initiative, the Board may give notice of an administrative hearing pursuant to Chapter 150B of the General Statutes or may, after diligent investigation, dismiss unfounded charges. Any person making a report pursuant to this section shall be immune from criminal prosecution or civil liability based on that report unless the person knew the report was false or acted in reckless disregard of whether or not the report was false.

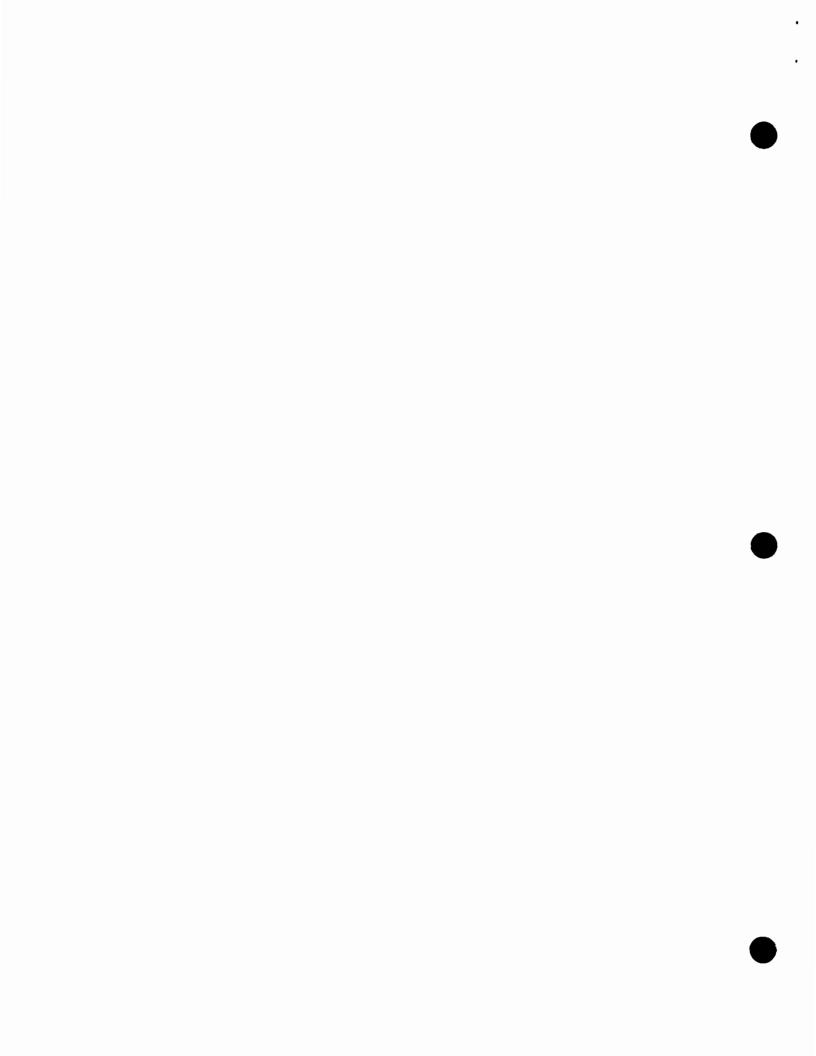
"§ 90C-36. Violations and penalties.

Any person not licensed under this Chapter who holds himself or herself out to be licensed under this Chapter or who practices recreational therapy or therapeutic recreation shall be guilty of a Class 1 misdemeanor. Any fine imposed as a result of conviction shall not exceed five hundred dollars (\$500.00).

"\§ 90C-37. Enjoining illegal practices.

- If the Board finds that a person is violating any of the provisions of this Chapter, it may apply in its own name to the superior court for a temporary or permanent restraining order or an injunction to prevent that person from continuing the illegal practices. The court is empowered to grant an injunction regardless of whether criminal prosecution or other action has been or may be instituted as a result of the violation. All actions by the Board shall be governed by the Rules of Civil Procedure.
- The venue for actions brought under this Chapter shall be in the county where the defendant resides or the county where the violation occurs.

SECTION 2. This act becomes effective January 1, 2018.



GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2017

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HOUSE BILL 192

Short Title: (Public) Establish Music Therapy Practice Act. Representatives Warren, Blackwell, Corbin, and Williams (Primary Sponsors). Sponsors: For a complete list of sponsors, refer to the North Carolina General Assembly web site. Referred to: Health, if favorable, Finance February 27, 2017 A BILL TO BE ENTITLED AN ACT ESTABLISHING THE NORTH CAROLINA MUSIC THERAPY PRACTICE ACT. Whereas, licensing individuals who seek to practice as music therapists would give the citizens of North Carolina a consistent standard when receiving music therapy services in this State: Now, therefore, 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 18E. "Music Therapy. "§ 90-270.85. Title. This Article shall be known and may be cited as the "North Carolina Music Therapy Practice Act." "§ 90-270.86. Purpose. The North Carolina Music Therapy Practice Act is established to safeguard the public health, safety, and welfare, to protect the public from being harmed by unqualified persons, to assure the highest degree of professional services and conduct on the part of music therapists, to provide for the establishment of licensure requirements, and to ensure the availability of music therapy services of high quality to persons in need of such services. It is the purpose of this Article to provide for the regulation of persons offering music therapy services to the public. "§ 90-270.87. Definitions. The following definitions apply in this Article: Board. – The North Carolina Board of Music Therapy. (1) Music therapist. – An individual licensed to practice music therapy under this (2) Article. Music Therapist-Board Certified. - An individual practicing music therapy who (3) has been credentialed as having passed a national examination administered by the Certification Board for Music Therapists, an accredited health certifying Music therapy. - The clinical and evidence-based use of music interventions to (4) accomplish individualized goals within a therapeutic relationship by a



credentialed professional who has completed an approved music therapy

program, including (i) assessment of a client's emotional, physical, and spiritual

health, social functioning, communication abilities, and cognitive skills through

the client's history and observation and interaction of the client in music and

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Music therapy services. - The provision of services to accomplish music therapy goals, including (i) conducting an individualized assessment for the purpose of collecting systematic, comprehensive, and accurate data necessary to determine the course of action subsequent to the individualized treatment plan; (ii) planning and developing the individualized music therapy treatment plan that identifies an individual's goals, objectives, and potential treatment intervention strategies; (iii) implementing the individualized music therapy treatment plan consistent with the individual's overall treatment program; (iv) systematically evaluating and comparing the individual's response to the individualized music therapy treatment plan and suggesting modifications, as appropriate; (v) developing a discharge plan in collaboration with the individual, the individual's family, treatment team, and other identified support networks, when appropriate; (vi) minimizing the impact of environmental constraints as a barrier to participation in least restrictive environments for individuals engaging in music therapy; (vii) collaborating with and educating the individual, family, caregiver, and others to foster an environment responsive to the developmental needs of the individual as addressed in music therapy; and (viii) consulting with groups, programs, organizations, or communities to improve accessibility to music therapy services.

"\$ 90-270.88. License required; exemptions.

- Persons practicing or offering to practice music therapy as defined in this Article, may not use the title "Music Therapist-Board Certified/Licensed" or "Licensed Music Therapist," use the letters "MT-BC/L" or "LMT," or use any other title or abbreviation that would otherwise indicate or imply that the person is a licensed music therapist unless that person is currently licensed as provided under this Article.
 - The provisions of this Article shall not apply to the following: (b)
 - Any person registered, certified, credentialed, or licensed to engage in another (1) profession or occupation or any person working under the supervision of a person registered, certified, credentialed, or licensed to engage in another profession or occupation in this State if the person is performing work incidental to the practice of that profession or occupation and the person does not represent himself or herself as a licensed music therapist.
 - A student enrolled in an approved music therapy education program if music (2)therapy services performed by the student are an integral part of the student's course of study and are performed under the direct supervision of a professional licensed in this State.
 - A music therapist employed by the United States government when performing (3) duties associated with that employment.

"§ 90-270.89. North Carolina Board of Music Therapy.

- Creation. The North Carolina Board of Music Therapy is created. (a)
- Composition and Terms. The Board shall consist of five members who shall serve (b) staggered terms. Two members shall be licensed music therapists, and one member shall represent the public at large.
 - The initial Board members shall be appointed on or before October 1, 2017, as follows:

General Assembly Of North Carolina

- (1) The General Assembly, upon the recommendation of the Speaker of the House of Representatives, shall appoint one music therapist who shall serve for a term of three years.
- (2) The General Assembly, upon the recommendation of the President Pro
 Tempore of the Senate, shall appoint one music therapist who shall serve for a
 term of two years.
- (3) The Governor shall appoint the following three members who shall serve for a term of one year:
 - a. A public member.
 - b. A member who is a licensed health care professional.
 - c. A member who is a licensed attorney.

Initial music therapist Board members do not have to be licensed upon appointment. However, once licensure requirements are established, those initial Board members shall satisfy the applicable requirements for licensure pursuant to this Article.

Upon the expiration of the terms of the initial Board members, each member shall be appointed for a term of three years and shall serve until a successor is appointed. No member may serve more than two consecutive full terms.

- (c) Qualifications. The music therapist members shall hold current licenses and shall reside or be employed in North Carolina. They shall have at least five years' experience as music therapists, including the three years immediately preceding appointment to the Board, and shall remain in active practice and in good standing with the Board as a licensee during their terms. Public members of the Board shall not be (i) trained or experienced in the practice of music therapy; (ii) an agent or employee of a person engaged in the practice of music therapy; (iii) a health care professional licensed under this Article or a person enrolled in a program to become a licensed health care professional; (iv) an agent or employee of a health care institution, a health care insurer, or a health care professional school; (v) a member of an allied health profession or a person enrolled in a program to become a member of an allied health profession; or (vi) a spouse of an individual who may not serve as a public member of the Board.
- (d) <u>Vacancies. A vacancy shall be filled in the same manner as the original appointment, except that all unexpired terms of Board members appointed by the General Assembly shall be filled in accordance with G.S. 120-122 and shall be filled within 45 days after the vacancy occurs. Appointees to fill vacancies shall serve the remainder of the unexpired term and until their successors have been duly appointed and qualified.</u>
- (e) Removal. By a majority vote of its members, the Board may remove any member for neglect of duty, incompetence, or unprofessional conduct. A member subject to disciplinary proceedings as a licensee shall be disqualified from participating in the official business of the Board until the charges have been resolved.
- (f) Compensation. Each member of the Board shall receive per diem and reimbursement for travel and subsistence as provided in G.S. 93B-5.
- (g) Officers. The officers of the Board shall be a chair, a vice-chair, and other officers deemed necessary by the Board to carry out the purposes of this Article. All officers shall be elected annually by the Board for one-year terms and shall serve until their successors are elected and qualified.
- (h) Meetings. The Board shall hold at least two meetings each year to conduct business and to review the standards and rules for improving music therapy services. The Board shall establish the procedures for calling, holding, and conducting regular and special meetings. A majority of Board members constitutes a quorum.
- "§ 90-270.90. Powers of the Board.

The Board shall have the following powers and duties:

(1) Administer this Article.

House Bill 192-First Edition

become a Music Therapist-Board Certified (MT-BC).

Has successfully completed a minimum of 1,200 hours of clinical training, with (5) at least 180 hours in pre-internship experiences and at least 900 hours in internship experiences. For purposes of this subdivision, the internship may be approved by an academic institution, the AMTA, or both.

"§ 90-270.92. Reciprocity.

The Board may grant, upon application and payment of proper fees, a license to a person who has been licensed to practice music therapy in another state or territory of the United States whose standards of competency are substantially equivalent to the requirements for licensure provided in this Article.

"§ 90-270.93. Expenses and fees.

- All salaries, compensation, and expenses incurred or allowed to carry out the purposes of this Article shall be paid by the Board exclusively out of the fees received by the Board as authorized by this Article or funds received from other sources. In no case shall any salary, expense, or other obligation of the Board be charged against the State treasury.
 - The Board shall establish a schedule of fees, not to exceed the following amounts: (b)
 - Issuance of a license.....\$ 100.00 (1)
 - (2)

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(4) Reasonable charges for duplication services and material.

"§ 90-270.94. License renewal; continuing education; inactive status.

(a) Every license issued under this Article shall be renewed on or before January 1 every five years. The license shall be renewed upon the payment of a renewal fee if, at the time of application for renewal, the applicant is not in violation of this Article, has completed a minimum of 100 hours of music therapy practice in accordance with rules adopted by the Board, has maintained the applicant's Music Therapy-Board Certified (MT-BC) credential, and has complied with the continuing education requirements under subsection (b) of this section.

(b) As a condition of license renewal, a licensee shall complete a minimum of 100 hours of continuing education in a program approved by the Certification Board of Music Therapists and

meet any other continuing education requirements established by the Board.

(c) The Board shall notify a licensee at least 30 days in advance of the expiration of his or

her license. The licensee shall inform the Board of any change of the licensee's address. Each licensee is responsible for renewing his or her license before the expiration date. Licenses that are not renewed automatically lapse.

(d) The Board may provide for the late renewal of an automatically lapsed license upon the payment of a reinstatement fee. No reinstatement renewal may be granted more than five years after a license expires.

(e) In accordance with rules adopted pursuant to this Article, a licensee may request that his or her license be declared inactive and may thereafter apply for active status.

"§ 90-270.95. Disciplinary authority.

- (a) The Board may deny, suspend, revoke, or refuse to renew a license or impose probationary conditions on a license if the licensee or applicant for licensure has engaged in any of the following conduct:
 - (1) Obtaining a license by means of fraud, misrepresentation, or concealment of material facts.
 - (2) Engaging in unprofessional conduct pursuant to rules established by the Board.
 - (3) Having been convicted of or pleaded guilty or nolo contendere to a crime involving moral turpitude or any crime which indicates that the music therapist is unfit or incompetent to practice music therapy or that the music therapist has deceived or defrauded the public.
 - (4) Engaging in any act or practice in violation of any of the provisions of this Article or any rule adopted by the Board or aiding, abetting, or assisting any person in such a violation.
 - (5) Committing an act or acts of malpractice, gross negligence, or incompetence in the practice of music therapy.
 - (6) Practicing as a licensed music therapist without a current license.
 - (7) Engaging in conduct that could result in harm or injury to the public.
 - (8) Having a music therapy license revoked or suspended or other disciplinary action taken whether in this State or another jurisdiction.
 - (9) Being unfit or incompetent to practice music therapy by reason of deliberate or negligent acts or omissions regardless of whether actual injury to a patient is established.
- (b) The denial, refusal to renew, suspension, revocation, or imposition of probationary conditions upon a license may be ordered by the Board after a hearing held in accordance with Chapter 150B of the General Statutes and rules adopted by the Board. An application may be made to the Board for reinstatement of a revoked license if the revocation has been in effect for at least one year.
- "§ 90-270.96. Violation a misdemeanor.

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 Session 2017

Any	persor	<u>who</u>	violates	any	provision	of	this	Article	shall	be	guilty	of a	a Class	1
misdeme	anor. E	ech act	of such	unlaw	ful practic	e sh	all co	nstitute	a disti	nct a	nd sepa	rate	offense.	
"§ 90-27	0.97. I	njunct	ive relief	•	-						-			

The Board may make application to any appropriate court for an order enjoining violations of
this Article, and upon a showing by the Board that any person has violated or is about to violate
this Article, the court may grant an injunction, restraining order, or take other appropriate action."
SECTION 2. This act becomes effective January 1, 2018



SENATE BILL 350: LME/MCO Claims Reporting/Mental Health Amdts.

2017-2018 General Assembly

Committee:

House Health

Introduced by: Analysis of:

Sens. Britt, Tucker, J. Jackson PCS to Third Edition

S350-CSTR-7

Date:

June 21, 2017

Prepared by:

Jennifer Hillman

Staff Attorney

OVERVIEW: The PCS to Senate Bill 350 modifies certain requirements pertaining to local management entities/managed care organizations (LME/MCOs), which manage the provision of publicly-funded behavioral health services throughout the State.

CURRENT LAW: S.L. 2011-264 (HB 916), as amended by Section 13, S.L. 2012-151 (SB 191), directed the Department of Health and Human Services (DHHS) to proceed with statewide restructuring of management responsibilities for the delivery of services to individuals with mental illness, intellectual and developmental disabilities, and substance abuse disorders, through the statewide expansion of the Section 1915(b)/(c) Medicaid Waiver and the operation of the waiver by regional LME/MCOs. As directed in the law, statewide expansion was completed by July 2013. LME/MCO operations are governed by Chapter 122C of the General Statutes.

BILL ANALYSIS: The PCS to SB 350 amends several sections of Chapter 122C, The Mental Health, Developmental Disabilities, and Substance Abuse Act of 1985, and other provisions of law pertaining to LME/MCOs.

<u>Section 1</u> requires DHHS to specify a standardized electronic format that all LME/MCOs must use to submit data to DHHS regarding claims billed for Medicaid and State-funded services and to work with LME/MCOs to ensure the success of the process for submitting this data. This section lists permissible uses of the data by DHHS and requires DHHS to report on the status of this requirement by February 1, 2018.

<u>Section 2</u> amends the statute pertaining to the powers and duties of the Secretary of DHHS relevant to the mental health, developmental disabilities, and substance abuse services system to require DHHS to use contracts with LME/MCOs for the management of State-only funding, federal block grant funding, and Medicaid funding that include quality outcome measures for covered services. This section applies to contracts entered into on or after the bill becomes law.

<u>Section 3</u> amends various definitions pertaining to the State's mental health, developmental disabilities, and substance abuse services system, including amending the definition of "area director" to clarify that the term refers to the administrative head of the LME/MCO, regardless of the title that individual uses. This section amends other definitions for clarity and to remove obsolete references.

<u>Section 4</u> amends the statute establishing the primary functions of an LME to require the prior written approval of the Secretary of DHHS before the LME enters into contracts for certain primary functions. This section applies to contracts entered into on or after the date the bill becomes law.

<u>Section 5</u> amends the statute pertaining to the status of an area authority to add cross references to other applicable laws governing area authorities and to remove obsolete references.

Karen Cochrane-Brown Director



Legislative Analysis Division 919-733-2578

Senate PCS 350

Page 2

<u>Section 6</u> amends the statute pertaining to the powers and duties of an area authority to codify certain powers and duties that were enacted in uncodified language in S.L. 2011-264. Among those powers is the authority to subcontract with other entities for certain managed care functions, and this section would require approval by the Secretary of DHHS of subcontracts entered into on or after the date the bill becomes law.

<u>Section 7</u> amends the statute that provides for the establishment of the board of an area authority, to make the following changes:

- Would require all area boards to comply with statutory membership composition requirements no later than October 1, 2017,
- Would alter the scope of the membership composition category requiring expertise in managed care insurance to instead require expertise in health insurance, health plan administration, or business expertise, or a combination of these areas.
- Would allow area authorities to seek approval from the Secretary of DHHS to appoint board members through a process other than the one required by the statute by submitting an adopted resolution from three-quarters of the counties in the area authority. This approval becomes void upon the merger or consolidation of the area authority. Merged or consolidated area authorities may use the same procedure for seeking approval to appoint board members through a process other than the one required by the statute.
- Would require each LME/MCO to report annually to DHHS on the status of the area board and the board's compliance with certain requirements, including the appointment process and membership composition.

<u>Section 8</u> adds a new section to Chapter 122C, which governs LME/MCOs, specifying that LME/MCOs can only use funds for purposes related to their functions and responsibilities under this Chapter, including operating the Medicaid waivers and carrying out other functions and responsibilities required by State or federal law or required by contract with DHHS. If an LME/MCO violates this statute, the Secretary of DHHS must transfer the operations of the LME/MCO to another compliant LME/MCO.

<u>Sections 9 and 10</u> amend the statutes pertaining to an area board's employment of an area director and other employees, to make the following changes:

- Would require the area director to be a full-time employee of the area board who cannot hold any other employment.
- Would clarify that an area director and other employees of the area authority may only be paid a salary above the range established by the State Human Resources Commission if the area board submits a request to both the Director of the Office of State Human Resources (OSHR) and the Secretary of DHHS and receives written approval for the salary or salary adjustment. Written approval must be based on documentation of comparable salaries in "comparable operations within a comparable region of North Carolina," as that term is defined by the Secretary of DHHS.
- Would specify that an area director cannot be paid a salary above the range, if the salary exceeds by more than 30% the average salary of the area directors of the other area authorities.
- Would specify that the area director's total compensation, including salary, benefits, and bonuses, cannot be increased without the written approval of the Director of OSHR and the Secretary of DHHS, and would require annual review of each area director's total compensation for written approval.

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- Would require that if the Secretary of DHHS determines that an area director's total compensation or salary exceeds the limitations in the statute, then the area board must bring the area director's total compensation or salary into compliance with the statute within 60 days after the Secretary's determination. If the area board does not bring the area director's total compensation or salary into compliance within that timeframe, then the Secretary must give notice to the area board related to the determination of noncompliance and allow the board another 60 days to bring the area director's total compensation or salary into compliance. If the area board does not comply within that timeframe, the Secretary must appoint a caretaker board for the area authority according to procedures in G.S. 122C-124.1, and the Secretary may terminate the employment of the area director.
- Would require the area board to annually submit to the Secretary of DHHS and the Director of OSHR all employment agreements and all documents relating to the area director's total compensation, and would require that these documents be submitted within 30 days after the bill becomes law.
- Would require the area director to ensure the area authority's compliance with its statutory powers and duties.
- Would require the appointment of an area director to be based on the recommendation of at least two candidates from a search committee of the area board, to include a consumer board member, a county commissioner, and an appointee of the Secretary of DHHS.
- Would require the area board to give an area director 30 days' notice prior to termination of employment, except after the merger or consolidation of the LME/MCO with another LME/MCO or if directed by the Secretary of DHHS.

<u>Section 11</u> amends the statute governing the establishment of local personnel systems to specify that a determination by the State Human Resources Commission that an LME/MCO's personnel system is substantially equivalent to standards established for certain other local governmental entities becomes void upon the merger or consolidation of two or more LME/MCOs. A newly merged or consolidated LME/MCO would be allowed to petition the State Human Resources Commission for a determination of substantial equivalency with the approval of three-quarters of the counties in the LME/MCO.

<u>Section 12</u> amends a provision in the 2015 Budget Act governing the timing of when DHHS makes single-stream funding payments to the LME/MCOs to establish a timeframe within which DHHS must make monthly distributions of this funding to LME/MCOs, beginning July 1, 2017.

Sections 13, 14, and 15 remove obsolete references from Chapter 122C.

EFFECTIVE DATE: Section 12 of the PCS would become effective July 1, 2017. The remainder of the bill would be effective when it becomes law.

BACKGROUND: Originally, 11 LME/MCOs were formed, and those have consolidated to the 7 LME/MCOs that currently exist in the State, which include Vaya Health, Partners Behavioral Health, Cardinal Innovations Health care Solutions, Sandhills Center, Alliance Behavioral Health, Eastpointe, and Trillium Health Resources.

LME/MCOs originated from area authorities, county programs, and consolidated human services agencies, which later became local management entities (LMEs). Today, all LME/MCOs are structured as area authorities, and county programs and consolidated human services agencies no longer operate. The terms "area authority," "LME," and "LME/MCO" all refer to the same entities.

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The LME/MCOs manage funding from 4 primary sources: State-only (single-stream) funding, State and federal Medicaid funds, federal block grant funds, and county funds.

GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2017

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SENATE BILL 350

Judiciary Committee Substitute Adopted 4/13/17 Health Care Committee Substitute Adopted 4/20/17 SED HOUSE COMMITTEE SUBSTITUTE 5350 CST

PROPOSED HOUSE COMMITTEE SUBSTITUTE S350-CSTR-7 [v.1] 06/20/2017 5:43:58 PM

Short Title: LME/MCO Claims Reporting/Mental Health Amdts.

(Public)

D

Sponsors:

Referred to:

March 23, 2017

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A BILL TO BE ENTITLED

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AN ACT MODIFYING CERTAIN REQUIREMENTS PERTAINING TO LOCAL MANAGEMENT ENTITIES/MANAGED CARE ORGANIZATIONS.

The General Assembly of North Carolina enacts:

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SECTION 1.(a) The Department of Health and Human Services (DHHS) shall specify a single, nationally recognized, standardized electronic format to be used by all local management entities/managed care organizations (LME/MCOs) when submitting encounter data to DHHS. LME/MCOs must submit to DHHS encounter data, consisting of records of claims payments made to providers, for Medicaid and State-funded mental health, intellectual and developmental disabilities, and substance abuse disorder services utilizing the single, nationally recognized, standardized electronic format specified by DHHS.

SECTION 1.(b) DHHS may use encounter data submitted by LME/MCOs for all of the following purposes:

- (1) Setting LME/MCO capitation rates.
- (2) Measuring the quality of services managed by LME/MCOs.
- (3) Assuring compliance with State and federal regulations.
- (4) Conducting oversight and audit functions.
- (5) Other purposes determined necessary by DHHS.

SECTION 1.(c) DHHS shall work with LME/MCOs to ensure that the process for submitting encounter claims through NCTracks is successful.

SECTION 1.(d) DHHS shall report to the Joint Legislative Oversight Committee on Health and Human Services regarding the status of subsection (a) of this section on or before February 1, 2018.

SECTION 2.(a) G.S. 122C-112.1(a)(39) reads as rewritten:

"(39) Develop and use a-standard eontract contracts for all local management entity/managed care organizations for operation of the 1915(b)/(c) Medicaid Waiver and management of State appropriations and federal block grant funds that requires compliance by each LME/MCO with all provisions of the contract contracts to operate the 1915(b)/(c) Medicaid Waiver and manage State appropriations and federal block grant funds and with all applicable provisions of State and federal law. Each of these standard contracts must include quality outcome measures for mental health, developmental disabilities, and substance use disorders."



SECTION 2.(b) This section applies to contracts entered into on or after the effective date of this act.

SECTION 3. G.S. 122C-3 reads as rewritten:

"§ 122C-3. Definitions.

The following definitions apply in this Chapter:

- (1) "Area authority" means the area mental health, developmental disabilities, and substance abuse authority.
- (2) "Area board" means the area mental health, developmental disabilities, and substance abuse board that is the governing body for the area authority, local management entity, or local management entity/managed care organization.
- "Area director" means the administrative head of the area authority program authority, local management entity, or local management entity/managed care organization appointed pursuant to G.S. 122C-121. All provisions of Chapter 122C of the General Statutes that apply to the area director also apply to the administrative head of the area authority, LME, or LME/MCO, regardless of whether (i) the administrative head uses the title "CEO" or any other name or title assigned to him or her by the area authority, LME, or LME/MCO and (ii) a contract, memorandum of understanding, or other agreement in effect between the Department and the area authority, LME, or LME/MCO refers to the administrative head as the "CEO" or any other name or title.
- (2b) "Board of county commissioners" includes the participating boards of county commissioners for multicounty area authorities and multicounty programs.authorities.
- (5) "Catchment area" means the geographic part of the State served by a specific area authority or county program.authority.
- (10a) "County program" means a mental health, developmental disabilities, and substance abuse services program established, operated, and governed by a county pursuant to G.S. 122C-115.1.
- (14) "Facility" means any person at one location whose primary purpose is to provide services for the care, treatment, habilitation, or rehabilitation of the mentally ill, the developmentally disabled, or substance abusers, and includes:
 - a. An "area facility", which is a facility that is operated by or under contract with the area authority or county program.authority. For the purposes of this subparagraph, a contract is a contract, memorandum of understanding, or other written agreement whereby the facility agrees to provide services to one or more clients of the area authority or county program.authority. Area facilities may also be licensable facilities in accordance with Article 2 of this Chapter. A State facility is not an area facility;
 - b. A "licensable facility", which is a facility that provides services to individuals who are mentally ill, developmentally disabled, or substance abusers for one or more minors or for two or more adults. These services shall be day services offered to the same individual for a period of three hours or more during a 24-hour period, or residential services provided for 24 consecutive hours or more.

- Facilities for individuals who are substance abusers include chemical dependency facilities;
- A "private facility", which is a facility that is either a licensable facility or a special unit of a general hospital or a part of either in which the specific service provided is not covered under the terms of a contract with an area authority;
- d. The psychiatric service of the University of North Carolina Hospitals at Chapel Hill;
- e. A "residential facility", which is a 24-hour facility that is not a hospital, including a group home;
- f. A "State facility", which is a facility that is operated by the Secretary;
- g. A "24-hour facility", which is a facility that provides a structured living environment and services for a period of 24 consecutive hours or more and includes hospitals that are facilities under this Chapter; and
- h. A Veterans Administration facility or part thereof that provides services for the care, treatment, habilitation, or rehabilitation of the mentally ill, the developmentally disabled, or substance abusers.
- (20b) "Local management entity" or "LME" means an area authority, county program, or consolidated human services agency. It is a collective term that refers to functional responsibilities rather than governance structure.authority.
- (29a) "Program director" means the director of a county program established pursuant to G.S. 122C 115.1.

SECTION 4.(a) G.S. 122C-115.4(b) reads as rewritten:

- "(b) The primary functions of an LME are designated in this subsection and shall not be conducted by any other entity unless an LME <u>obtains the prior written approval of the Secretary to voluntarily enters enter into a contract with that entity under subsection (c) of this section. The primary functions include all of the following:</u>
 - (1) Access for all citizens to the core services and administrative functions described in G.S. 122C-2. In particular, this shall include the implementation of a 24-hour a day, seven-day a week screening, triage, and referral process and a uniform portal of entry into care.
 - (2) Provider monitoring, technical assistance, capacity development, and quality control. If at anytime the LME has reasonable cause to believe a violation of licensure rules has occurred, the LME shall make a referral to the Division of Health Service Regulation. If at anytime the LME has reasonable cause to believe the abuse, neglect, or exploitation of a client has occurred, the LME shall make a referral to the local Department of Social Services, Child Protective Services Program, or Adult Protective Services Program.
 - (3) Utilization management, utilization review, and determination of the appropriate level and intensity of services. An LME may participate in the development of person centered plans for any consumer and shall monitor the implementation of person centered plans. An LME shall review and approve person centered plans for consumers who receive State-funded services and shall conduct concurrent reviews of person centered plans for consumers in the LME's catchment area who receive Medicaid funded services.

- (8) Each LME shall develop a waiting list of persons with intellectual or developmental disabilities that are waiting for specific services. The LME shall develop the list in accordance with rules adopted by the Secretary to ensure that waiting list data are collected consistently across LMEs. Each LME shall report this data annually to the Department. The data collected should include numbers of persons who are:
 - a. Waiting for residential services.

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- b. Potentially eligible for CAP-MRDD.
- c. In need of other services and supports funded from State appropriations to or allocations from the Division of Mental Health,

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Developmental Disabilities, and Substance Abuse Services, including CAP-MRDD.

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Subject to all applicable State and federal laws and rules established by the Secretary and the Commission, nothing in this subsection shall be construed to preempt or supersede the regulatory or licensing authority of other State or local departments or divisions."

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effective date of this act.

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SECTION 5. G.S. 122C-116 reads as rewritten:

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"§ 122C-116. Status of area authority; status of consolidated human services agency, authority.

An area authority is a local political subdivision of the State State established by

SECTION 4.(b) This section applies to contracts entered into on or after the

An area authority is a local political subdivision of the State-State established by (a) counties pursuant to G.S. 122C-115(a) and (c) for the management and delivery of services for individuals with mental illness, intellectual or other developmental disabilities, and substance use disorders under a 1915(b)/(c) Medicaid Waiver. An area authority is a local management entity that must perform the local management entity functions described in G.S. 122C-115.4 and monitor and manage all public resources that may be available for mental health, intellectual and developmental disabilities, and substance use disorder services, including federal block grants, federal funding for Medicaid and NC Health Choice, and all other public funding sources as described in Section 1(a) of S.L. 2011-264 and in compliance with G.S. 122C-111 and G.S. 122C-112.1(a)(39). LMEs are the single entities authorized to operate and manage the 1915(b)/(c) Medicaid Waiver, which operation and management must be performed in accordance with a standard contract developed by the Secretary under the authority of G.S. 122C-112.1(a)(39) that is subject to the enforcement provisions of G.S. 122C-124.1, G.S. 122C-124.2, and all other applicable provisions of this Chapter. LMEs are the sole entities authorized to enter into the contract described in G.S. 122C-124.2(g)(2) and G.S. 122C-112.1(a)(39) for the operation of the 1915(b)/(c) Medicaid Waiver. A local management entity that is under contract with the Department to operate the combined Medicaid Waiver program authorized under section 1915(b) and section 1915(c) of the Social Security Act shall be known as a "local management entity/managed care organization" or "LME/MCO."

(b) A consolidated human services agency is a department of the county."

SECTION 6.(a) G.S. 122C-117 reads as rewritten:

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"§ 122C-117. Powers and duties of the area authority.

(a) The area authority shall do all of the following:

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(7) Appoint an area director in accordance with G.S. 122C-121(d).G.S. 122C-121.

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(18) Maintain disability-specific infrastructure and competency to address the clinical, treatment, rehabilitative, habilitative, and support needs of all disabilities covered by the 1915(b)/(c) Medicaid Waiver.

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(19) Maintain administrative and clinical functions, including requirements for customer service, quality management, due process, provider network development, information systems, financial reporting, and staffing.

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(20) Maintain full accountability for all aspects of Medicaid Waiver operations and for meeting all contract requirements specified by the Department.

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(a2) An area authority may, but shall not be required to, subcontract to other entities, upon the prior written approval of the Secretary, only the following managed care functions:

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(1) <u>Information systems.</u>

(2) Customer service (including call center) operations.

- (3) Claims processing.
 - (4) Provider, enrollment, credentialing, and monitoring.
 - (5) Professional services.
 - (6) Treatment Plan development.
 - (7) Referral to services.

An area authority shall not subcontract to other entities any other managed care functions or nonservice activities.

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SECTION 6.(b) G.S. 122C-117(a2), as enacted by subsection (a) of this section, applies to area authority subcontracts to other entities entered into on or after the date this act becomes law.

SECTION 7.(a) G.S. 122C-118.1 reads as rewritten:

"§ 122C-118.1. Structure of area board.

- (a) An area board shall have no fewer than 11 and no more than 21 voting members. The
- <u>subsection (a2) of this section, the</u> board of county commissioners, or the boards of county commissioners within the area, shall appoint members in a manner that ensures participation from each of the constituent counties of the area authority and is consistent with the requirements provided in subsection (b) of this section. The process for appointing members shall ensure participation from each of the constituent counties of a multicounty area authority. If the board or boards fail to comply with the requirements of subsection (b) of this section, the Secretary shall appoint the unrepresented category. If the board or boards fail to comply with the requirements of subsection (b) of this section, the Secretary shall appoint members of the unrepresented categories.
- The boards of county commissioners within a multicounty area with a catchment (a2)population of at least 1,250,000 shall have the option to appoint members of the area board in a manner or with a composition through a process other than as required by subsection (a1) of this section by if at least three-quarters of the constituent counties each county adopting adopt a resolution to that effect and receiving obtain written approval from the Secretary. When seeking written approval from the Secretary to use an alternative board appointment process, the area authority shall submit to the Secretary its proposed board appointment process and copies of county resolutions requesting approval of the proposed board appointment process. In cases in which two or more area authorities seek to merge or consolidate, if one or more of these area authorities received approval by the Secretary for an alternative board appointment process prior to the merger or consolidation, all prior approvals for an alternative board appointment process become void 30 days after the effective date of the merger or consolidation. The newly merged or consolidated area authority and the boards of county commissioners within the multicounty area may appoint members of the area board through a process other than as provided in subsection (a1) of this section if at least three-quarters of the constituent counties each adopt a resolution to that effect and obtain written approval from the Secretary in the manner prescribed by this subsection. No area board shall be exempt from, and the Secretary shall not waive, any provision of this section except as provided in subsection (a1) of this section with respect to the board appointment process.
- (a3) A member of the board may be removed with or without cause by the initial appointing authority. The area board may declare vacant the office of an appointed member who does not attend three consecutive scheduled meetings without justifiable excuse. The chair of the area board shall notify the appropriate appointing authority of any vacancy. Vacancies on the board shall be filled by the initial appointing authority before the end of the term of the vacated seat or within 90 days of after the vacancy, whichever occurs first, and the appointments shall be for the remainder of the unexpired term.

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- (b) Within the maximum membership provided in subsection (a) of this section, the membership of the area board shall reside within the catchment area and be composed as follows:
 - (1) At least one member who is a current county commissioner.
 - (2) The chair of the local Consumer and Family Advisory Committee (CFAC) or the chair's designee.
 - (3) At least one family member of the local CFAC, as recommended by the local CFAC, representing the interests of the following:
 - a. Individuals with mental illness.
 - b. Individuals in recovery from addiction.
 - c. Individuals with intellectual or other developmental disabilities.
 - (4) At least one openly declared consumer member of the local CFAC, as recommended by the local CFAC, representing the interests of the following:
 - a. Individuals with mental illness.
 - b. Individuals with intellectual or other developmental disabilities.
 - c. Individuals in recovery from addiction.
 - (5) An individual with health care expertise and experience in the fields of mental health, intellectual or other developmental disabilities, or substance abuse services.
 - (6) An individual with health care administration expertise consistent with the scale and nature of the managed care organization.
 - (7) An individual with financial expertise consistent with the scale and nature of the managed care organization.
 - (8) An individual with insurance expertise consistent with the scale and nature of the managed care organization. health insurance, health plan administration, or business expertise, or any combination of expertise in these areas.
 - (9) An individual with social services expertise and experience in the fields of mental health, intellectual or other developmental disabilities, or substance abuse services.
 - (10) An attorney with health care expertise.
 - (11) A member who represents the general public and who is not employed by or affiliated with the Department of Health and Human Services, as appointed by the Secretary.
 - (12) The President of the LME/MCO Provider Council or the President's designee to serve as a nonvoting member who shall participate only in Board activities that are open to the public.
 - (13) An administrator of a hospital providing mental health, developmental disabilities, and substance abuse emergency services to serve as a nonvoting member who shall participate only in Board activities that are open to the public.

Except as provided in subdivisions (12) and (13) of this subsection, an individual that contracts with a local management entity (LME) for the delivery of mental health, developmental disabilities, and substance abuse services may not serve on the board of the LME for the period during which the contract for services is in effect. No person registered as a lobbyist under Chapter 120C of the General Statutes shall be appointed to or serve on an area authority-board. Of the members described in subdivisions (2) through (4) of this subsection, the boards of county commissioners shall ensure there is at least one member representing the interest of each of the following: (i) individuals with mental illness, (ii) individuals with intellectual or other developmental disabilities, and (iii) individuals in recovery from addiction.

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2	(d1) Beginning on July 1, 2017, each LME/MCO annually shall notify the Secretary of						
3	all of the following						
4	<u>(1)</u>	The area board appointment process, the process for filling vacancies on the					
5	area board, and the appointing authority for each area board position.						
6	(2)	The membership of the area board.					
7	(3)	The county of residence of each member.					
8	<u>(4)</u>	How the membership composition requirements of subsection (b) of this					
9	(5)	section are being met.					
10	<u>(5)</u>	The term of office of the chair of the area board and each member.					
11 12	<u>(6)</u>	The LME/MCO's compliance status with training requirements for its board					
13	(7)	members. The board's policies and procedures for conducting the area director's annual					
14	<u>(7)</u>	performance review, including at least all of the following:					
15							
16							
17		b. The criteria used to award bonuses to the area director and other employees.					
18							
19		 <u>c.</u> The process for soliciting comments from county commissioners. d. The results of the area director's most recent performance evaluation. 					
20	"	d. The results of the area director's most recent performance evaluation.					
21		TION 7.(b) Any area board that does not meet the composition requirements					
22		8.1(b) on the effective date of this act shall comply with these composition					
23		later than October 1, 2017.					
24		TION 8.(a) Part 4 of Article 4 of Chapter 122C of the General Statutes is					
25		ing a new section to read:					
26		LME/MCO use of funds.					
27		shall use funds only for purposes related to their functions and responsibilities					
28		ter, including operation of the combined Medicaid Waiver program authorized					
29	under section 19	915(b) and 1915(c) of the Social Security Act, or to carry out functions and					
30		required by State law, federal law, or contract with the Department of Health					
31		vices. A violation of this section constitutes noncompliance for purposes of					
32	G.S. 122C-124.2						
33		TION 8.(b) G.S. 122C-124.2(c) reads as rewritten:					
34		e Secretary (i) does not provide a local management entity/managed care					
35		th the certification of compliance required by this section based upon the					
36		ilure to comply with any of the requirements specified in subdivisions (1)					
37		ubsection (b) of this section, section or (ii) determines that an LME/MCO has					
38		with G.S. 122C-147.3, the Secretary shall do the following:					
39	(1)	Prepare a written notice informing the LME/MCO of the provisions of					
40		subdivision (1), (2), or (3) of subsection (c) of this section or the provisions					
41		of G.S. 122C-147.3 with which the LME/MCO is deemed not to be in					
42	(2)	compliance and the reasons for the determination of noncompliance.					
43 44	(2)	Cause the notice of the noncompliance to be delivered to the LME/MCO.					
44	(3)	Not later than 10 days after the Secretary's notice of noncompliance is provided to the LME/MCO, assign the Contract of the noncompliant					
46		LME/MCO to a compliant LME/MCO.					
46	(4)	Oversee the transfer of the operations and contracts from the noncompliant					
48	(4)	LME/MCO to the compliant LME/MCO in accordance with the provisions					
49		in subsection (e) of this section."					
49	OFO	In subsection (e) of this section.					

SECTION 9.(a) G.S. 122C-121 reads as rewritten:

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"§ 122C-121. Area director.

- (a) The area director is an-a full-time employee of the area board, shall serve full time at the pleasure of the area board, and shall be appointed by the area board in accordance with G.S. 122C-117(7). The area director shall not be employed in any other capacity or enter into any other contract for the performance of services while serving as area director. As used in this subsection, "employee" means an individual and does not include a corporation, a partnership, a limited liability corporation, or any other business association.
- (a1) The area board shall establish the area director's salary under Article 3 of Chapter 126 of the General Statutes. Notwithstanding G.S. 126-9(b), an area director may be paid a salary that is in excess of the salary ranges established by the State Human Resources Commission. Any salary that is higher than the maximum of the applicable salary range shall be Commission so long as all of the following requirements are met:
 - The area board must submit to the Director of the Office of State Human Resources and the Secretary a request to exceed the maximum of the applicable salary range. The request must be supported by documentation of comparable salaries in comparable operations within the a comparable region of North Carolina and shall also include the specific amount the board proposes to pay the director. For the purpose of this subdivision, the Secretary shall determine what constitutes comparable operations within a comparable region of North Carolina.
 - The area board must obtain prior written approval for the proposed salary from both the Director of the Office of State Human Resources and the Secretary. In no instance shall the area board, the Director of the Office of State Human Resources, or the Secretary approve a salary for an area director that is higher than the maximum of the applicable salary range if it exceeds by more than thirty percent (30%) the average salary of the area directors of the remaining LME/MCOs, as determined by the Secretary. If the Secretary determines that an area director's salary is higher than the maximum of the applicable salary range and exceeds by more than thirty percent (30%) the average salary of the area directors of the remaining LME/MCOs, that area director's salary shall be reduced to achieve compliance with this subdivision within 60 days after such determination by the Secretary.

The requirements of subdivisions (1) and (2) of this subsection may not be waived by the area board, the Director of the Office of State Human Resources, or the Secretary regardless of whether the State Human Resources Commission has made a determination under G.S. 126-11 that all or a portion of the board's personnel system has been determined to be substantially equivalent to, and therefore exempt from, the provisions of Chapter 126 of the General Statutes.

- (a2) The area board shall not authorize any salary adjustment for an area director that is results in a salary above the normal allowable salary range without obtaining prior approval from the Director of the Office of State Human Resources range, or pay any salary above the normal allowable salary range, unless all of the following requirements are met:
 - (1) The area board must submit to the Director of the Office of State Human Resources and the Secretary a request to exceed the maximum of the applicable salary range. The request must be supported by documentation of comparable salaries in comparable operations within a comparable region of North Carolina and shall also include the specific amount of the salary adjustment the board proposes to pay the area director and the resulting salary. For the purpose of this subdivision, the Secretary shall determine what constitutes comparable operations within a comparable region of North Carolina.

(2)

The area board must obtain prior written approval for the proposed salary adjustment from both the Director of the Office of State Human Resources and the Secretary. In no instance shall the area board, the Director of the Office of State Human Resources, or the Secretary approve a salary adjustment for an area director that results in a salary that is higher than the maximum of the applicable salary range if it exceeds by more than thirty percent (30%) the average salary of the area directors of the remaining LME/MCOs, as determined by the Secretary. If the Secretary determines that an area director's salary is higher than the maximum of the applicable salary range and exceeds by more than thirty percent (30%) the average salary of the area directors of the remaining LME/MCOs, that area director's salary shall be reduced to achieve compliance with this subdivision within 60 days after such determination by the Secretary.

The requirements of subdivisions (1) and (2) of this subsection may not be waived by the area board, the Director of the Office of State Human Resources, or the Secretary regardless of whether the State Human Resources Commission has made a determination under G.S. 126-11 that all or a portion of the board's personnel system has been determined to be substantially equivalent to, and therefore exempt from, the provisions of Chapter 126 of the General Statutes.

If the Secretary determines that the compensation of an area director, including (a3) salary, benefits, and bonuses, exceeds the limitations specified in this section, the area board shall prospectively reduce that area director's compensation, including salary, benefits, and bonuses, to achieve compliance with this section and notify the Secretary within 60 days after such determination by the Secretary. If an area board does not bring an area director's compensation, including salary, benefits, and bonuses, into compliance with this section within the 60-day period, the Secretary shall notify, in writing, the area board and the applicable participating boards of county commissioners of the area authority specifically how the Secretary determined that the area director's compensation, including salary, benefits, and bonuses, does not comply with this section, and that the area board must bring the area director's compensation, including salary, benefits, and bonuses, into compliance with this section or a caretaker board of directors will be appointed as provided in G.S. 122C-124.1(c). The area board shall have 60 days from the date it receives notice under this subsection to bring the area director's compensation, including salary, benefits, and bonuses, into compliance with this section.

If, at the end of the 60-day notice period, the area board has not brought the area director's compensation, including salary, benefits, and bonuses, into compliance with this section, the Secretary shall appoint a caretaker board of directors as provided in G.S. 122C-124.1(c). The Secretary may assign any or all of the powers and duties of the area director or of the area board to the caretaker board as the Secretary deems necessary and appropriate. In addition to performing all of these powers and duties, the caretaker board shall bring the area director's compensation, including salary, benefits, and bonuses, into compliance with this section. The Secretary may terminate the area director's employment when it appoints a caretaker board. Neither party to any applicable employment contract shall be entitled to damages. After a caretaker board has been appointed, the General Assembly shall consider, at its next regular session, the future governance of the identified area authority.

(a2)(a4) The area board shall not provide the <u>area</u> director with any benefits <u>or bonuses</u> that are not also provided by the area board to all permanent employees of the area program, except that the area board may, in its discretion, offer severance benefits, relocation expenses, or both, to an applicant for the position of <u>area</u> director as an incentive for the applicant to accept an offer of employment. The <u>area</u> director shall be reimbursed only for allowable

Page 10 Senate Bill 350 S350-CSTR-7 [v.1]

employment-related expenses at the same rate and in the same manner as other employees of the area program.

- (a5) The total compensation provided or recommended to be provided by each area board to its area director, including salary, benefits, and bonuses, shall be reviewed for written approval by the Director of the Office of State Human Resources and the Secretary on at least an annual basis to determine compliance with the requirements of this section. An area board shall not increase compensation to an area director without prior written approval for the increase from the Director of the Office of State Human Resources and the Secretary.
- (a6) Annually on June 30, each area board shall submit to the Secretary and the Director of the Office of State Human Resources a copy of all current employment agreements, employment contracts, and any amendments to those agreements and contracts that the area board has entered into with its area director, as well as any other documents relating to the area director's compensation, including salary, benefits, and bonuses.
- (b) The <u>Secretary and the</u> area board shall evaluate annually the area director for performance based on criteria established by the Secretary and the area board. In conducting the evaluation, the <u>Secretary and the</u> area board shall consider comments from the board of county commissioners.
- (c) The area director is the administrative head of the area program. In addition to the duties under G.S. 122C-111, the area director shall:
 - (1) Appoint, supervise, and terminate area program staff.
 - (2) Administer area authority services.
 - (3) Develop the budget of the area authority for review by the area board.
 - (4) Provide information and advice to the board of county commissioners through the county manager.
 - (5) Act as liaison between the area authority and the Department.
 - (6) Ensure compliance by the area authority with the powers and duties of the area authority established under G.S. 122C-117.
- (d) Except when specifically waived by the Secretary, the area director shall meet all the following minimum qualifications:
 - (1) Masters degree.
 - (2) Related experience.
 - (3) Management experience.
 - (4) Any other qualifications required under G.S. 122C-120.1.
- (e) The appointment of the area director shall be based upon the recommendation of at least two candidates by a search committee of the area board. The search committee shall include a consumer board member, a county commissioner, and an appointee of the Secretary. The Secretary may waive this requirement when appointment of the area director results from the merger or consolidation of LME/MCOs.
- (f) The area board may not terminate the employment of an area director without 30 days' prior written notice to the Secretary, unless the termination (i) results from the merger or consolidation of LME/MCOs or (ii) is directed by the Secretary."
- SECTION 9.(b) The limitations on compensation, including salary, benefits, and bonuses specified in G.S. 122C-121, as amended by subsection (a) of this section, apply to currently employed area directors hired prior to the effective date of this act as well as to area directors hired on or after the effective date of this act. If the Secretary of the Department of Health and Human Services determines that the compensation, including salary, benefits, and bonuses, of a currently employed area director hired prior to the effective date of this act exceeds the limitations specified in G.S. 122C-121, as amended by subsection (a) of this section, the area board shall prospectively reduce that area director's compensation, including salary, benefits, and bonuses, to achieve compliance with G.S. 122C-121, as amended by subsection (a) of this section, within 60 days after such determination by the Secretary. If an

area board does not comply with the directive of this subsection to reduce an area director's compensation, including salary, benefits, and bonuses, to achieve compliance with G.S. 122C-121, as amended by subsection (a) of this section, within the 60-day period prescribed by this subsection, the Secretary shall appoint a caretaker board of directors, as prescribed in G.S. 122C-121(a3), as amended by subsection (a) of this section.

SECTION 9.(c) Each LME/MCO shall, within 30 day after the effective date of this act, submit to the Secretary and the Director of the Office of State Human Resources a copy of all current employment agreements, employment contracts, and any amendments to those agreements and contracts that the LME/MCO has entered into with its area director, as well as any other documents relating to the area director's compensation, including salary, benefits, and bonuses.

SECTION 10. G.S. 122C-154 reads as rewritten: "\$ 122C-154. Personnel.

(a) Employees under the direct supervision of the area director are employees of the area authority. For the purpose of personnel administration, Chapter 126 of the General Statutes applies unless otherwise provided in this Article. Employees appointed by the county program director are employees of the county. In a multicounty program, employment of county program staff shall be as agreed upon in the interlocal agreement adopted pursuant to G.S. 122C-115.1.

(b) Notwithstanding G.S. 126-9(b), an employee of an area authority may be paid a salary that is in excess of the salary ranges established by the State Human Resources Commission. Any salary that is higher than the maximum of the applicable salary range shall Commission so long as all of the following requirements are met:

The area board must submit to the Director of the Office of State Human Resources and the Secretary a request to exceed the maximum of the applicable salary range. The request must be supported by documentation of comparable salaries in comparable operations within the a comparable region of North Carolina and shall also include the specific amount the board proposes to pay the employee. For the purpose of this subdivision, the Secretary shall determine what constitutes comparable operations within a comparable region of North Carolina.

(2) The area board must obtain prior written approval for the proposed salary from both the Director of the Office of State Human Resources and the Secretary.

 The requirements of subdivisions (1) and (2) of this subsection may not be waived by the area board, the Director of the Office of State Human Resources, or the Secretary regardless of whether the State Human Resources Commission has made a determination under G.S. 126-11 that all or a portion of the board's personnel system has been determined to be substantially equivalent to, and therefore exempt from, the provisions of Chapter 126 of the General Statutes.

(c) The area board shall not authorize any salary adjustment that is-results in a salary above the normal allowable salary range without obtaining prior approval the Director of the Office of State Human Resources.unless all of the following requirements are met:

(1) The area board must submit to the Director of the Office of State Human Resources and the Secretary a request to exceed the maximum of the applicable salary range. The request must be supported by documentation of comparable salaries in comparable operations within a comparable region of North Carolina and shall also include the specific amount of the salary adjustment the board proposes to pay the employee and the resulting salary. For the purpose of this subdivision, the Secretary shall determine what

 1 2 3

constitutes comparable operations within a comparable region of North Carolina.

(2) The area board must obtain prior written approval for the proposed salary adjustment from both the Director of the Office of State Human Resources and the Secretary.

The requirements of subdivisions (1) and (2) of this subsection may not be waived by the area board, the Director of the Office of State Human Resources, or the Secretary regardless of whether the State Human Resources Commission has made a determination under G.S. 126-11 that all or a portion of the board's personnel system has been determined to be substantially equivalent to, and therefore exempt from, the provisions of Chapter 126 of the General Statutes."

SECTION 11. G.S. 126-11 reads as rewritten:

"§ 126-11. Local personnel system may be established; approval and monitoring; rules and regulations.

- (a) The board of county commissioners of any county may establish and maintain a personnel system for all employees of the county subject to its jurisdiction, which system and any substantial changes to the system, shall be approved by the State Human Resources Commission as substantially equivalent to the standards established under this Chapter for employees of local departments of social services, local health departments, and area mental health programs, and local emergency management programs. If approved by the State Human Resources Commission, the employees covered by the county system shall be exempt from all provisions of this Chapter except Article 6.
- (a1) With approval of each of the boards of commissioners of the county or counties which comprise the area mental health authority, the area mental health authority may establish and maintain a personnel system for all employees of the area mental health authority, which system and any substantial changes to the system, shall be equivalent to the standards established under this Chapter for employees of area mental health authorities. If approved by the State Human Resources Commission, the employees covered by the area mental health authority system shall be exempt from all provisions of this Chapter except Article 6.
- (b) A board of county commissioners may petition the State Human Resources Commission to determine whether any portion of its total personnel system meets the requirements in (a) above. of subsection (a) of this section. Upon such determination, county employees shall be exempt from the provisions of this Chapter relating to the approved portions of the county personnel system.
- (b1) The board of an area mental health authority, with the approval of each of the boards of commissioners of the county or counties which comprise the area mental health authority, may petition the State Human Resources Commission to determine whether any portion of its total personnel system meets the requirements in subsection (a1) above. of subsection (a1) of this section. Upon such determination, area mental health authority employees shall be exempt from the provisions of this Chapter relating to the approved portions of the area mental health authority personnel system except as provided in G.S. 122C-121.
- (b2) Upon the merger or consolidation of two or more local management entities/managed care organizations, any determination made prior to the effective date of that merger or consolidation that all or a portion of any applicable area mental health authority personnel system is substantially equivalent is void. The board of the newly merged or consolidated area mental health authority, with the approval of the boards of commissioners of three-quarters of the counties which comprise the newly merged or consolidated area mental health authority, may petition the State Human Resources Commission to determine whether any portion of its total personnel system meets the requirements of subsection (a1) of this section. Upon such determination, area mental health authority employees shall be exempt from

the provisions of this Chapter relating to the approved portions of the area mental health authority personnel system except as provided in G.S. 122C-121 and G.S. 122C-154.

- (c) The Office of State Human Resources shall monitor at least annually county or area mental health authority personnel systems approved under this section in order to ensure compliance.
- (d) In order to define "substantially equivalent," the State Human Resources Commission is authorized to promulgate rules and regulations to implement the federal merit system standards and these regulations at a minimum shall include: recruitment and selection of employees; position classification; pay administration; training; employee relations; equal employment opportunity; and records and reports."

SECTION 12. Section 12F.2(a) of S.L. 2015-241 reads as rewritten:

"SECTION 12F.2.(a) For the purpose of mitigating cash flow problems that many LME/MCOs experience at the beginning of each fiscal year relative to single stream funding, the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS), shall distribute not less than one-twelfth of each LME/MCO's continuation—base budget allocation at the beginning of the fiscal year and subtract the amount of that distribution from the LME/MCO's total reimbursements for the fiscal year. For each month of the fiscal year after July, the DMH/DD/SAS shall distribute, on the first Tuesday of the month, one-eleventh of the amount of each LME/MCO's single-stream allocation that remains after subtracting the amount of the distribution that was made to the LME/MCO in July of the fiscal year."

SECTION 13. G.S. 122C-141(d)(1) reads as rewritten:

"(1) The public provider must meet all the provider qualifications as defined by rules adopted by the Commission. A county that satisfies its duties under G.S. 122C-115(a) through a consolidated human services agency may not be considered a qualified provider for purposes of this subdivision."

SECTION 14. G.S. 122C-115.1 and Part 2A of Article 4 of Chapter 122C of the General Statutes are repealed.

SECTION 15. The Revisor of Statutes shall delete every reference to G.S. 122C-115.1, G.S. 122C-127, and the phrases "county program" and "consolidated human services agency" wherever they occur in Chapter 122C of the General Statutes.

SECTION 16. Section 12 of this act becomes effective July 1, 2017. The remainder of this act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2017

S

SENATE BILL 350

Judiciary Committee Substitute Adopted 4/13/17 Health Care Committee Substitute Adopted 4/20/17

	nend Drug Laws/Ellison v. Treadway. (Public)
Sponsors:	
Referred to:	
	March 23, 2017
NOT PUNIS THE CRIMI The General Ass	A BILL TO BE ENTITLED ARIFY THAT POSSESSION OF CERTAIN PRESCRIPTION DRUGS IS HABLE AS TRAFFICKING IN OPIUM OR HEROIN AND TO SET OUT THAT OFFENSE. Simbly of North Carolina enacts:
"(4)	Any—Except as provided in subdivision (4c) of this subsection, any person who sells, manufactures, delivers, transports, or possesses four grams or more of opium or opiate, or any salt, compound, derivative, or preparation of opium or opiate (except apomorphine, nalbuphine, analoxone and naltrexone and their respective salts), including heroin, or any mixture containing such substance, shall be guilty of a felony which felony shall be known as "trafficking in opium or heroin" and if the quantity of such controlled substance or mixture involved: a. Is four grams or more, but less than 14 grams, such person shall be punished as a Class F felon and shall be sentenced to a minimum term of 70 months and a maximum term of 93 months in the State's prison and shall be fined not less than fifty thousand dollars (\$50,000);
	b. Is 14 grams or more, but less than 28 grams, such person shall be punished as a Class E felon and shall be sentenced to a minimum term of 90 months and a maximum term of 120 months in the State's prison and shall be fined not less than one hundred thousand dollars (\$100,000);
	c. Is 28 grams or more, such person shall be punished as a Class C felon and shall be sentenced to a minimum term of 225 months and a maximum term of 282 months in the State's prison and shall be fined not less than five hundred thousand dollars (\$500,000)."
SEC	ION 2. G.S. 90-95(h) is amended by adding a new subdivision to read:
" <u>(4c)</u>	The illegal sale, delivery, transportation, or possession of pills, tablets, or capsules of a controlled substance that contains an opiate, as defined in G.S. 90-87(18), combined with a noncontrolled substance and that is a commercial drug product with FDA approval manufactured and distributed by a pharmaceutical company lawfully doing business in the United States



shall be governed by this section and by subsections (b) and (d) of this

SECTION 3. This act becomes effective December 1, 2017, and applies to

(\$200,000)."

offenses committed on or after that date.

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NORTH CAROLINA GENERAL ASSEMBLY HOUSE OF REPRESENTATIVES

HEALTH COMMITTEE REPORT

Representative Josh Dobson, Co-Chair Representative Nelson Dollar, Co-Chair Representative Bert Jones, Co-Chair Representative Donny Lambeth, Co-Chair Representative Gregory F. Murphy, MD, Co-Chair

FAVORABLE COM SUB, UNFAVORABLE ORIGINAL BILL AND RE-REFERRED

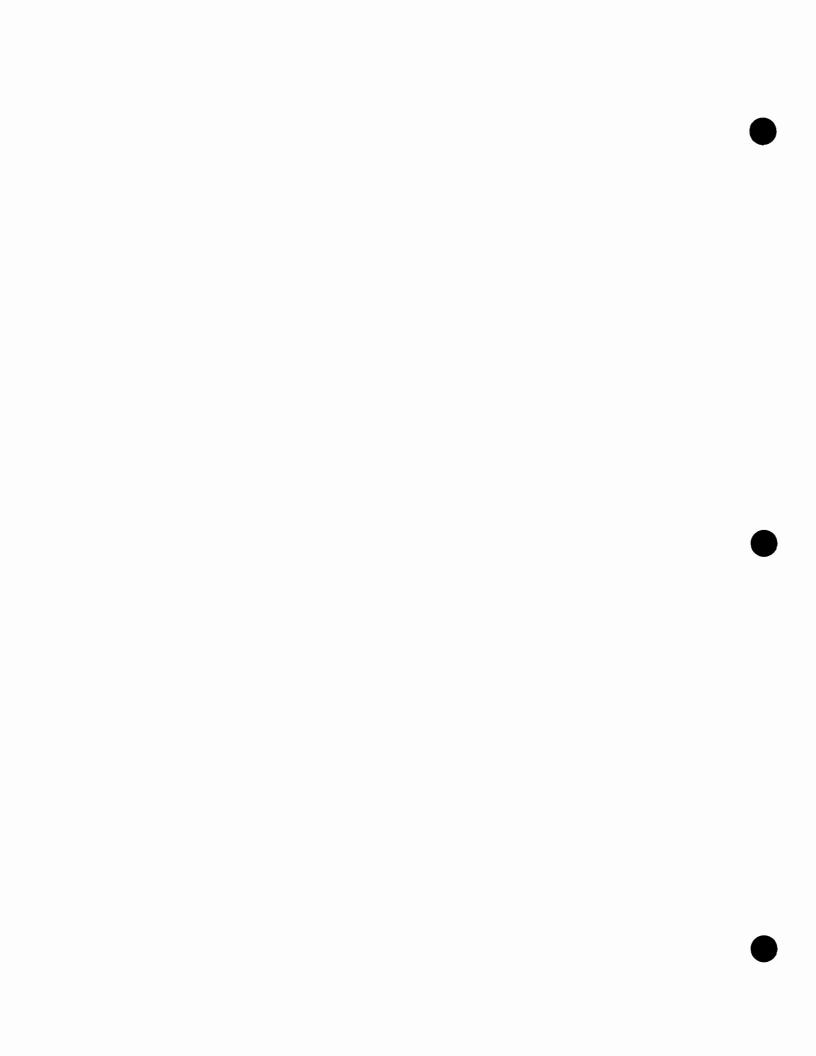
HB 192 Establish Music Therapy Practice Act.

Draft Number: H192-PCS30419-BCf-30

Serial Referral: FINANCE
Recommended Referral: None
Long Title Amended: Yes
Floor Manager: Warren

TOTAL REPORTED: 1





NORTH CAROLINA GENERAL ASSEMBLY HOUSE OF REPRESENTATIVES

HEALTH COMMITTEE REPORT

Representative Josh Dobson, Co-Chair Representative Nelson Dollar, Co-Chair Representative Bert Jones, Co-Chair Representative Donny Lambeth, Co-Chair Representative Gregory F. Murphy, MD, Co-Chair

FAVORABLE HOUSE COM SUB, UNFAVORABLE SENATE COM SUB NO. 2

SB 350 (CS#2) Amend Drug Laws/Ellison v. Treadway.

Draft Number: S350-PCS45461-TR-7

Serial Referral: None
Recommended Referral: None
Long Title Amended: Yes
Floor Manager: Dollar

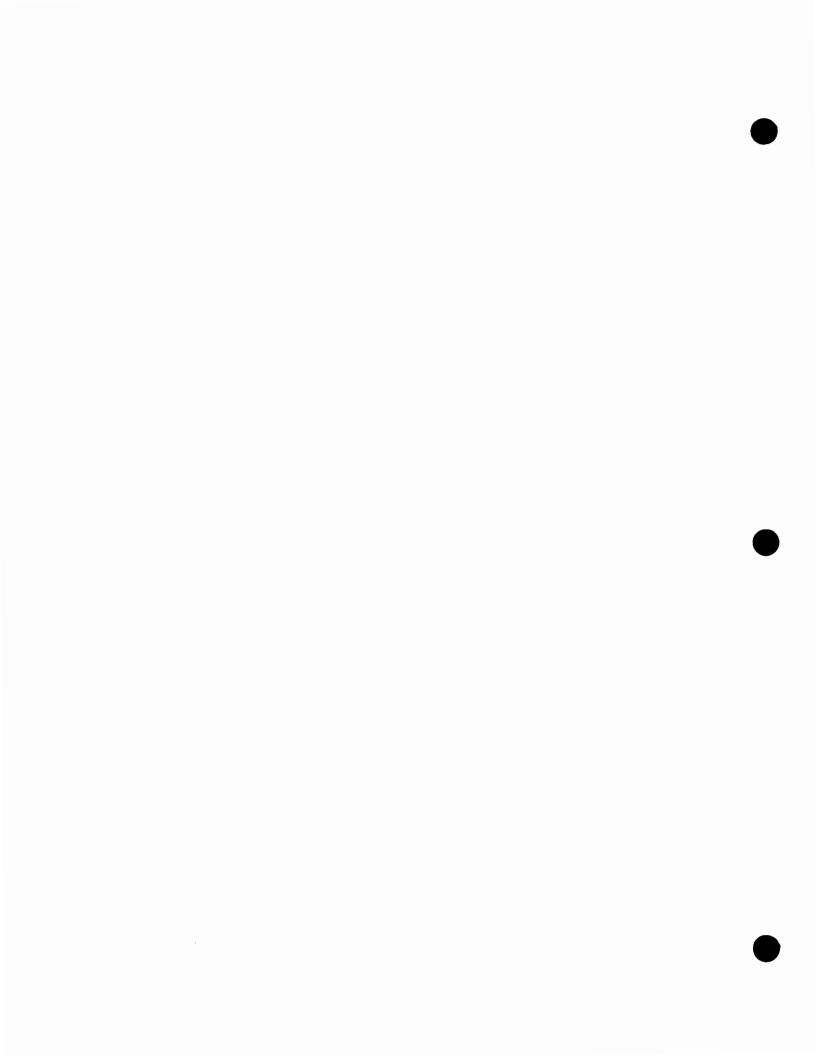
TOTAL REPORTED: 1





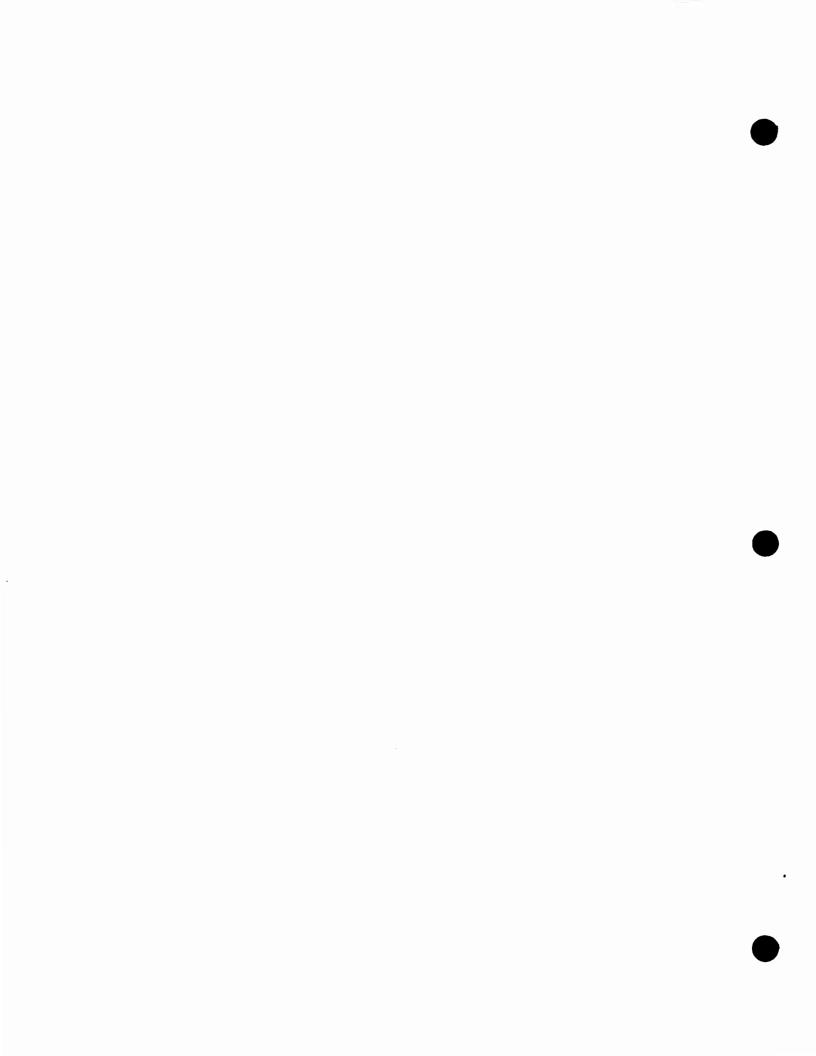
Committee Sergeants at Arms

NAME OF COMMITTEE H	louse Comr	n. on Health	1
DATE: 06/21/17	Room:	643	
,			
	House Sgt-At Ar	ms:	
1. Name: Young Bae			
2. Name: Jim Moran			
3. Name: Warren Hawl	kins	<i>t</i> -	
4. Name: Malachi McC	ullough		
5. Name:		-	٠
	Senate Sgt-At Aru	ns:	
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House Pages Assignments Wednesday, June 21, 2017

Member	Comments	Staff	Time	Room	Committee
Rep. Charles Graham		Vince Graham	10:00 AM	544	State and Local Government II
Rep. John Sauls		Fischer Pearson			
Rep. Mike Clampitt		Isaac Brooks	10:00 AM	423	State and Local Government
Rep. John Torbett		Carter Brown			
Rep. Verla Insko		Logan Martin			
Rep. Nelson Dollar		Kari Davis	11:00 AM	643	Health
Rep. Verla Insko		Evan Morris			
Rep. Rosa Gill		Alexis Oliver	11:00 AM	1228/1327	Wildlife Resources
Rep. Kelly Alexander		Rollie Tillman, IV			



VISITOR REGISTRATION SHEET

House Comm. on Health

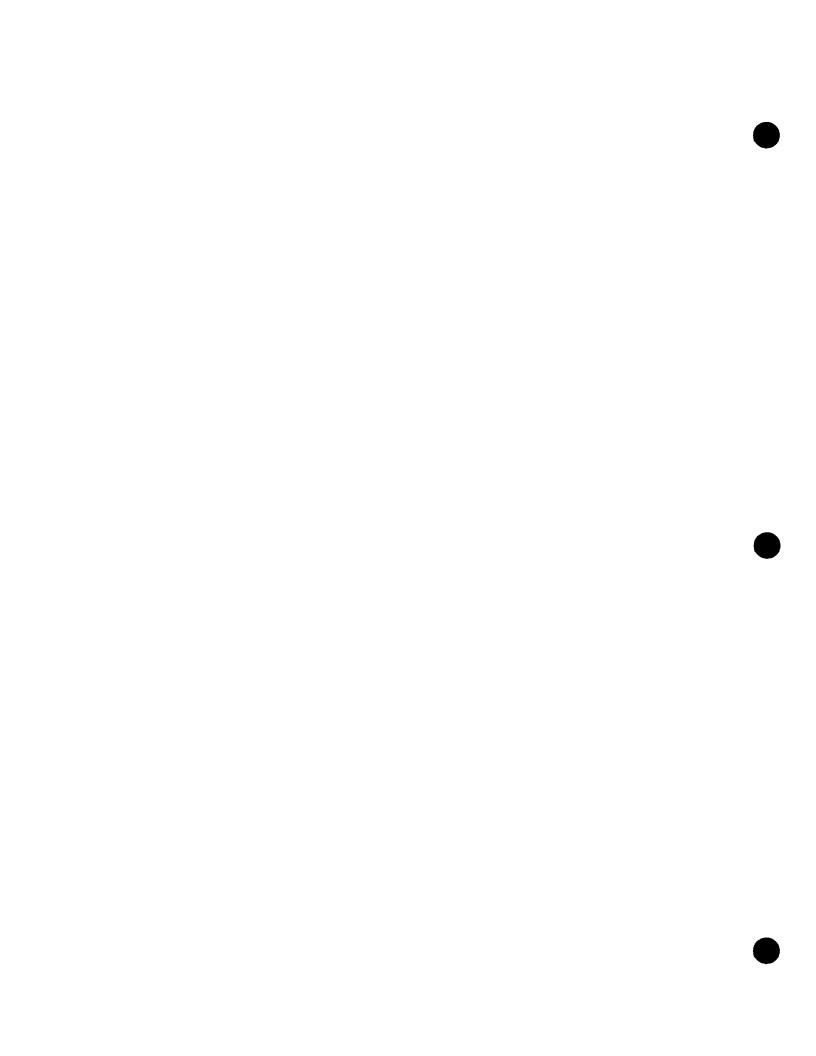
06/21/17

Name of Committee

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jorathan le Crone	Brody School of Medicine
Noopur Doch	Brody School of Medicine
Lastel Morry	(1)
Allison Williams	Brody SOM
Samantna forlenza	Bridy school of Midleine
Therens	C55
Henry Zaytous	TSS
JOC LANIBR	T35



VISITOR REGISTRATION SHEET

House Comm. on Health

06/21/17

Name of Committee

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
STA .	SA
SourcePeters	CSS
J. Du	655
Dodu Renfer	CCL
Ben Mack	Brody School of Medicine @ Ex
Meera Patel	2/ 55
Amber Gautam	Brody SOM @ ECU
	ELV
SueAm Former	MMS
Chirag Patel	Brody Som@ ECU
Jubager Ahmed	Brody sam @ Eeu

House Comm. on Health

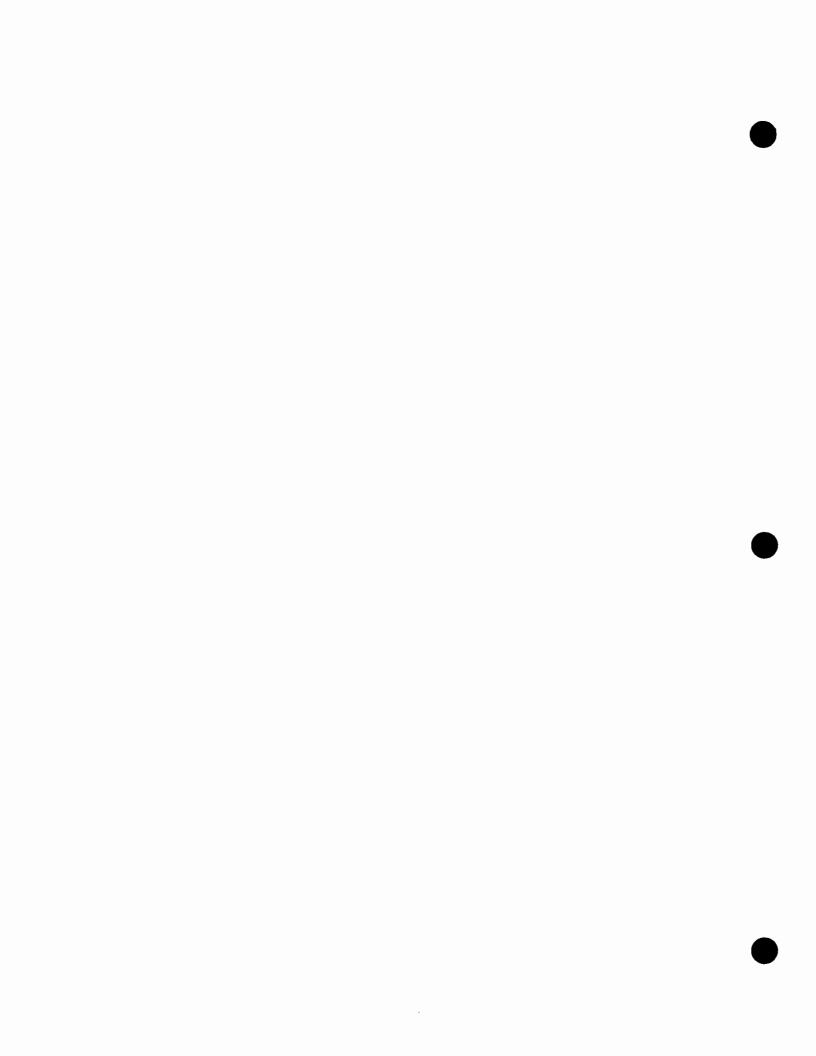
06/21/17

Name of Committee

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Chip Englis	ners
Pen my	
DEL MAYMARO	OFF & ASSQ
LTC Kroll	Novant
CPT HERON	Duce
BJ MILLER	ORLANDE HEALTH
CODY HAND	NCHA
R.H.Blackley	Con Health
Mclea Pira	NCGA.
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House Comm. on Health

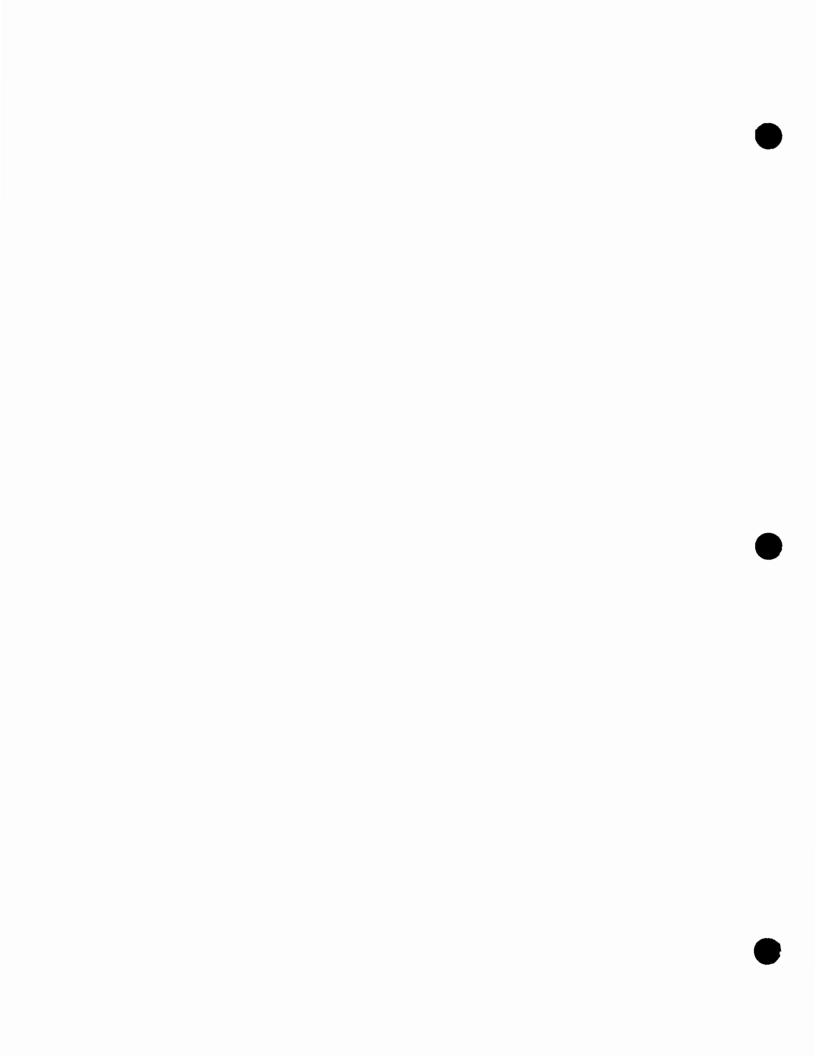
06/21/17

Name of Committee

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
John McMellan	MF+5
John Del Gioro	B+A
Deb Claring	NCSP
Sasan De Laver	NCANP
Pate all Jones	NCANP
C546/1.5	35/8
Julia Adams Scheurich	Oak City GR
Michelle Brooks	ECU
Pullel Buli	RBlai
If Barnhant	Mwc
Brian Perkins	Alliance OHC



House Comm. on Health

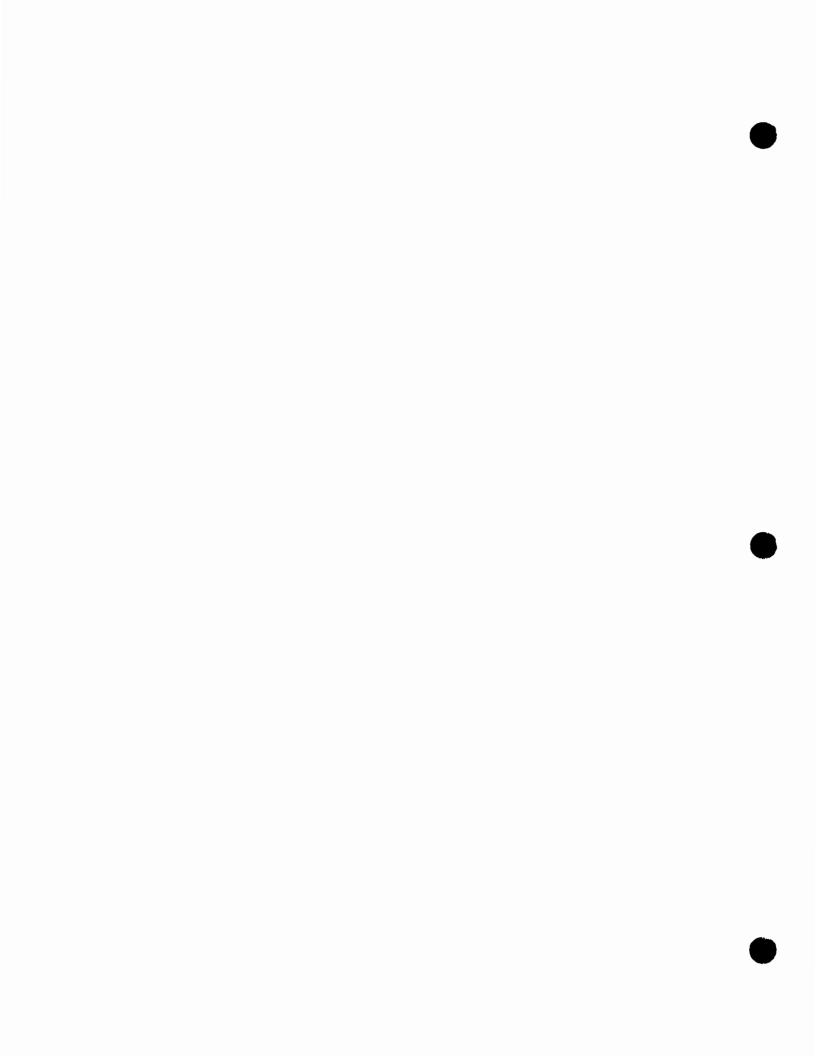
06/21/17

Name of Committee

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Caillin Little	UNC 30G
Steve Mitchell	Astellas
Smuth Dos	NCAME
Beacham WRAY	Parent
Janul Gittie	· MTANC
Tony Adams	Odans and assur.
Knasger Jackson	Trans Carolina
Sudvece Mornez	Hearth and Numan service
M. He McJosty	Biogen
Jud Bon	Bore: \$350,
Andy Chase	KMA.



	(Committee Name)
JUNE	21. 2017

<u>VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE</u> <u>CLERK</u>

NAME	FIRM OR AGENCY AND ADDRESS
Martine Bullard, MT-BC	3417 Lovena Lynn Ct. Fuguay
·	

09-21-201

HOUSE HEALTH COMMITTEE 2018 SHORT SESSION

Chairs:

Rep. Josh Dobson

Rep. Nelson Dollar

Rep. Bert Jones

Rep. Donny Lambeth

Rep. Gregory Murphy

Vice-Chairs:

Rep. William Brisson

Rep. Beverly Earle

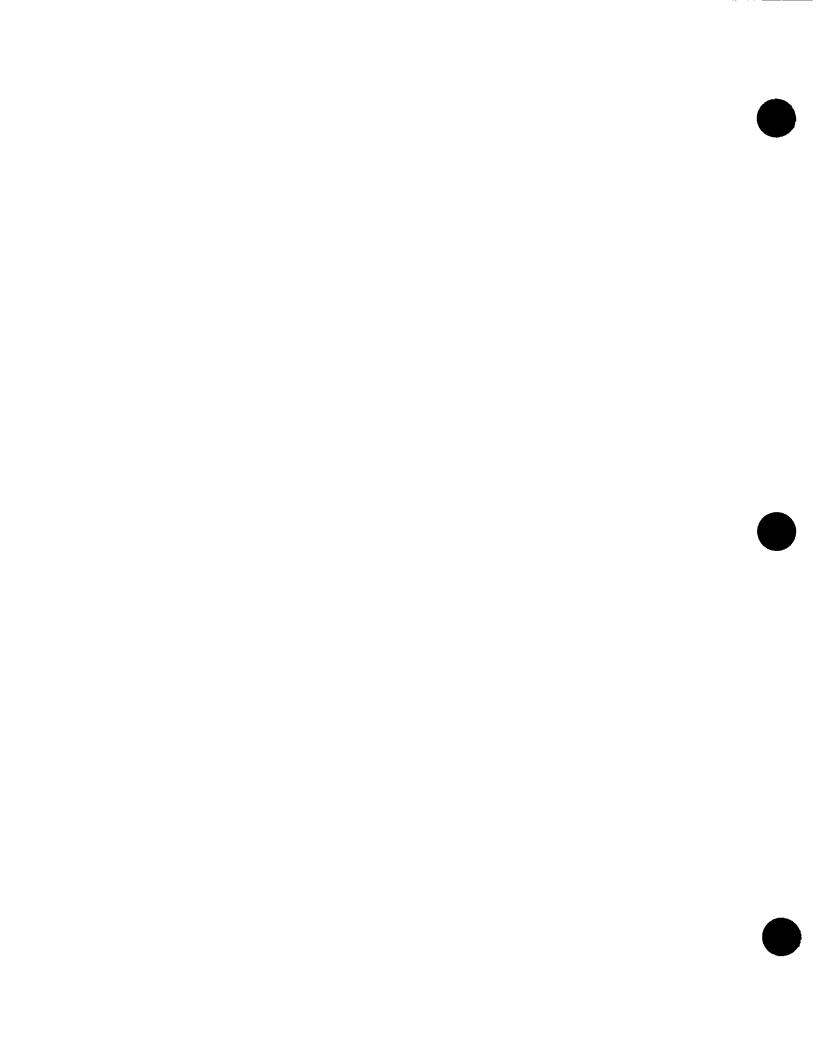
Rep. Jean Farmer-Butterfield

Committee Clerks:

Theresa Lopez

Julie Ryan

Anne Harvey Smith



HOUSE COMMITTEE ON (NAME OF COMMITTEE) 2013 SESSION

Clerks: Theresa Lopez, Julie Ryan, Anne Harvey Smith



Rep. Dobson Chairman



Rep. Dollar Chairman



Rep. Jones Chairman



Rep. Lambeth Chairman



Rep. Murphy Chairman



Rep. Brisson Vice-Chair



Rep. Earle Vice-Chair



Rep. Farmer-Butterfield Vice-Chair



Rep. Adcock



Rep. Ball



Rep. Blackwell



Rep. Boswell



Rep. Burr



Rep. Carney



Rep. Cunningham



Rep. Dulin



Rep. Ford



Rep. Howard



Rep. Hunter



Rep. Insko



Rep. Jackson



Rep. Lewis



Rep. Lucas



Rep. Malone



Rep. Potts



Rep. Rogers



Rep. Setzer



Rep. Shepard



Rep. Szoka



Rep. White



Rep. Wray



Rep. Yarborough



Rep. Zachary

HOUSE COMMITTEE ON HEALTH 2017-2018 SESSION

<u>MEMBER</u>		<u>ASSISTANT</u>	<u>PHONE</u>	<u>OFFICE</u>	<u>SEAT</u>
DOBSON, Josh	Chair	Julie Ryan	733-5862	301N	114
DOLLAR, Nelson	Chair	Candace Slate	715-0795	307B	04
JONES, Bert	Chair	Theresa Lopez	733-5779	416A	54
LAMBETH, Donny	Chair	Pan Briles	733-5747	303	65
MURPHY, Greg	Chair	Anne Harvey Smith	733-5757	632	85
BRISSON, William	Vice-Chair	Caroline Sterling	733-5772	405	23
EARLE, Beverly	Vice-Chair	Ann Raeford	715-2530	514	60
FARMER-BUTTERFIELD, Jean	Vice-Chair	Portia Bright	733-5898	1220	33
ADCOCK, Gale		Suzanne Smith	733-5602	1213	119
BALL, Cynthia		Patty Williams	733-5860	1319	118
BLACKWELL, Hugh		Dixie Riehm	733-5805	541	102
BOSWELL, Beverly		Beth Strandberg	733-5906	531	97
BURR, Justin		Dina Long	733-5908	307A	16
CARNEY, Becky		Beth LeGrande	733-5827	1221	12
CUNNINGHAM, Carla		Sherrie Burnette	733-5807	1109	59
DULIN, Andy		Wanda Benson	715-3009	609	100
FORD, Carl		Olivia Baumann	733-5881	608	64
HOWARD, Julia		Cody Huneycutt	733-5904	302	01
HUNTER, Howard		Brenda Bennett	733-5780	1307	46
INSKO, Verla		Young Bae	733-7208	502	72
JACKSON, Darren		Angela McMillan	733-5974	506	57
LEWIS, David		Grace Rogers	715-3015	2301	06
LUCAS, Marvin		Thelma Utley	733-5775	509	22

MALONE, Chris	Ben Malone	715-3010	1229	38
POTTS, Larry	Caroline Craig	715-0873	306B2	110
ROGERS, David	Baxter Knight	733-5749	418C	86
SETZER, Mitchell	Margaret Herring	733-4948	2204	02
SHEPARD, Phillip	Pamela Pate	715-9644	530	53
SZOKA, John	Beverly Slagle	733-9892	2207	30
WHITE, Donna	Susan Mullins	733-5605	306A2	111
WRAY, Michael	Susan Burleson	733-5662	503	24
YARBOROUGH, Larry	Leslie Murray	715-0850	1301	67
ZACHARY, Lee	Martha Jenkins	715-8361	1002	74

HOUSE HEALTH COMMITTEE STAFF (733-2578)

Theresa Matula (Coordinating Staff person) Jason Moran-Bates Jessica Boney

Jennifer Hillman Susan Barham

ATTENDANCE HEALTH

DATES	05/16/2018						
DOBSON, Josh - Chair	X						
DOLLAR, Nelson - Chair							
JONES, Bert - Chair	X						
LAMBETH, Donny - Chair	X						
MURPHY, Greg - Chair	X						
BRISSON, William – Vice-Chair	X						
EARLE, Beverly - Vice-Chair	X						
FARMER-BUTTERFIELD, Jean - Vice-Chair	X						
ADCOCK, Gale	X						
BALL, Cynthia	X						
BLACKWELL, Hugh	X						
BOSWELL, Beverly	X						
BURR, Justin							
CARNEY, Becky	X						
CUNNINGHAM, Carla	X						
DULIN, Andy	X						
FORD, Carl	X						
HOWARD, Julia	X						
HUNTER, Howard	X						
INSKO, Verla	X						
JACKSON, Darren							
LEWIS, David							
LUCAS, Marvin	X						
MALONE, Chris	X						

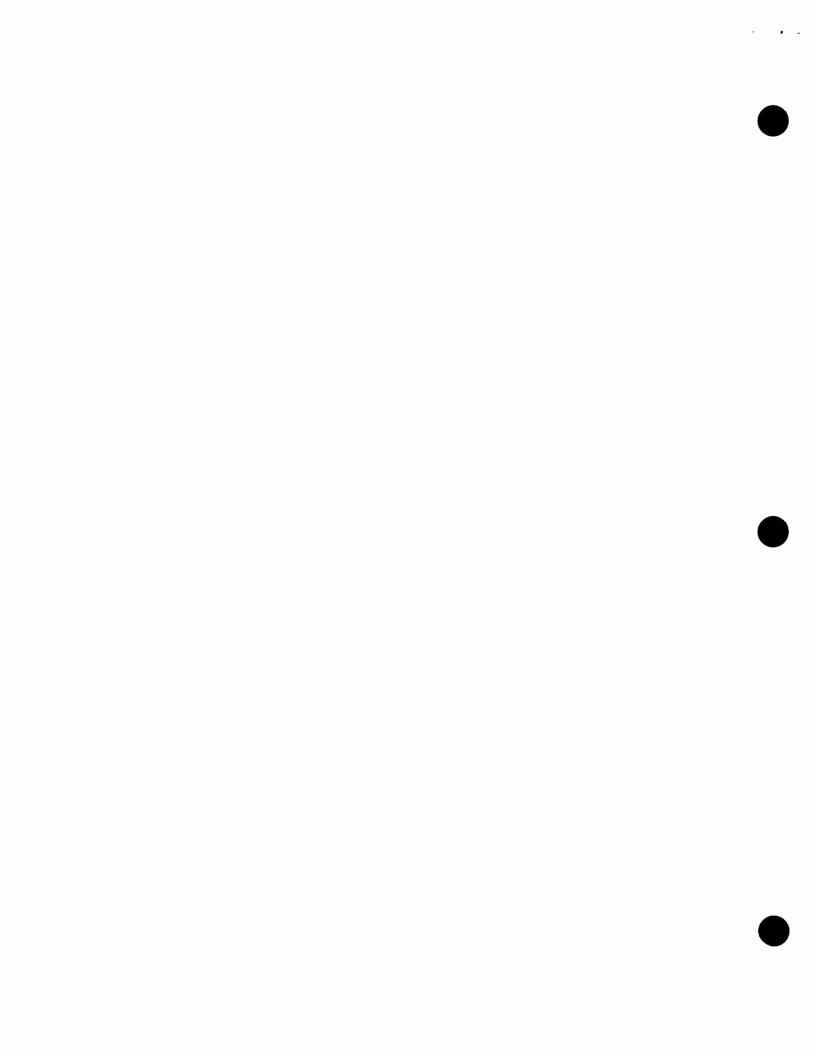
ATTENDANCE

HEALTH

DATES	05/16/2018							
POTTS, Larry	X							
ROGERS, David	X							
SETZER, Mitchell	X							
SHEPARD, Phillip	X							
SZOKA, John								
WHITE, Donna	X							
WRAY, Michael	X							
YARBOROUGH, Larry	X							
ZACHARY, Lee	X							
HOUSE CLERKS	77							
Theresa Lopez	X	-		+				
Julie Ryan Anne Harvey Smith	X							
HOUSE COMMITTEE STAFF								
Theresa Matula	X			-				
Jason Moran-Bates	X			-				
Jessica Boney	X							
Jennifer Hillman								
Susan Barham								
								-

ATTENDANCE HEALTH

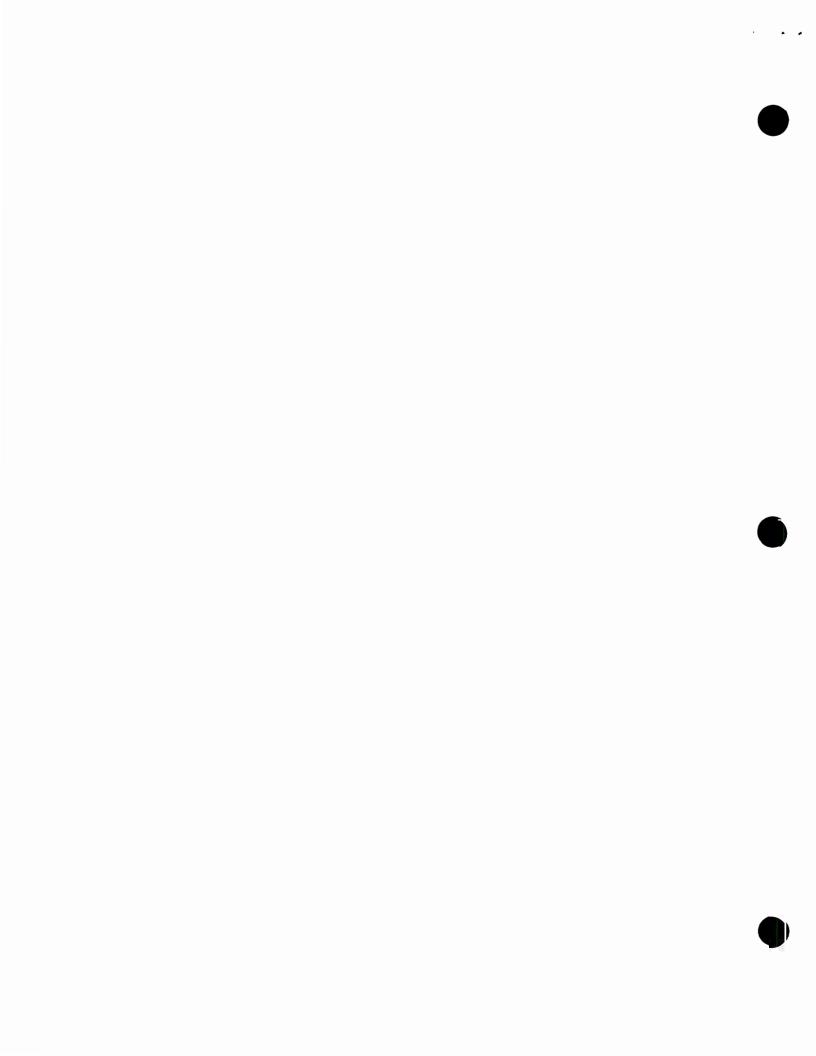
DATES	5/30/18						
DOBSON, Josh - Chair							
DOLLAR, Nelson - Chair	V						
JONES, Bert - Chair	V						
LAMBETH, Donny - Chair	1						
MURPHY, Greg - Chair	/						
BRISSON, William – Vice-Chair							
EARLE, Beverly - Vice-Chair	/						
FARMER-BUTTERFIELD, Jean - Vice-Chair	/						
ADCOCK, Gale							
BALL, Cynthia							
BLACKWELL, Hugh	V						
BOSWELL, Beverly	1						
BURR, Justin							
CARNEY, Becky	V						
CUNNINGHAM, Carla	V						
DULIN, Andy	/						
FORD, Carl	V						
HOWARD, Julia	1						
INSKO, Verla	V						
JACKSON, Darren							
LEWIS, David							
LUCAS, Marvin	V						
MALONE, Chris	V						
POTTS, Larry	/						



ATTENDANCE

HEALTH

DATES								
ROGERS, David								
SETZER, Mitchell								
SHEPARD, Phillip								
SZOKA, John	/							
WHITE, Donna	/							
WRAY, Michael	V							
YARBOROUGH, Larry	1							
ZACHARY, Lee	V							
HOUSE CLERKS								
Theresa Lopez	V							
Julie Ryan	V							
Anne Harvey Smith	/							
HOUSE COMMITTEE STAFF								
Theresa Matula	/							
Jessica Boney	V,							
Jason Moran-Bates	1							
Susan Barham	*							
Jennifer Hillman	V							



ATTENDANCE HEALTH

DATES	06/06/2018									
DOBSON, Josh - Chair	X									
DOLLAR, Nelson - Chair	X									
JONES, Bert - Chair	X									
LAMBETH, Donny - Chair	X									
MURPHY, Greg - Chair	X									
BRISSON, William – Vice-Chair	X									
EARLE, Beverly - Vice-Chair										
FARMER-BUTTERFIELD, Jean – Vice-Chair		-	_							
ADCOCK, Gale	X				ALLEN STATE OF THE					
BALL, Cynthia	X									
BLACKWELL, Hugh	X									
BOSWELL, Beverly	X									
BURR, Justin										
CARNEY, Becky	X									
CUNNINGHAM, Carla	X									
DULIN, Andy	X									
FORD, Carl										
HOWARD, Julia	X									
HUNTER, Howard	X									
INSKO, Verla	X									
JACKSON, Darren										
LEWIS, David										
LUCAS, Marvin	X									
MALONE, Chris										

ATTENDANCE

HEALTH

DATES	06/06/2018							
POTTS, Larry	X							
ROGERS, David								
SETZER, Mitchell	X							
SHEPARD, Phillip	X							
SZOKA, John	X							
WHITE, Donna	X							
WRAY, Michael								
YARBOROUGH, Larry	X							
ZACHARY, Lee	X							
HOUSE CLERKS								
Theresa Lopez	X							
Julie Ryan	X							
Anne Harvey Smith	X							
HOUSE COMMITTEE STAFF								
Theresa Matula	X	_						
Jason Moran-Bates	X							
Jessica Boney	X							
Jennifer Hillman								
Susan Barham								

ATTENDANCE HEALTH

DATES	06/13/2018							
DOBSON, Josh - Chair	X							
DOLLAR, Nelson - Chair	X							
JONES, Bert - Chair	X							
LAMBETH, Donny - Chair	X							
MURPHY, Greg - Chair	X		-					
BRISSON, William – Vice-Chair	X							
EARLE, Beverly – Vice-Chair	X							
FARMER-BUTTERFIELD, Jean – Vice-Chair	X							
ADCOCK, Gale	X							
BALL, Cynthia	X							
BLACKWELL, Hugh	X							
BOSWELL, Beverly	X							
BURR, Justin								
CARNEY, Becky	X							
CUNNINGHAM, Carla	X							
DULIN, Andy	X							
FORD, Carl	X							
HOWARD, Julia	X							
HUNTER, Howard	X							
INSKO, Verla	X							
JACKSON, Darren	X							
LEWIS, David								
LUCAS, Marvin								
MALONE, Chris	X							

ATTENDANCE

HEALTH

DATES	06/13/2018						
POTTS, Larry	X						
ROGERS, David	X						
SETZER, Mitchell	X						
SHEPARD, Phillip	X						
SZOKA, John	X						
WHITE, Donna	X						
WRAY, Michael	X						
YARBOROUGH, Larry	X						
ZACHARY, Lee	X						
HOUSE CLERKS							
Theresa Lopez	X						
Julie Ryan	X						
Anne Harvey Smith	X						
HOUSE COMMITTEE STAFF							
Theresa Matula	X						
Jason Moran-Bates	X						
Jessica Boney	X						
Jennifer Hillman							
Susan Barham							

House Committee on Health Wednesday, May 16, 2018 at 1:00 PM Room 643 of the Legislative Office Building

MINUTES

The House Committee on Health met at 1:00 PM on May 16, 2018 in Room 643 of the Legislative Office Building. Representatives Adcock, Ball, Blackwell, Boswell, Brisson, Carney, Cunningham, Dobson, Dulin, Earle, Farmer-Butterfield, Ford, Howard, Hunter, Insko, Bert Jones, Lambeth, Lucas, Malone, Murphy, Potts, Rogers, Setzer, Shepard, White, Wray, and Yarborough attended.

Representative Bert Jones, Chair, presided.

The following bills were considered:

HB 933 - Reciprocity/School Psychologist Licensure. (Representatives Dobson, Torbett, Lewis, Lucas)

Representative Dobson was recognized to explain the bill. House Bill 933 would require the State Board of Education to issue a school psychologist license to any individual who holds the Nationally Certified School Psychologist (NCSP) credential issued by the National Association of School Psychologists (NASP). It would also make some technical changes to the licensing statute for school support personnel.

Lynn Makor, Department of Public Instruction, Consultant for School Psychologists was recognized to assist with questions from members of the committee. After discussion, Representative Jones recognized Representative Farmer-Butterfield for a motion. Representative Farmer-Butterfield moved for a Favorable report on HB 933 and the motion passes.

The meeting adjourned at 1:25.

Representative Bert Jones, Chair

Presiding

Theresa Lopez, Committee Cie

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Updated #1: HB 933 Added

NORTH CAROLINA HOUSE OF REPRESENTATIVES COMMITTEE MEETING NOTICE AND BILL SPONSOR NOTIFICATION 2017-2018 SESSION

You are hereby notified that the House Committee on Health will meet as follows:

DAY & DATE: Wednesday, May 16, 2018

TIME: 1:00 PM LOCATION: 643 LOB

The following bills will be considered:

BILL NO. SHORT TITLE SPONSOR

HB 933 Reciprocity/School Psychologist Representative Dobson Licensure. Representative Torbett

Representative Torbett Representative Lewis Representative Lucas

Respectfully,

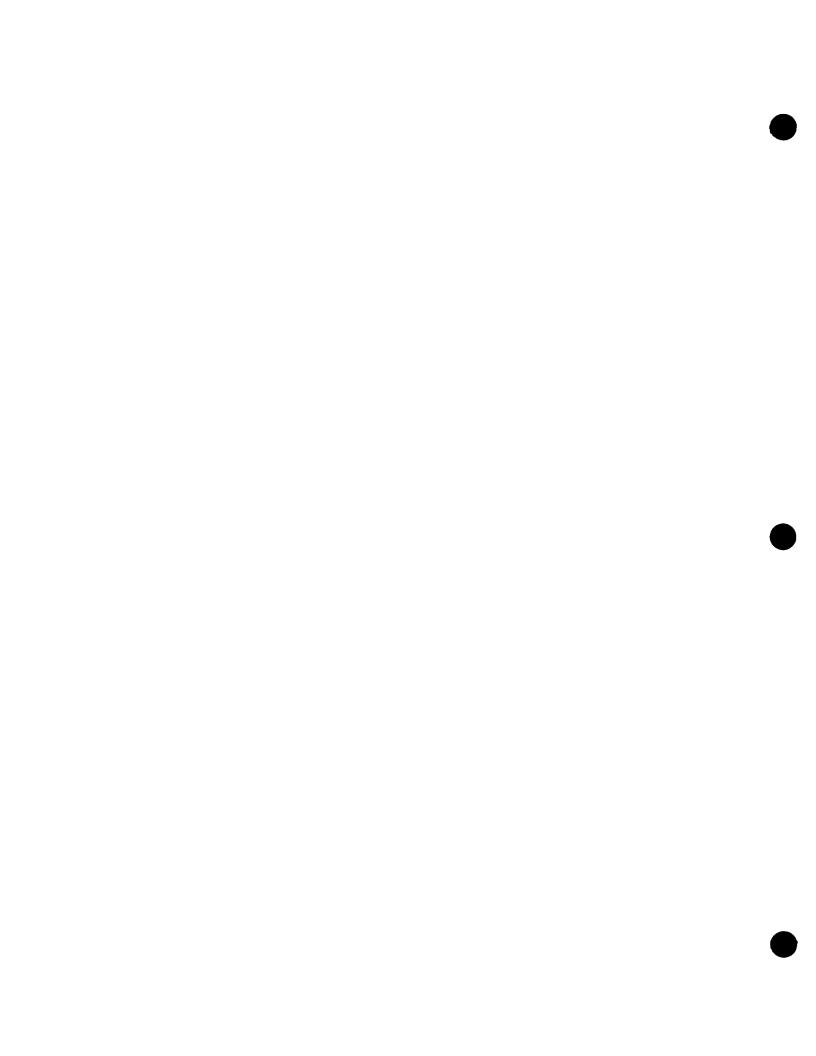
Representative Josh Dobson, Co-Chair Representative Nelson Dollar, Co-Chair Representative Bert Jones, Co-Chair Representative Donny Lambeth, Co-Chair

Representative Gregory F. Murphy, MD, Co-Chair

I hereby certify this notice	was filed by the committee	e assistant at the followin	g offices at 8:58 AM on
Tuesday, June 26, 2018.			-

___ Principal Clerk
___ Reading Clerk – House Chamber

Theresa Lopez (Committee Assistant)



House Committee on Health Wednesday, May 16, 2018, 1:00 PM 643 Legislative Office Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

BILL NO. SHORT TITLE

HB 933 Reciprocity/School Psychologist

Licensure.

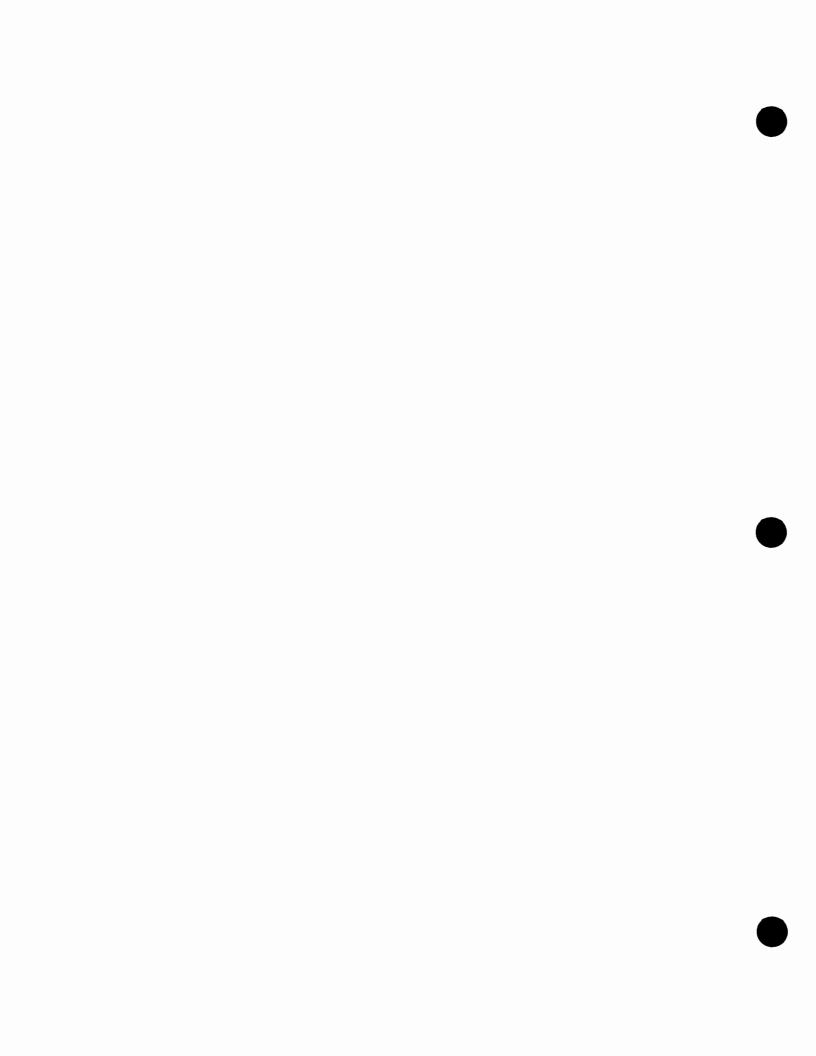
SPONSOR

Representative Dobson Representative Torbett Representative Lewis Representative Lucas

Presentations

Other Business

Adjournment



NORTH CAROLINA GENERAL ASSEMBLY HOUSE OF REPRESENTATIVES

HEALTH COMMITTEE REPORT

Representative Josh Dobson, Co-Chair Representative Nelson Dollar, Co-Chair Representative Bert Jones, Co-Chair Representative Donny Lambeth, Co-Chair Representative Gregory F. Murphy, MD, Co-Chair

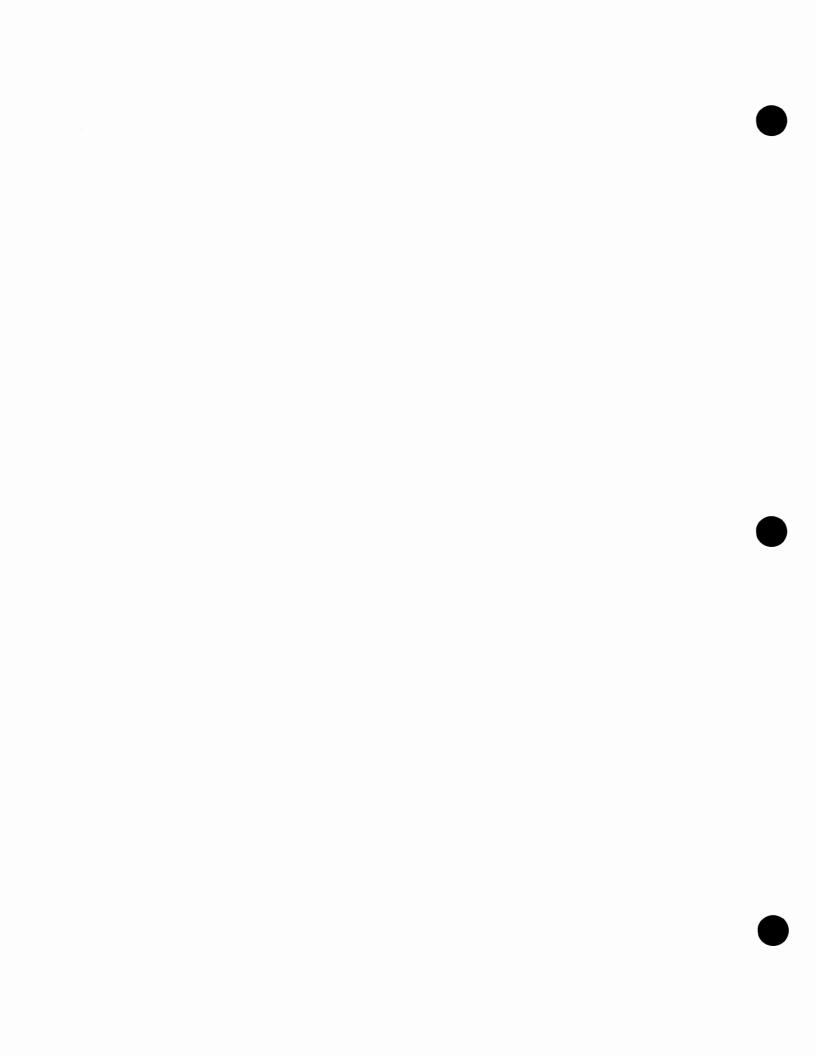
FAVORABLE

HB 933 Reciprocity/School Psychologist Licensure.

Draft Number:
Serial Referral:
Recommended Referral:
None
Long Title Amended:
No
Floor Manager:
Dobson

TOTAL REPORTED: 1







HOUSE BILL 933: Reciprocity/School Psychologist Licensure.

May 16, 2018

Jason Moran-Bates

2017-2018 General Assembly

House Health Committee:

Date: Introduced by: Reps. Dobson, Torbett, Lewis, Lucas Prepared by:

Filed Edition Staff Attorney Analysis of:

OVERVIEW: House Bill 933 would require the State Board of Education to issue a school psychologist license to any individual who holds the Nationally Certified School Psychologist (NCSP) credential issued by the National Association of School Psychologists (NASP). It would also make some technical changes to the licensing statute for school support personnel.

CURRENT LAW: Under current law, individuals who are already licensed as school psychologists in other states must follow the same process and meet the same criteria as North Carolina residents seeking initial licensure. First, they must complete an approved program in school psychology at the sixth-year level (about 75 semester hours). Secondly, they must pass the school psychology Praxis test. Finally, they must have a professional educator's continuing license issued by the Department of Public Instruction. In order to obtain that license, individuals fully licensed in other states must have at least three years of experience in addition to meeting the North Carolina State Board of Education's approved licensure exam requirements, or have a national board certification

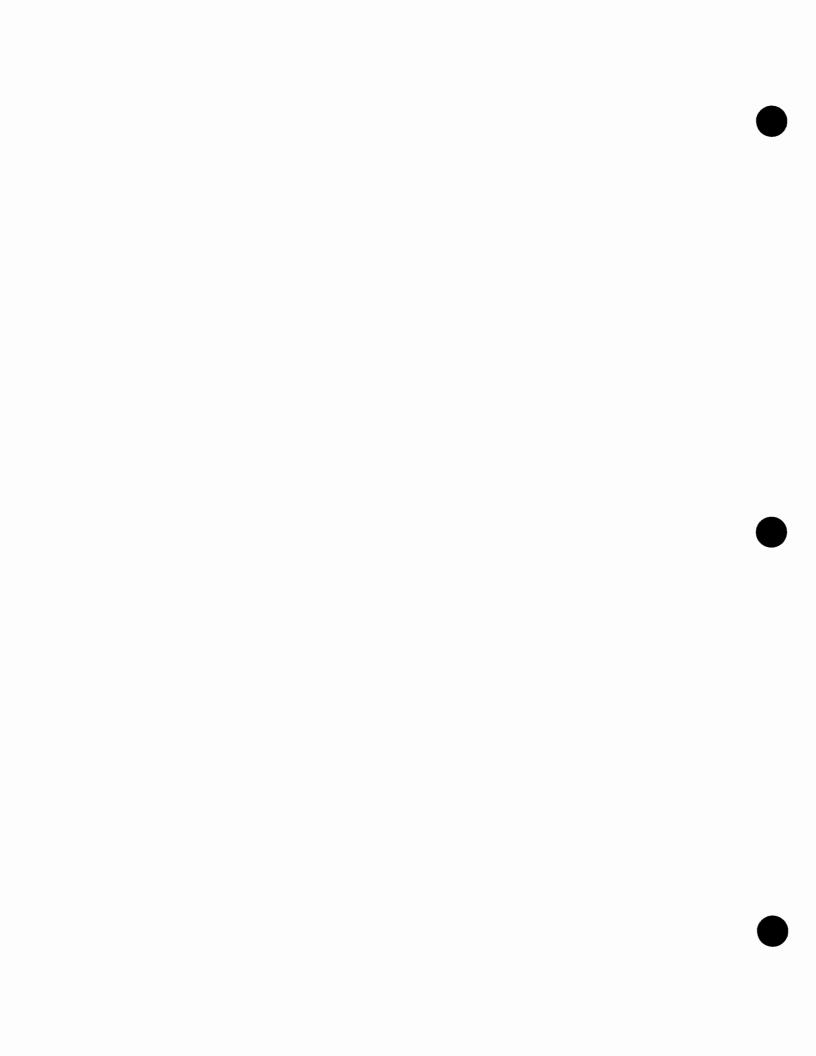
BILL ANALYSIS: House Bill 933 would require the State Board of Education to issue a school psychologist license to any individual who holds an NCSP credential issued by the NASP.

EFFECTIVE DATE: This bill would be effective when it becomes law and apply to applications for licensure submitted on or after that date.

BACKGROUND: In order to obtain the NCSP, individuals must 1) complete at least 60 semester hours of graduate-level coursework in a school psychology program of study, 2) complete a series of supervised practicum experiences, 3) complete 1,200 hours of school psychology internship, at least 600 of which must be in a school setting, and 4) pass the school psychologist Praxis test. Currently, 32 states, including Florida, Georgia, Maryland, South Carolina, and Virginia, recognize NASP certification as meeting or partially meeting the requirements for licensure as a school psychologist.







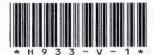
GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2017

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for licensure submitted on or after that date.

HOUSE BILL 933

Short Title:	Reciprocity/School Psychologist Licensure. (Public)
Sponsors:	Representatives Dobson, Torbett, Lewis, and Lucas (Primary Sponsors).
	For a complete list of sponsors, refer to the North Carolina General Assembly web site.
Referred to:	Health
	May 16, 2018
PRACTION THE NAME OF THE NAME	A BILL TO BE ENTITLED RECTING THE STATE BOARD OF EDUCATION TO GRANT A LICENSE TO CE AS A SCHOOL PSYCHOLOGIST TO ANY INDIVIDUALS WHO HOLD ATIONALLY CERTIFIED SCHOOL PSYCHOLOGIST CREDENTIAL, AS MENDED BY THE HOUSE SELECT COMMITTEE ON SCHOOL SAFETY. Whereas, school psychologists perform essential services for the social, emotional, ealth of students throughout North Carolina; and Whereas, the number of school psychologists in the State has been steadily declining 3-2014 academic year; and Whereas, one reason the State faces a shortage of school psychologists is the lack of ranted to individuals who are licensed as school psychologists in other states and
may wish to we credential frostandards the The General	Practice in North Carolina; and Phereas, the standards to receive a Nationally Certified School Psychologist on the National Association of School Psychologists are at least as stringent as the State currently requires for licensure as a school psychologist; Now, therefore, Assembly of North Carolina enacts: ECTION 1.(a) G.S. 115C-270.20(b) is repealed. ECTION 1.(b) The catch line of G.S. 115C-270.20 reads as rewritten: .20. Licensure-Teacher licensure requirements."
Sadding a new	ECTION 2. Article 17E of Chapter 115C of the General Statutes is amended by section to read:
(a) A preparation n	.21. Administrator and student services personnel licensure requirements. dministrators. – The State Board shall establish classification and levels of secessary for issuance of licenses for administrators, as provided in this Chapter. dudent Services Personnel. – The State Board shall establish classification and levels in necessary for issuance of licenses for student services personnel, as provided in
does any of the by the State I the National	Board of Education shall issue a school psychologist license to an individual who he following: (i) meets the criteria for licensure as a school psychologist established Board or (ii) holds the Nationally Certified School Psychologist credential issued by Association of School Psychologists." ECTION 3. This act is effective when it becomes law and applies to applications



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VISITOR REGISTRATION SHEET

House Comm on Heath 5/16/18

Name of Committee Date

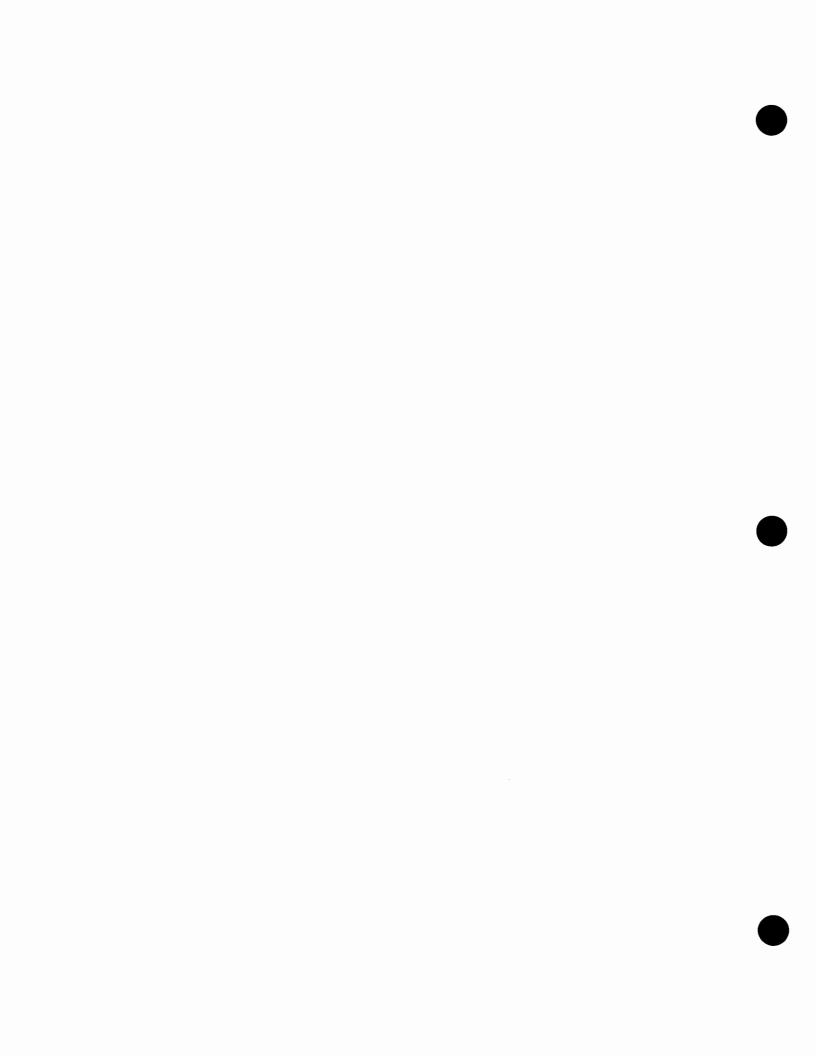
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Dong LASSID	NESTA
heigh Kokones	Educator
Your Monsdy	Educator
Nate Ding	NOT
Matt Grass	MH145
Carl Gilmore	Bode 3 Harrell LLP
Logan Marin	Benchmarks
Athley Pollard	Durham Public Schools
Sarah Spaeth	Durham "



V	SITO	R	RE	GISTR	ATION	SHEET

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Hose Comm on Hatth	5/10/18	

, NAME	FIRM OR AGENCY AND ADDRESS	
Lesley Wade	WCP55	
Sherry Stephens	WCASS	
Scarlett Dolampo	LICESE	
Ame Altman	UNC logra =	
Scott Riley	CIS Durham	,
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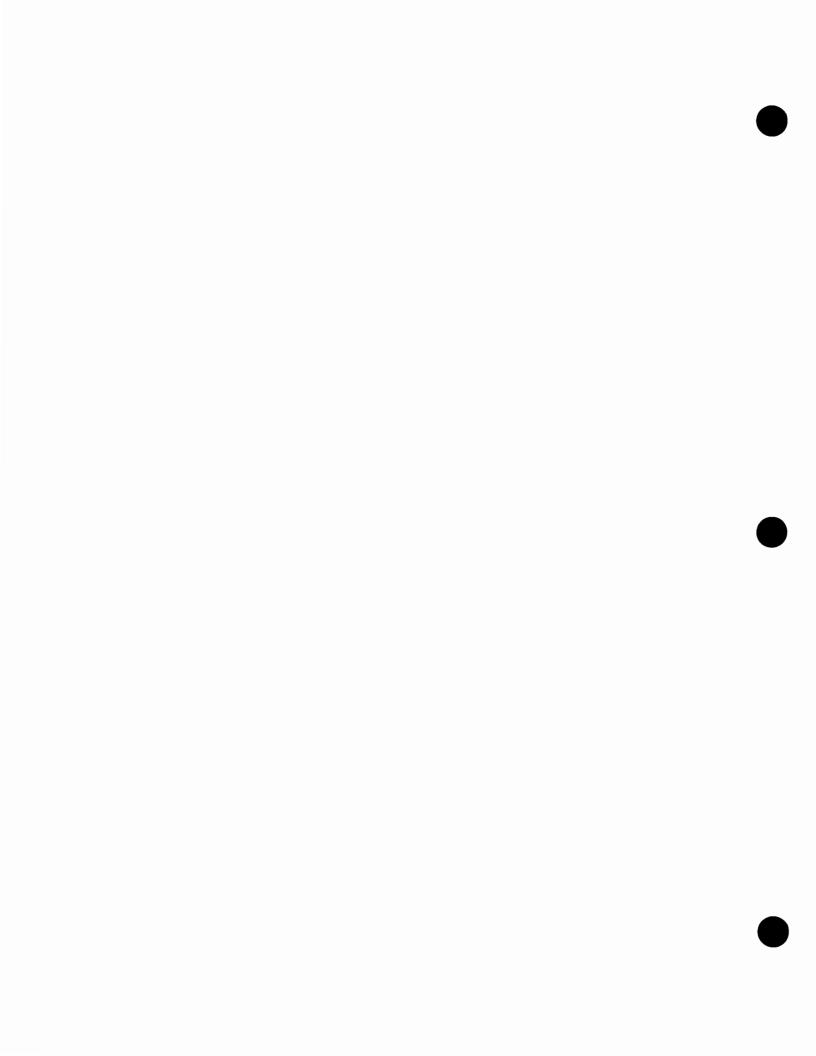
VISITOR REGISTRATION SHEET

House Comm on Health

Date

Name of Committee

NAME ,	FIRM OR AGENCY AND ADDRESS
Thompson	TPG
Hamar	NETEN
Nathan Bublack	PPAB
Que	
Pachl Bealie	PBlan
Phagan Jukson	Forur Carolinas
AMES SYMMONS	EQUALITY NC
Bradford Sneeder	NCDOI
dom Host	NCICU
Duson P. Mars	NETCU
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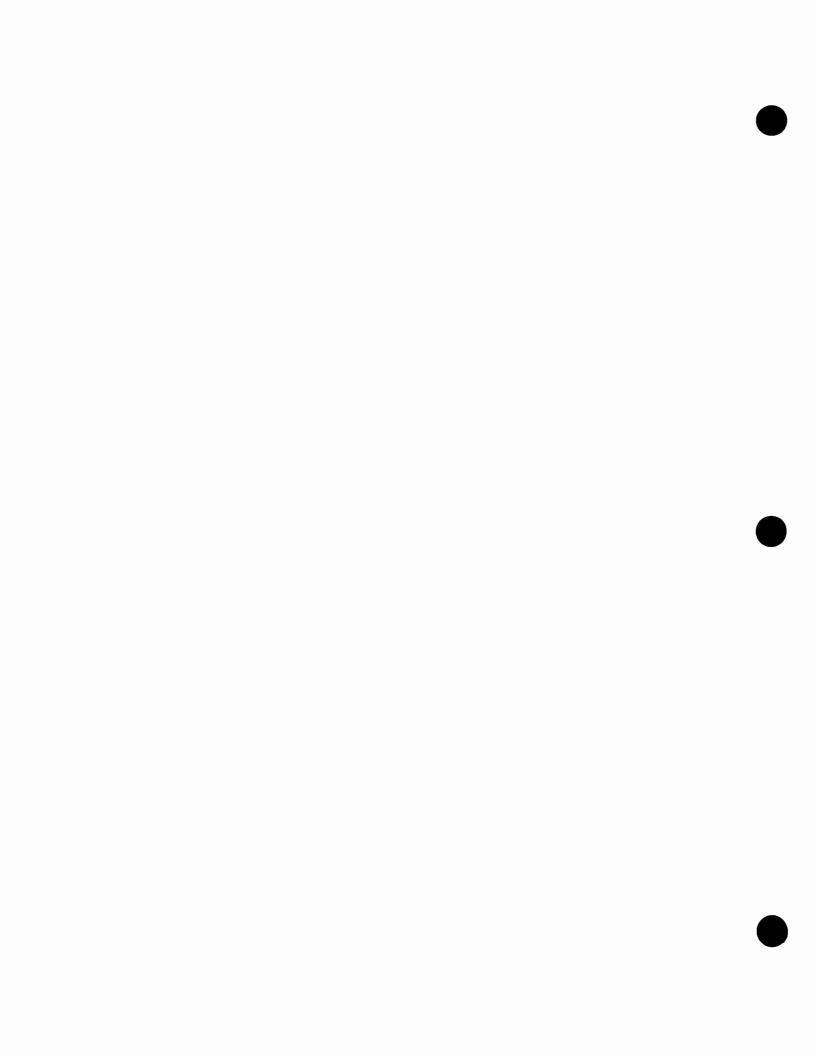


VISITOR REGISTRATION SHEET

House Comm on Hearth 5/16/18

Name of Committee Date

NAME ,	FIRM OR AGENCY AND ADDRESS
Lashamar	Phy.
Im Small	NCDPI
Justin Clayton	Governu
(1/3/4	SBE/PRI
LYND MAKOR	DPI
Zane Stilwell	576
Hendell Hathaway	Mern
Sinthia Shabnum	Intern-Adrock
Courtney Crawder	Crowder Consulary Co.
LEE LILLEY	GOVERNON



House Committee on Health Wednesday, May 30, 2018 at 11:00 AM Room 643 of the Legislative Office Building

MINUTES

The House Committee on Health met at 11:00 AM on May 30, 2018 in Room 643 of the Legislative Office Building. Representatives Ball, Blackwell, Boswell, Brisson, Carney, Cunningham, Dollar, Dulin, Earle, Farmer-Butterfield, Ford, Howard, Hunter, Insko, Bert Jones, Lambeth, Lucas, Malone, Murphy, Potts, Szoka, White, Wray, Yarborough, and Zachary attended.

Representative Gregory F. Murphy, MD, Chair, presided.

The following bills were considered:

HB 984 Oversight IDD Employment/Educ. Programs. (Representatives Bradford, Dollar, Lambeth, Sauls)

Representative Bradford spoke on the bill. Representative Dollar moved for adoption of an amendment. Representative Farmer-Butterfield motioned for a favorable report as amended and rolled into a Proposed Committee Substitute. The motion passed and the committee substitute was re-referred to the Committee on Appropriations.

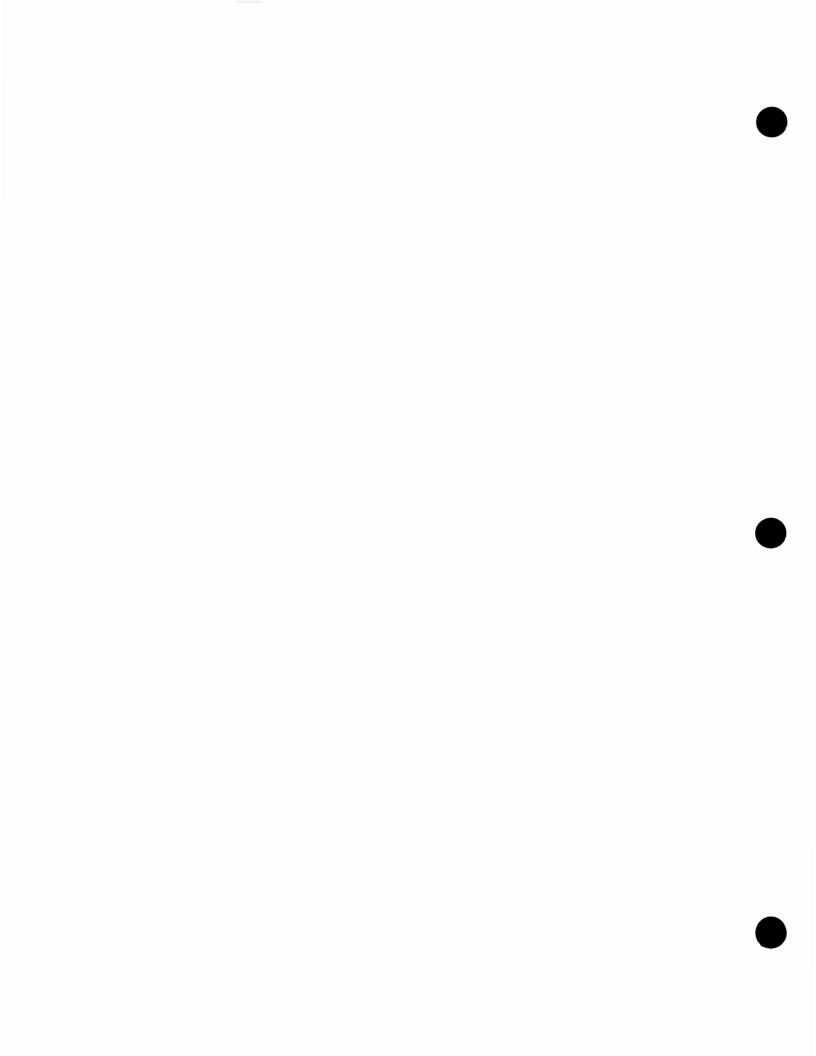
HB 982 IDD Data Sharing/Longitudinal Data System. (Representatives Bradford, Dollar, Lambeth, Sauls)

Representative Bradford spoke on the bill. There was a motion for a proposed committee substitute by Representative Dulin. There was discussion on the bill by Representatives Insko, Carney, Ball and Dulin. Representative Dollar motioned for a favorable report. The motion passed and a serial referral was made to the Committee on Education-Universities.

HB 983 ABLE Act Changes/Study. (Representatives Bradford, Dollar, Lambeth, Sauls)

Representative Bradford spoke on the bill. There was no discussion. Representative Jones motioned for a favorable report. The motion passed and a serial referral was made to the Committee on Finance.

The meeting adjourned at 11:25pm.



Representative Gregory F. Murphy, MD, Chair Presiding

Anne Harvey Smith, Committee Clerk

Updated #1: Removed HB967

NORTH CAROLINA HOUSE OF REPRESENTATIVES **COMMITTEE MEETING NOTICE** AND **BILL SPONSOR NOTIFICATION 2017-2018 SESSION**

You are hereby notified that the House Committee on Health will meet as follows:

DAY & DATE: Wednesday, May 30, 2018

TIME:

11:00 AM

LOCATION:

643 LOB

The following bills will be considered:

BILL NO. HB 984	SHORT TITLE Oversight IDD Employment/Educ. Programs.	SPONSOR Representative Bradford Representative Dollar Representative Lambeth
<u>HB 982</u>	IDD Data Sharing/Longitudinal Data System.	Representative Sauls Representative Bradford Representative Dollar
HB 983	ABLE Act Changes/Study.	Representative Lambeth Representative Sauls Representative Bradford
	The state of the s	Representative Dollar Representative Lambeth Representative Sauls



Respectfully,

Representative Josh Dobson, Co-Chair Representative Nelson Dollar, Co-Chair Representative Bert Jones, Co-Chair Representative Donny Lambeth, Co-Chair Representative Gregory F. Murphy, MD, Co-Chair

I hereby certify this notice was filed by the committee assistant at the following offices at 8:59 AM or Tuesday, June 26, 2018.
Principal Clerk Reading Clerk – House Chamber
Theresa Lopez (Committee Assistant)

House Committee on Health Wednesday, May 30, 2018, 11:00 AM 643 Legislative Office Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

BILL NO.	SHORT TITLE	SPONSOR
HB 984	Oversight IDD Employment/Educ.	Representative Bradford
	Programs.	Representative Dollar
		Representative Lambeth
		Representative Sauls
HB 982	IDD Data Sharing/Longitudinal Data	Representative Bradford
	System.	Representative Dollar
		Representative Lambeth
		Representative Sauls
HB 983	ABLE Act Changes/Study.	Representative Bradford
		Representative Dollar
		Representative Lambeth
		Representative Sauls

Presentations

Other Business

Adjournment

NORTH CAROLINA GENERAL ASSEMBLY HOUSE OF REPRESENTATIVES

HEALTH COMMITTEE REPORT

Representative Josh Dobson, Co-Chair Representative Nelson Dollar, Co-Chair Representative Bert Jones, Co-Chair Representative Donny Lambeth, Co-Chair Representative Gregory F. Murphy, MD, Co-Chair

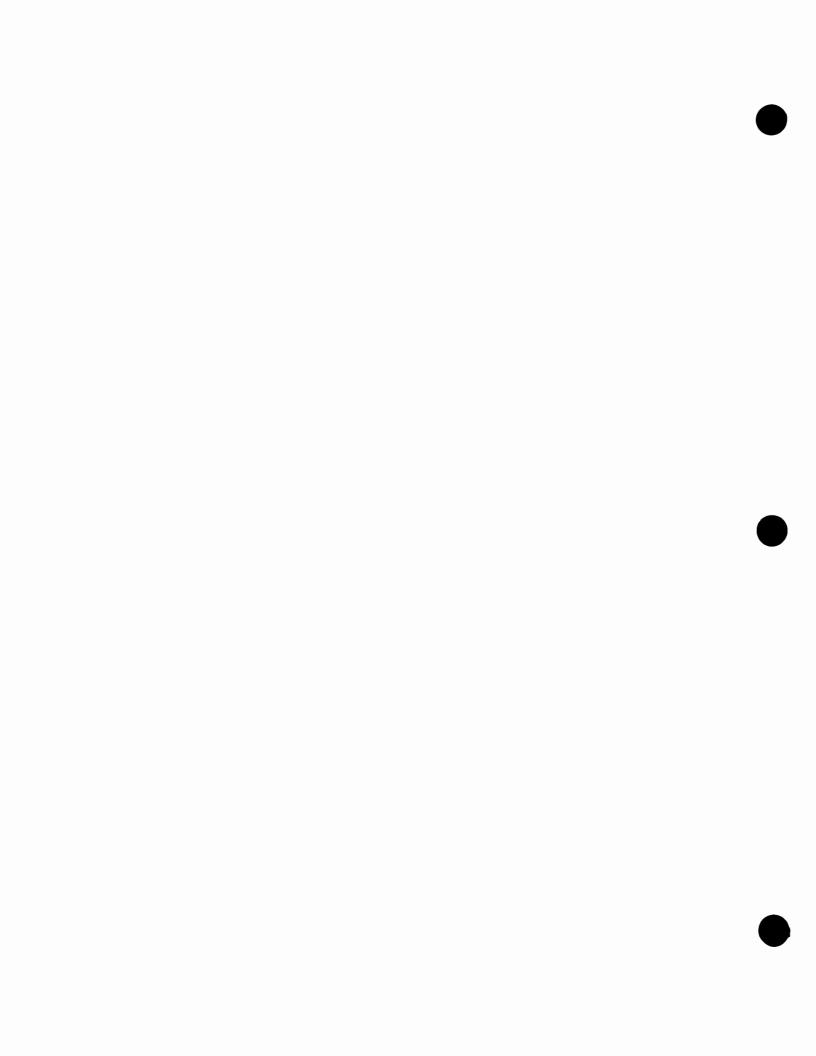
FAVORABLE AND RE-REFERRED

HB 983 ABLE Act Changes/Study.

Draft Number: None
Serial Referral: FINANCE
Recommended Referral: None
Long Title Amended: No
Floor Manager: Bradford

TOTAL REPORTED: 1





NORTH CAROLINA GENERAL ASSEMBLY HOUSE OF REPRESENTATIVES

HEALTH COMMITTEE REPORT

Representative Josh Dobson, Co-Chair Representative Nelson Dollar, Co-Chair Representative Bert Jones, Co-Chair Representative Donny Lambeth, Co-Chair Representative Gregory F. Murphy, MD, Co-Chair

FAVORABLE COM SUB, UNFAVORABLE ORIGINAL BILL AND RE-REFERRED

HB 982 IDD Data Sharing/Longitudinal Data System.

Draft Number:

H982-PCS30468-BP-3

Serial Referral:

EDUCATION - UNIVERSITIES

Recommended Referral: None Long Title Amended:

No

Floor Manager:

Bradford

HB 984 Oversight IDD Employment/Educ. Programs.

Draft Number:

H984-PCS30469-SH-32

Serial Referral:

APPROPRIATIONS

Recommended Referral: None Long Title Amended:

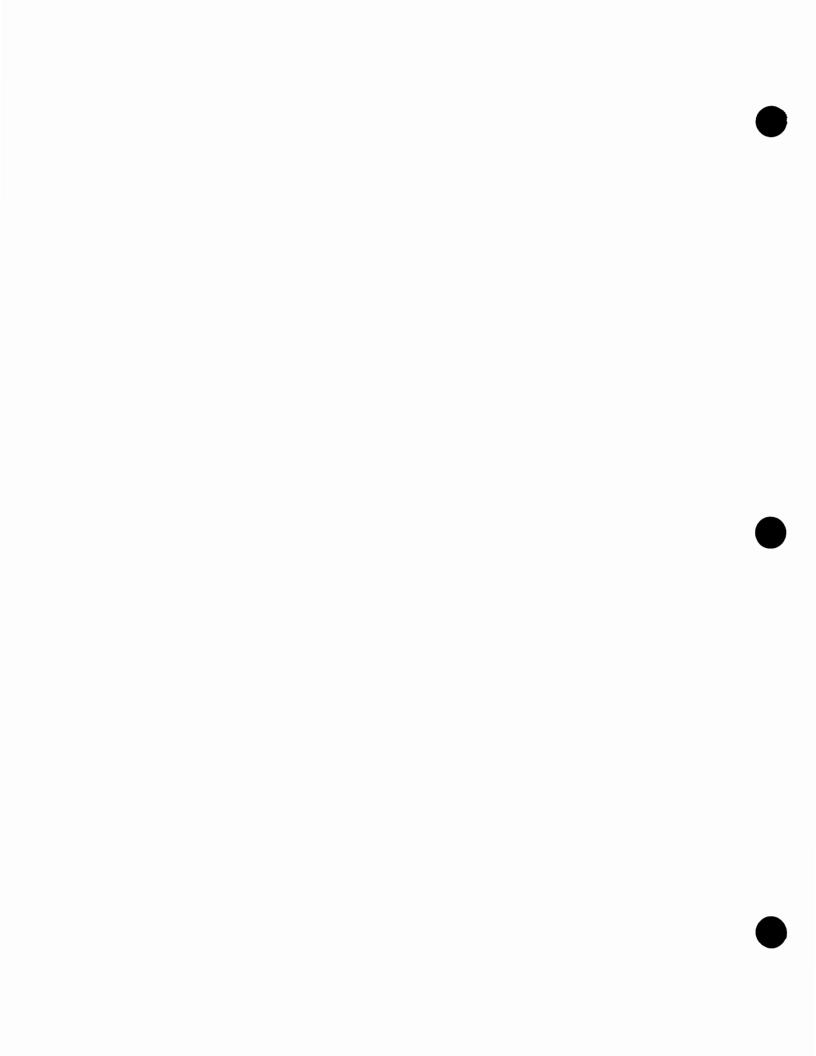
Yes

Floor Manager:

Bradford

TOTAL REPORTED: 2







HOUSE BILL 984: Oversight IDD Employment/Educ. Programs.

This Bill Analysis reflects the contents of the bill as it was presented in committee.

2017-2018 General Assembly

Committee: House Health. If favorable, re-refer to Date: May 29, 2018

Appropriations

Introduced by: Reps. Bradford, Dollar, Lambeth, Sauls Prepared by: Theresa Matula

Analysis of: First Edition Legislative Analyst

OVERVIEW: House Bill 984 would create a Director of Education and Employment Opportunities for Individuals with Intellectual and Developmental Disabilities position in the Department of Health and Human Services and appropriate funds for the position; add the Director to the Council on Developmental Disabilities and the Council on Educational Services for Exceptional Children; and require a report to the Joint Legislative Education Oversight Committee and the Joint Legislative Oversight Committee on Health and Human Services by March 1, 2019. The bill is a recommendation from the Joint Legislative Research Commission, Committee on Intellectual and Developmental Disabilities.

BILL ANALYSIS:

Sections 1, 3, 5 and 7 of the bill pertain to the establishment of a Director of Education and Employment Opportunities for Individuals with Intellectual and Developmental Disabilities (IDD) position in the Department of Health and Human Services (DHHS). Section 1 amends Chapter 143B, Article 3, Part 13, to add a new statutory section providing for a Director of Education and Employment Opportunities for Individuals with IDD. The new section does the following: establishes the position, provides for the appointment of the Director by the DHHS Secretary, provides for staff, and outlines 14 duties and responsibilities of the Director. The Director is required to report on the interagency coordination of education and employment programs and services for individuals with IDD, including the evaluation of available programs and services and outcomes in attaining postsecondary education and employment. The report is made to the Joint Legislative Education Oversight Committee and the Joint Legislative Oversight Committee on Health and Human Services by March 1 of each year. Section 3 exempts the Director of Education and Employment Opportunities for Individuals with IDD from most of the Articles in the State Human Resources Act. Section 5 requires the DHHS Secretary to appoint a Director of Education and Employment Opportunities for Individuals with IDD by October 1, 2018. Section 7 appropriates \$150,000 for the 2018-2019 fiscal year in recurring funds to the Department of Health and Human Services for the salary and benefits of the Director of Education and Employment Opportunities for Individuals with IDD and any necessary staff, as well as \$18,000 in nonrecurring funds for furniture and equipment costs.

<u>Section 2</u> amends G.S. 143B-179 to add the Director of Education and Employment Opportunities for Individuals with IDD as an ex officio member of the Council on Developmental Disabilities.

Section 4 amends G.S. 115C-112.1(b) pertaining to the membership of the Council on Educational Services for Exceptional Children to add the Director of Education and Employment Opportunities for Individuals with IDD as an ex officio member and to add the Deputy Commissioner for the Division of Adult Correction and Juvenile justice or designee as an ex officio in place of the Secretary of Public Safety who is listed twice.

Karen Cochrane-Brown Director



Legislative Analysis Division 919-733-2578

House Bill 984

Page 2

<u>Section 6</u> requires the Director of Education and Employment Opportunities for Individuals with IDD to submit an initial report containing information on four specific items to the Joint Legislative Education Oversight Committee and the Joint Legislative Oversight Committee on Health and Human Services by March 1, 2019.

EFFECTIVE DATE: The act would become effective July 1, 2018.

BACKGROUND: House Bill 984 is a recommendation from the Joint Legislative Research Commission, Committee on Intellectual and Developmental Disabilities. The Committee recommended that a position be created within DHHS to oversee administration and coordination of education and employment programs for individuals with IDD. The Committee further recommended that the position provide an annual report to the General Assembly on interagency coordination of education and employment programs and services for individuals with IDD and the evaluation of available programs.

GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2017

H

HOUSE BILL 984
TTEE SURSTITUTE H984-PC\$30469-SH-32

D

Short Title: Oversight IDD Employment/Educ. Programs.	(Public)
Sponsors:	
Referred to:	
May 23, 2018	
A BILL TO BE ENTITLED	
AN ACT TO CREATE A POSITION WITHIN THE DEPARTMENT O	F HEALTH AND
HUMAN SERVICES TO OVERSEE ADMINISTRATION AND COO	ORDINATION OF
EDUCATION AND EMPLOYMENT PROGRAMS FOR INDIV	VIDUALS WITH
INTELLECTUAL AND DEVELOPMENTAL DISABILITIES.	
The General Assembly of North Carolina enacts:	
SECTION 1. Part 13 of Article 3 of Chapter 143B of the General S	Statutes is amended
by adding a new section to read:	
"§ 143B-179.1. Director of Education and Employment Opportunities for	r Individuals with
Intellectual and Developmental Disabilities.	CYY 1.1
(a) Establishment of the Position. – There is established within the De	
and Human Services the position of Director of Education and Employmen	t Opportunities for
Individuals with Intellectual and Developmental Disabilities. The Disabilities and Disabilities and Disabilities are Disabilities.	
professional, administrative, technical, and clerical personnel as may be necessary to be a second of the control of the contr	
carrying out his or her duties. The Director shall oversee the interagence	
education and employment programs and services for individuals with developmental disabilities.	n interfectual and
(b) Appointment and Staff. – The Director of Education and Employe	ment Opportunities
for Individuals with Intellectual and Developmental Disabilities shall be	
Secretary of Health and Human Services at a salary established by the Secreta	
available for that purpose. The Director may be removed from the position by	-
Director shall report directly to the Deputy Secretary for Human Services. The	
exempt from the provisions of Chapter 126 of the General Statutes, except for	
of Chapter 126 of the General Statutes.	
All other staff shall be appointed, supervised, and directed by the Director a	and shall be subject
to the provisions of Chapter 126 of the General Statutes. Except for the Dir	
compensation of all staff shall be fixed in the manner provided by law for fix	
salaries and compensation by other State agencies.	
(c) <u>Duties. – The Director of Education and Employment Opportunit</u>	
with Intellectual and Developmental Disabilities shall be the coordinator and	
access to education and employment programs and services for individuals w	
developmental disabilities and, in doing so, shall have at least the followed	lowing duties and
responsibilities:	

employment for individuals with intellectual and developmental disabilities to be used by State agencies that serve those individuals.

(1)



Establish a statewide vision for inclusive postsecondary education and quality

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1 utilizing the North Carolina Longitudinal Data System established under
2 Chapter 116E of the General Statutes.
3 (13) Serve as an ex officio member on the Council on Developmental Disabilities
4 of the Department of Health and Human Services.

(14) Serve as an ex officio member on the Council on Educational Services for Exceptional Children.

(d) Reporting Requirement. – By March 1 of each year, the Director of Education and Employment Opportunities for Individuals with Intellectual and Developmental Disabilities shall report to the Joint Legislative Education Oversight Committee and the Joint Legislative Oversight Committee on Health and Human Services on the interagency coordination of education and employment programs and services for individuals with intellectual and developmental disabilities, including the evaluation of available programs and services and outcomes in attaining postsecondary education and employment."

SECTION 2. G.S. 143B-179 reads as rewritten:

"§ 143B-179. Council on Developmental Disabilities – members; selection; quorum; compensation.

(a) The Council on Developmental Disabilities of the Department of Health and Human Services shall consist of 3231 members appointed by the Governor and two ex officio members. The composition of the Council shall be as follows:

(1) Eleven members from the General Assembly and State government agencies as follows: One person who is a member of the Senate, one person who is a member of the House of Representatives, one representative of the Department of Public Instruction, one representative of the Division of Adult Correction and Juvenile Justice of the Department of Public Safety, and sevensix representatives of the Department of Health and Human Services to include the Secretary or his designee. Services.

Sixteen members designated as consumers of service for the developmentally (2) disabled. A consumer of services for the developmentally disabled is a person who (i) has a developmental disability or is the parent or guardian of such a person, or (ii) is an immediate relative or guardian of a person with mentally impairing developmental disability, and (iii) is not an employee of a State agency that receives funds or provides services under the provisions of Part B, Title 1, P.L. 98-527, as amended, the Developmental Disabilities Act of 1984, is not a managing employee (as defined in Section 1126(b) of the Social Security Act) of any other entity that receives funds or provides services under such that Part, and is not a person with an ownership or control interest (within the meaning of Section 1124(a)(3) of the Social Security Act) with respect to such an entity. Of these 16 members, at least one third shall be persons with developmental disabilities and at least another one third shall be the immediate relatives or guardians of persons with mentally impairing developmental disabilities, disabilities that impair their intellectual functioning, of whom at least one shall be an immediate relative or guardian of an institutionalized developmentally disabled person.

(3) Five members at large as follows: One representative of the university affiliated facility, one representative of the State protection and advocacy system, one representative of a local agency, one representative of a nongovernmental agency or nonprofit group concerned with services to persons with developmental disabilities, and one representative from the public at large.

(4) The Secretary of Health and Human Services or the Secretary's designee.

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(5)The Director of Education and Employment Opportunities for Individuals with Intellectual and Developmental Disabilities.

The appointments of all members, with the exception of those from the General Assembly and State agencies shall be for terms of four years and until their successors are appointed and qualify. Any appointment to fill a vacancy on the Council created by the resignation, dismissal, death, or disability of a member shall be for the balance of the unexpired term.

The Governor shall make appropriate provisions for the rotation of membership on the Council.

(b) The Governor shall have the power to remove any appointed member of the Council from office in accordance with the provisions of G.S. 143B-16.

The Governor shall designate one member of the Council to serve as chairman at his pleasure. Members of the Council shall receive per diem and necessary travel and subsistence expenses in accordance with the provisions of G.S. 138-5.

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

All clerical and other services required by the council shall be supplied by the Secretary of Health and Human Services."

SECTION 3. G.S. 126-5(c1) is amended by adding a new subdivision to read:

"(36) The Director of Education and Employment Opportunities for Individuals with Intellectual and Developmental Disabilities."

SECTION 4. G.S. 115C-112.1(b) reads as rewritten:

The Council shall consist of a minimum of 2425 members to be appointed as follows: fourfive ex officio members; one individual with a disability and one representative of a private school appointed by the Governor; one member of the Senate and one parent of a child with a disability between the ages of birth and 26 appointed by the President Pro Tempore of the Senate: one member of the House of Representatives and one parent of a child with a disability appointed by the Speaker of the House of Representatives; and 14 members appointed by the State Board of Education. The State Board shall appoint members who represent individuals with disabilities, teachers, local school administrative units, institutions of higher education that prepare special education and related services personnel, administrators of programs for children with disabilities, charter schools, parents of children with disabilities, a State or local official who carries out activities under the federal McKinney-Vento Homeless Assistance Act, vocational, community, or business organizations concerned with the provision of transition services, and others as required by IDEA. The majority of members on the Council shall be individuals with disabilities or parents of children with disabilities. The Council shall designate a chairperson from among its members. The designation of the chairperson is subject to the approval of the State Board of Education. The Board shall adopt rules to carry out this subsection.

Ex officio members of the Council shall be the following:

- The Secretary of Health and Human Services or the Secretary's designee. (1)
- (2) The Secretary of Public Safety or the Secretary's designee.
- The Secretary of Public Safety Deputy Commissioner for the Division of Adult (3) Correction and Juvenile Justice or the Secretary's Deputy Commissioner's designee.
- The Superintendent of Public Instruction or the Superintendent's designee. (4)
- The Director of Education and Employment Opportunities for Individuals (5)with Intellectual and Developmental Disabilities.

The term of appointment for all members except those appointed by the State Board of Education is two years. The term for members appointed by the State Board of Education is four years. No person appointed by the State Board shall serve more than two consecutive four-year

Each Council member shall serve without pay, but shall receive travel allowances and per diem in the same amount provided for members of the North Carolina General Assembly."

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SECTION 5. Notwithstanding G.S. 143B-179.1, as enacted by this act, the Secretary of Health and Human Services shall appoint a Director of Education and Employment Opportunities for Individuals with Intellectual and Developmental Disabilities by October 1, 2018.

SECTION 6. Notwithstanding G.S. 143B-179.1(d), as enacted by this act, the Director of Education and Employment Opportunities for Individuals with Intellectual and Developmental Disabilities, after consultation with other divisions within the Department of Health and Human Services and the Department of Public Instruction, shall submit an initial report to the Joint Legislative Education Oversight Committee and the Joint Legislative Oversight Committee on Health and Human Services by March 1, 2019, with the following information:

- (1) A list of all State agencies, departments, divisions, councils, commissions, and units of State and local government with authority to (i) direct, manage, or provide funding; (ii) engage with federal agencies; and (iii) direct organizational or individual planning related to the preparation for and support of postsecondary education and employment for individuals with intellectual and developmental disabilities.
- (2) A list of current funding streams, including Medicaid and Medicaid waivers, federal funds other than from Medicaid, State funds, local funds, public and private grants, and all other sources of funding currently used or that are available for activities related to the preparation for and support of postsecondary education and employment for individuals with intellectual and developmental disabilities.
- (3) Data sets collected by State agencies, departments, divisions, councils, commissions, and units of State and local government, including local school administrative units and charter schools, and any other entities receiving public or publicly managed funds related to the preparation for and support of postsecondary education and employment for individuals with intellectual and developmental disabilities. This information shall include barriers to uniform collection and evaluation of relevant data among agencies.
- (4) Strategies to improve the coordination of (i) funding; (ii) data collection, evaluation, and reporting; and (iii) operational efficiencies for the purpose of allowing the fair assessment of outcomes, use of funds, gaps and overlaps in services and supports related to the preparation for and support of postsecondary education, and employment for individuals with intellectual and developmental disabilities.

SECTION 7. For the 2018-2019 fiscal year, there is appropriated from the General Fund to the Department of Health and Human Services the sum of up to one hundred fifty thousand dollars (\$150,000) in recurring funds for the salary and benefits of the Director of Education and Employment Opportunities for Individuals with Intellectual and Developmental Disabilities and any necessary staff to the Director and for the Director's operating costs and the sum of up to eighteen thousand dollars (\$18,000) in nonrecurring funds for furniture and equipment costs in establishing the position.

SECTION 8. The University of North Carolina General Administration shall study whether the waiting list for university-based, postsecondary education opportunities for individuals with IDD could be reduced or eliminated if full-time students who are enrolled in a two-year (four semester) or four-year (eight semester) certificate of accomplishment program approved as a Comprehensive Transition Program (CTP) by the U.S. Department of Education at a constituent institution of The University of North Carolina were categorized the same as full-time students who are enrolled in four-year degree programs. The study shall assess the impact of this change on the reduction or elimination of waiting lists for CTPs and the associated

General Assembly Of North Carolina

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Session 2017

- 1 costs. The University of North Carolina shall report findings and recommendations resulting
- 2 from the study to the Joint Legislative Education Oversight Committee and the Joint Legislative
- 3 Oversight Committee on Health and Human Services not later than October 31, 2019.
 - **SECTION 9.** This act becomes effective July 1, 2018.

Page 6 House Bill 984 H984-PCS30469-SH-32

GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2017

H

HOUSE BILL 984

Short Title: Oversight IDD Employment/Educ. Programs. (Public)

Sponsors: Representatives Bradford, Dollar, Lambeth, and Sauls (Primary Sponsors).

For a complete list of sponsors, refer to the North Carolina General Assembly web site.

Referred to: Health, if favorable, Appropriations

May 23, 2018

A BILL TO BE ENTITLED
AN ACT TO CREATE A POSITION WITHIN THE DEPART

AN ACT TO CREATE A POSITION WITHIN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO OVERSEE ADMINISTRATION AND COORDINATION OF EDUCATION AND EMPLOYMENT PROGRAMS FOR INDIVIDUALS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES, AS RECOMMENDED BY THE LEGISLATIVE RESEARCH COMMISSION COMMITTEE ON INTELLECTUAL AND DEVELOPMENTAL DISABILITIES.

The General Assembly of North Carolina enacts:

SECTION 1. Part 13 of Article 3 of Chapter 143B of the General Statutes is amended by adding a new section to read:

"§ 143B-179.1. Director of Education and Employment Opportunities for Individuals with Intellectual and Developmental Disabilities.

- (a) Establishment of the Position. There is established within the Department of Health and Human Services the position of Director of Education and Employment Opportunities for Individuals with Intellectual and Developmental Disabilities. The Director shall have professional, administrative, technical, and clerical personnel as may be necessary to assist in carrying out his or her duties. The Director shall oversee the interagency coordination of education and employment programs and services for individuals with intellectual and developmental disabilities.
- (b) Appointment and Staff. The Director of Education and Employment Opportunities for Individuals with Intellectual and Developmental Disabilities shall be appointed by the Secretary of Health and Human Services at a salary established by the Secretary within the funds available for that purpose. The Director may be removed from the position by the Secretary. The Director shall report directly to the Deputy Secretary for Human Services. The Director shall be exempt from the provisions of Chapter 126 of the General Statutes, except for Articles 6 and 7 of Chapter 126 of the General Statutes.

All other staff shall be appointed, supervised, and directed by the Director and shall be subject to the provisions of Chapter 126 of the General Statutes. Except for the Director, salaries and compensation of all staff shall be fixed in the manner provided by law for fixing and regulating salaries and compensation by other State agencies.

(c) <u>Duties. – The Director of Education and Employment Opportunities for Individuals with Intellectual and Developmental Disabilities shall be the coordinator and point of contact for access to education and employment programs and services for individuals with intellectual and developmental disabilities and, in doing so, shall have at least the following duties and responsibilities:</u>



development of employer partnerships.

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- (12) Develop methods to collect and evaluate data relevant to secondary and postsecondary education and employment for individuals with intellectual and development disabilities in compliance with State and federal law, including utilizing the North Carolina Longitudinal Data System established under Chapter 116E of the General Statutes.

 (13) Serve as an experior member on the Council on Developmental Disabilities
- (13) Serve as an ex officio member on the Council on Developmental Disabilities of the Department of Health and Human Services.
- (14) Serve as an ex officio member on the Council on Educational Services for Exceptional Children.
- (d) Reporting Requirement. By March 1 of each year, the Director of Education and Employment Opportunities for Individuals with Intellectual and Developmental Disabilities shall report to the Joint Legislative Education Oversight Committee and the Joint Legislative Oversight Committee on Health and Human Services on the interagency coordination of education and employment programs and services for individuals with intellectual and developmental disabilities, including the evaluation of available programs and services and outcomes in attaining postsecondary education and employment."

SECTION 2. G.S. 143B-179 reads as rewritten:

"§ 143B-179. Council on Developmental Disabilities – members; selection; quorum; compensation.

- (a) The Council on Developmental Disabilities of the Department of Health and Human Services shall consist of 3231 members appointed by the Governor. Governor and two ex officio members. The composition of the Council shall be as follows:
 - (1) Eleven members from the General Assembly and State government agencies as follows: One person who is a member of the Senate, one person who is a member of the House of Representatives, one representative of the Department of Public Instruction, one representative of the Division of Adult Correction and Juvenile Justice of the Department of Public Safety, and sevensix representatives of the Department of Health and Human Services to include the Secretary or his designee. Services.
 - (2) Sixteen members designated as consumers of service for the developmentally disabled. A consumer of services for the developmentally disabled is a person who (i) has a developmental disability or is the parent or guardian of such a person, or (ii) is an immediate relative or guardian of a person with mentally impairing developmental disability, and (iii) is not an employee of a State agency that receives funds or provides services under the provisions of Part B, Title 1, P.L. 98-527, as amended, the Developmental Disabilities Act of 1984, is not a managing employee (as defined in Section 1126(b) of the Social Security Act) of any other entity that receives funds or provides services under such that Part, and is not a person with an ownership or control interest (within the meaning of Section 1124(a)(3) of the Social Security Act) with respect to such an entity. Of these 16 members, at least one third shall be persons with developmental disabilities and at least another one third shall be the immediate relatives or guardians of persons with mentally impairing developmental disabilities, disabilities that impair their intellectual functioning, of whom at least one shall be an immediate relative or guardian of an institutionalized developmentally disabled person.
 - (3) Five members at large as follows: One representative of the university affiliated facility, one representative of the State protection and advocacy system, one representative of a local agency, one representative of a nongovernmental agency or nonprofit group concerned with services to

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- persons with developmental disabilities, and one representative from the 1 2 public at large. 3
 - The Secretary of Health and Human Services or the Secretary's designee. <u>(4)</u>
 - The Director of Education and Employment Opportunities for Individuals (5) with Intellectual and Developmental Disabilities.

The appointments of all members, with the exception of those from the General Assembly and State agencies shall be for terms of four years and until their successors are appointed and qualify. Any appointment to fill a vacancy on the Council created by the resignation, dismissal, death, or disability of a member shall be for the balance of the unexpired term.

The Governor shall make appropriate provisions for the rotation of membership on the Council.

(b) The Governor shall have the power to remove any appointed member of the Council from office in accordance with the provisions of G.S. 143B-16.

The Governor shall designate one member of the Council to serve as chairman at his pleasure. Members of the Council shall receive per diem and necessary travel and subsistence expenses in accordance with the provisions of G.S. 138-5.

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

All clerical and other services required by the council shall be supplied by the Secretary of Health and Human Services."

SECTION 3. G.S. 126-5(c1) is amended by adding a new subdivision to read:

"(36) The Director of Education and Employment Opportunities for Individuals with Intellectual and Developmental Disabilities."

SECTION 4. G.S. 115C-112.1(b) reads as rewritten:

The Council shall consist of a minimum of 2425 members to be appointed as follows: fourfive ex officio members; one individual with a disability and one representative of a private school appointed by the Governor; one member of the Senate and one parent of a child with a disability between the ages of birth and 26 appointed by the President Pro Tempore of the Senate; one member of the House of Representatives and one parent of a child with a disability appointed by the Speaker of the House of Representatives; and 14 members appointed by the State Board of Education. The State Board shall appoint members who represent individuals with disabilities. teachers, local school administrative units, institutions of higher education that prepare special education and related services personnel, administrators of programs for children with disabilities, charter schools, parents of children with disabilities, a State or local official who carries out activities under the federal McKinney-Vento Homeless Assistance Act, vocational, community, or business organizations concerned with the provision of transition services, and others as required by IDEA. The majority of members on the Council shall be individuals with disabilities or parents of children with disabilities. The Council shall designate a chairperson from among its members. The designation of the chairperson is subject to the approval of the State Board of Education. The Board shall adopt rules to carry out this subsection.

Ex officio members of the Council shall be the following:

- The Secretary of Health and Human Services or the Secretary's designee. (1)
- (2) The Secretary of Public Safety or the Secretary's designee.
- The Secretary of Public Safety Deputy Commissioner for the Division of Adult (3) Correction and Juvenile Justice or the Secretary's Deputy Commissioner's designee.
- The Superintendent of Public Instruction or the Superintendent's designee. (4)
- The Director of Education and Employment Opportunities for Individuals (5) with Intellectual and Developmental Disabilities.

The term of appointment for all members except those appointed by the State Board of Education is two years. The term for members appointed by the State Board of Education is four

 years. No person appointed by the State Board shall serve more than two consecutive four-year terms.

Each Council member shall serve without pay, but shall receive travel allowances and per diem in the same amount provided for members of the North Carolina General Assembly."

SECTION 5. Notwithstanding G.S. 143B-179.1, as enacted by this act, the Secretary of Health and Human Services shall appoint a Director of Education and Employment Opportunities for Individuals with Intellectual and Developmental Disabilities by October 1, 2018.

SECTION 6. Notwithstanding G.S. 143B-179.1(d), as enacted by this act, the Director of Education and Employment Opportunities for Individuals with Intellectual and Developmental Disabilities, after consultation with other divisions within the Department of Health and Human Services and the Department of Public Instruction, shall submit an initial report to the Joint Legislative Education Oversight Committee and the Joint Legislative Oversight Committee on Health and Human Services by March 1, 2019, with the following information:

- (1) A list of all State agencies, departments, divisions, councils, commissions, and units of State and local government with authority to (i) direct, manage, or provide funding; (ii) engage with federal agencies; and (iii) direct organizational or individual planning related to the preparation for and support of postsecondary education and employment for individuals with intellectual and developmental disabilities.
- (2) A list of current funding streams, including Medicaid and Medicaid waivers, federal funds other than from Medicaid, State funds, local funds, public and private grants, and all other sources of funding currently used or that are available for activities related to the preparation for and support of postsecondary education and employment for individuals with intellectual and developmental disabilities.
- (3) Data sets collected by State agencies, departments, divisions, councils, commissions, and units of State and local government, including local school administrative units and charter schools, and any other entities receiving public or publicly managed funds related to the preparation for and support of postsecondary education and employment for individuals with intellectual and developmental disabilities. This information shall include barriers to uniform collection and evaluation of relevant data among agencies.
- (4) Strategies to improve the coordination of (i) funding; (ii) data collection, evaluation, and reporting; and (iii) operational efficiencies for the purpose of allowing the fair assessment of outcomes, use of funds, gaps and overlaps in services and supports related to the preparation for and support of postsecondary education, and employment for individuals with intellectual and developmental disabilities.

SECTION 7. For the 2018-2019 fiscal year, there is appropriated from the General Fund to the Department of Health and Human Services the sum of up to one hundred fifty thousand dollars (\$150,000) in recurring funds for the salary and benefits of the Drector of Education and Employment Opportunities for Individuals with Intellectual and Developmental Disabilities and any necessary staff to the Director and for the Director's operating costs and the sum of up to eighteen thousand dollars (\$18,000) in nonrecurring funds for furniture and equipment costs in establishing the position.

SECTION 8. This act becomes effective July 1, 2018.

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House Bill 984-First Edition

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HOUSE BILL 982: IDD Data Sharing/Longitudinal Data System.

2017-2018 General Assembly

Committee: House Health. If favorable, re-refer to Date: May 30, 2018

Education - Universities

Introduced by: Reps. Bradford, Dollar, Lambeth, Sauls Prepared by: Jessica Boney

Analysis of: PCS to First Edition Staff Attorney

OVERVIEW: House Bill 982 would create a task force to study the collection and use of data on education and employment outcomes for individuals with intellectual and development disabilities ("IDD") through the North Carolina Longitudinal Data System ("Data System"). The bill is a recommendation from the Legislative Research Commission Committee on Intellectual and Developmental Disabilities.

The PCS would add a representative from North Carolina Independent Colleges and Universities to the task force and remove a representative from private colleges or universities.

BILL ANALYSIS:

- House Bill 982 would create a task force to study the collection and use of data on education and employment outcomes for individuals with IDD through the Data System.
- The task force would include representatives from: the Department of Health and Human Services, the Department of Public Instruction, the North Carolina Community College System, the University of North Carolina, local school administrative units and charter schools, North Carolina Independent Colleges and Universities, the Department of Commerce, the Department of Labor, the Department of Revenue, the North Carolina Postsecondary Education Alliance, and community organizations serving individuals with IDD.
- The task force would be required to consider:
 - Establishing uniform definitions of disability.
 - o Conducting an inventory of the unique individual identifiers used within each agency.
 - o Identifying common performance measures and establishing key indicators.
 - o Establishing a uniform length of time in which individuals are tracked.
 - o Developing interagency data sharing agreements.
 - o Identifying any limitations to sharing data.

EFFECTIVE DATE: This act is effective when it becomes law.

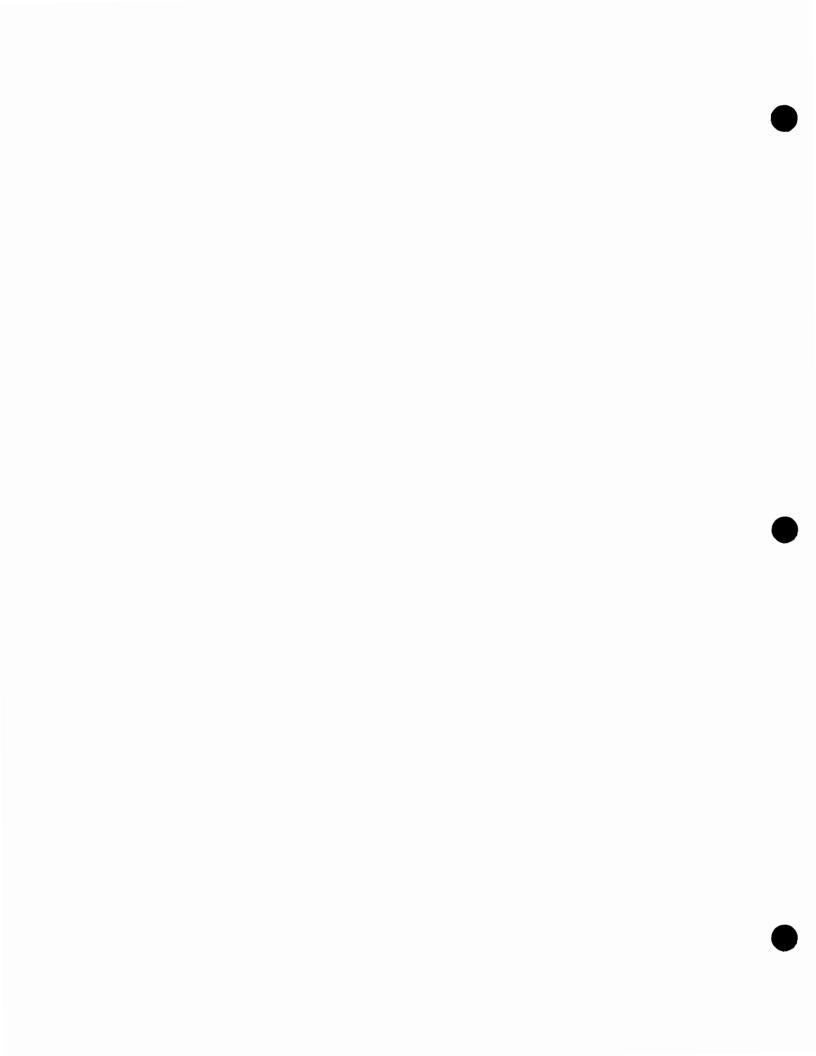
BACKGROUND: The Legislative Research Commission Committee on Intellectual and Developmental Disabilities presented the finding below in their 2018 report.

"There is a need for coordinated data collection and analysis among and across various State agencies and stakeholders in order to be able to evaluate program effectiveness."

Karen Cochrane-Brown Director



Legislative Analysis Division 919-733-2578



GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2017

H D

HOUSE BILL 982 PROPOSED COMMITTEE SUBSTITUTE H982-PCS30468-BP-3

Short Title:	IDD Data Sharing/Longitudinal Data System.	(Public)
Sponsors:		
Referred to:		

May 23, 2018

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE GOVERNMENT DATA ANALYTICS CENTER TO ESTABLISH A TASK FORCE TO STUDY THE COLLECTION AND USE OF DATA ON EDUCATION AND EMPLOYMENT OUTCOMES FOR INDIVIDUALS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES THROUGH THE NORTH CAROLINA LONGITUDINAL DATA SYSTEM, AS RECOMMENDED BY THE LEGISLATIVE RESEARCH COMMISSION COMMITTEE ON INTELLECTUAL AND DEVELOPMENTAL DISABILITIES.

The General Assembly of North Carolina enacts:

SECTION 1. The Government Data Analytics Center (GDAC) shall establish a task force to study the collection and use of data among State agencies and stakeholders to evaluate education and employment programs and services for individuals with intellectual and developmental disabilities as part of the North Carolina Longitudinal Data System (System), established pursuant to Chapter 116E of the General Statutes. The task force shall include representatives from at least the following State agencies and stakeholders:

- (1) The Department of Health and Human Services.
- (2) The Department of Public Instruction.
- (3) The North Carolina Community College System.
- (4) The University of North Carolina.
- (5) Local school administrative units and charter schools.
- (6) North Carolina Independent Colleges and Universities.
- (7) The Department of Commerce.
- (8) The Department of Labor.
- (9) The Department of Revenue.
- (10) The North Carolina Postsecondary Education Alliance.
- (11) Community organizations serving individuals with intellectual and developmental disabilities.

SECTION 2. The task force shall study issues related to collecting and sharing individual-level data among agencies through the System, including the Common Follow-Up System and NC SchoolWorks (P-20W), for the purpose of evaluating and reporting whether federal and State-supported education and employment programs and services for individuals with intellectual and developmental disabilities are effective in providing education and employment opportunities resulting in positive outcomes for those individuals. In doing so, the task force shall consider at least the following:

(1) Establishing uniform definitions of disability and requiring specificity by type of disability to be used in the collection of data among agencies.



Gen	eral Asseml	oly Of North Carolina Session 2017
	(2)	Conducting an inventory of the unique individual identifiers used within each agency and determining whether any identifiers need to be added to facilitate the sharing of data.
	(3)	Identifying common performance measures and establishing key indicators such as enrollment in postsecondary education or training, attainment of a postsecondary degree or credential, employment status and earnings, and poverty and receipt of public assistance.
	(4)	Establishing a uniform length of time in which individuals are tracked that is sufficient to evaluate long-term outcomes.
	(5)	Developing interagency data sharing agreements to facilitate the evaluation of data and reporting of outcomes.
	(6)	Identifying any limitations to sharing data through the System for the purpose of evaluating programs and services, including ensuring compliance with State and federal privacy laws, such as the Family Educational Rights and Privacy Act, the Internal Revenue Code, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The task force shall propose best practices for maximizing data sharing and the evaluation and reporting of data
	(7)	using the System within the parameters of State and federal privacy laws. Developing strategies to facilitate data sharing, evaluation, and reporting of outcomes of programs and services when the System cannot be utilized under certain circumstances, such as with small population sample sizes.
	SEC	FION 3. By October 1, 2018, GDAC shall report to the Joint Legislative
Educ		ight Committee and the Joint Legislative Oversight Committee on Health and
		s on the results of the study required by this act and any legislative
reco		s from the task force.
	SEC.	FION 4. This act is effective when it becomes law.

House Bill 982 H982-PCS30468-BP-3 Page 2

GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2017

H

HOUSE BILL 982

Short Title: IDD Data Sharing/Longitudinal Data System. (Public)

Sponsors: Representatives Bradford, Dollar, Lambeth, and Sauls (Primary Sponsors).

For a complete list of sponsors, refer to the North Carolina General Assembly web site.

Referred to: Health, if favorable, Education - Universities

May 23, 2018

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE GOVERNMENT DATA ANALYTICS CENTER TO ESTABLISH
A TASK FORCE TO STUDY THE COLLECTION AND USE OF DATA ON
EDUCATION AND EMPLOYMENT OUTCOMES FOR INDIVIDUALS WITH
INTELLECTUAL AND DEVELOPMENTAL DISABILITIES THROUGH THE NORTH
CAROLINA LONGITUDINAL DATA SYSTEM, AS RECOMMENDED BY THE
LEGISLATIVE RESEARCH COMMISSION COMMITTEE ON INTELLECTUAL AND
DEVELOPMENTAL DISABILITIES.

The General Assembly of North Carolina enacts:

SECTION 1. The Government Data Analytics Center (GDAC) shall establish a task force to study the collection and use of data among State agencies and stakeholders to evaluate education and employment programs and services for individuals with intellectual and developmental disabilities as part of the North Carolina Longitudinal Data System (System), established pursuant to Chapter 116E of the General Statutes. The task force shall include representatives from at least the following State agencies and stakeholders:

- (1) The Department of Health and Human Services.
- (2) The Department of Public Instruction.
- (3) The North Carolina Community College System.
- (4) The University of North Carolina.
 - (5) Local school administrative units and charter schools.
- (6) Private colleges or universities.
- (7) The Department of Commerce.
 - (8) The Department of Labor.
 - (9) The Department of Revenue.
 - (10) The North Carolina Postsecondary Education Alliance.
 - (11) Community organizations serving individuals with intellectual and developmental disabilities.

SECTION 2. The task force shall study issues related to collecting and sharing individual-level data among agencies through the System, including the Common Follow-Up System and NC SchoolWorks (P-20W), for the purpose of evaluating and reporting whether federal and State-supported education and employment programs and services for individuals with intellectual and developmental disabilities are effective in providing education and employment opportunities resulting in positive outcomes for those individuals. In doing so, the task force shall consider at least the following:



General Asser	nbly Of North Carolina	Session 2017
(1)	Establishing uniform definitions of disability and requiring s of disability to be used in the collection of data among agen	
(2)	Conducting an inventory of the unique individual identifiers agency and determining whether any identifiers need to be a the sharing of data.	used within each
(3)	Identifying common performance measures and establishing such as enrollment in postsecondary education or training postsecondary degree or credential, employment status a poverty and receipt of public assistance.	, attainment of a
(4)	Establishing a uniform length of time in which individuals a sufficient to evaluate long-term outcomes.	are tracked that is
(5)	Developing interagency data sharing agreements to facilitate data and reporting of outcomes.	the evaluation of
(6)	Identifying any limitations to sharing data through the System of evaluating programs and services, including ensuring State and federal privacy laws, such as the Family Educate Privacy Act, the Internal Revenue Code, and the Health Insurance Code,	compliance with tional Rights and
	and Accountability Act of 1996 (HIPAA). The task force s practices for maximizing data sharing and the evaluation and	hall propose best reporting of data
(7)	using the System within the parameters of State and federal Developing strategies to facilitate data sharing, evaluation,	and reporting of
	outcomes of programs and services when the System cannot certain circumstances, such as with small population sample	e sizes.
	CTION 3. By October 1, 2018, GDAC shall report to the	
	rsight Committee and the Joint Legislative Oversight Committ	
numan servic	es on the results of the study required by this act and	any legisiative

recommendations from the task force. **SECTION 4.** This act is effective when it becomes law.

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HOUSE BILL 983: ABLE Act Changes/Study.

2017-2018 General Assembly

Committee:House Health. If favorable, re-refer to FinanceDate:May 29, 2018Introduced by:Reps. Bradford, Dollar, Lambeth, SaulsPrepared by:Theresa MatulaAnalysis of:First EditionLegislative Analyst

OVERVIEW: House Bill 983 would allow funds from a Parental Savings Trust Fund to rollover to an ABLE (Achieving a Better Life Experience) account without the funds being treated as income and direct the ABLE Board of Trustees to report any recommendations for legislative modifications to the ABLE Program by December 1, 2018. The bill was a recommendation from the Joint Legislative Research Commission, Committee on Intellectual and Developmental Disabilities.

BILL ANALYSIS:

Under current law, G.S. 105-153.5(c) outlines the items that an individual taxpayer must add to the taxpayer's adjusted gross income if they are not already included. Subdivision (7) under this subsection addresses amounts withdrawn from the Parental Savings Trust Fund of the State Education Assistance Authority and not used to pay for qualified higher education expenses of the designated beneficiary unless the withdrawal was made due to the death or permanent disability of the designated beneficiary. **Section 1** of House Bill 983 excludes amounts withdrawn from the Parental Savings Trust Fund and not used to pay for the qualified higher education expenses of the designated beneficiary if the withdrawal was made pursuant to section 529 of the Code and was rolled over to an ABLE account established and owned by an eligible individual and maintained under Chapter 147, Article 6F Achieving a Better Life Experience Program Trust.

Section 2 of the bill requires the ABLE Board of Trustees to report to the Joint Legislative Oversight Committee on Health and Human Services and the Joint Legislative Oversight Committee on General Government recommendations for legislative modifications that may be needed to the ABLE Act. The report may include recommendations pertaining to recent changes to federal law and improvements for administration of the program and must be made by December 1, 2018.

EFFECTIVE DATE: Section 1, containing the amendment to tax statutes, is effective for taxable years beginning on or after January 1, 2018. The remainder of the act is effective when it becomes law.

BACKGROUND: Congress enacted the ABLE Program as provided under the Tax Increase Prevention Act of 2014, Pub. L. No. 113-295. S.L. 2015-203 established the ABLE Act in North Carolina. The ABLE Program Trust is administered by the ABLE Program Board of Trustees and enables contributors to save funds to meet the costs of the qualified disability expenses of eligible individuals.

The Legislative Research Commission, Committee on Intellectual and Developmental Disabilities, presented the finding below in their 2018 report.

"A change in federal law applicable to ABLE accounts was recently enacted on December 22, 2017, when President Trump signed H.R. 1, the Tax Cuts and Jobs Act, into law. Federal law now allows the rollover of funds from 529 qualified tuition plans into 529A (ABLE) accounts, up to the annual maximum contribution amount. Modifying State law to

Karen Cochrane-Brown Director



Legislative Analysis Division 919-733-2578

House Bill 983

Page 2

exempt a withdrawal of funds from a Parental Savings Trust Fund when rolled over to an ABLE account from the requirement that the withdrawn funds be added to the taxpayer's adjusted gross income would preserve the intent of tax exclusions already granted to holders of Parental Savings Trust Funds and would be beneficial to individuals with IDD. Additional changes to State law applicable to ABLE accounts that would benefit individuals with IDD and promote their ability to work should be explored further."

The NC ABLE Program's Annual Evaluation and Report for 2017 was provided to the Joint Legislative Oversight Committee on Health and Human Services and the Joint Legislative Oversight Committee on General Government on February 14, 2018.

GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2017

H HOUSE BILL 983

Short Title:	ABLE Act Changes/Study.	(Public)
Sponsors:	Representatives Bradford, Dollar, Lambeth, and Sauls (Presentatives Bradford, Dollar, Bradford, Dollar, Bradford, Bradfo	
Referred to:	Health, if favorable, Finance	ierui iissemoty web suc.

May 23, 2018

A BILL TO BE ENTITLED

AN ACT TO ALLOW FOR FUNDS FROM THE PARENTAL SAVINGS TRUST FUND TO ROLLOVER TO AN ABLE ACCOUNT WITHOUT THE FUNDS BEING CONSIDERED AS INCOME AND TO DIRECT THE ABLE PROGRAM BOARD OF TRUSTEES TO REPORT ON ANY LEGISLATIVE RECOMMENDATIONS FOR MODIFICATIONS TO THE STATE ABLE ACT, AS RECOMMENDED BY THE LEGISLATIVE RESEARCH COMMISSION COMMITTEE ON INTELLECTUAL AND DEVELOPMENTAL DISABILITIES.

The General Assembly of North Carolina enacts:

1 2

SECTION 1. G.S. 105-153.5(c)(7) reads as rewritten:

"(7) The amount deducted in a prior taxable year to the extent this amount was withdrawn from the Parental Savings Trust Fund of the State Education Assistance Authority established pursuant to G.S. 116-209.25 and not used to pay for the qualified higher education expenses of the designated beneficiary, unless the withdrawal was made <u>pursuant to section 529 of the Code and was either (i)</u> without penalty <u>under section 529 of the Code</u> due to the death or permanent disability of the designated <u>beneficiary.beneficiary or (ii) rolled</u> over to an ABLE account as defined in G.S. 147-86.70(b)."

SECTION 2. By December 1, 2018, the ABLE Program Board of Trustees (Board) shall report to the Joint Legislative Oversight Committee on Health and Human Services and the Joint Legislative Oversight Committee on General Government on legislative recommendations for modifications to the Achieving a Better Life Experience (ABLE) Program Trust and its related statutes consistent with the federal ABLE Act. The Board shall include recommendations regarding any recent changes in the federal law and improvements for the administration of the program.

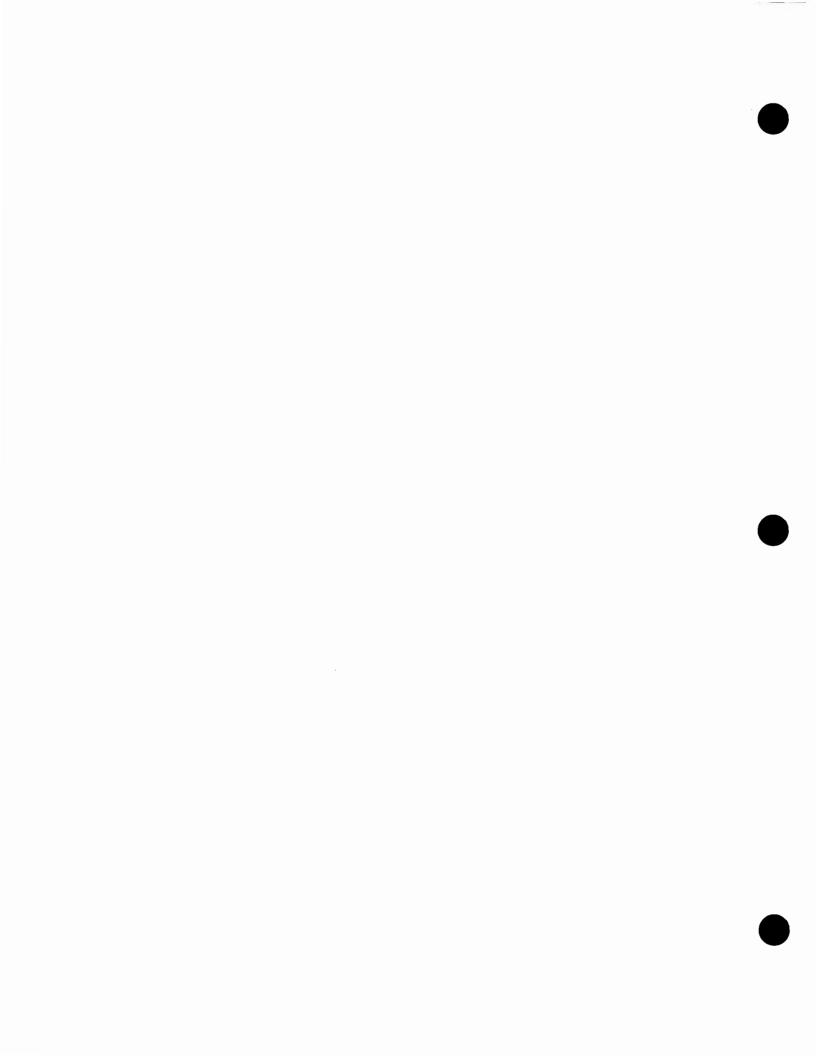
SECTION 3. Section 1 of this act is effective for taxable years beginning on or after January 1, 2018. The remainder of this act is effective when this act becomes law.



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Committee Sergeants at Arms

NAME OF COMMITTEE House Committee on Health		
DATE: _5/30/2018	Room: 643	
	House Sgt-At Arms:	
1. Name: Warren Hawkins		
2. Name: Rex Foster		
Name: Doug Harris		
4. Name: Malachi McCullough, Jr		
5. Name:	-	
	Senate Sgt-At Arms:	
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House Pages Assignments Wednesday, May 30, 2018 Session: 12:30 PM

Member	Comments	Staff	Time	Room	Committee
Rep. Larry Yarborough		John Cooper	11:00 AM	643	Health
Rep. Becky Carney		Reilly Gallagher			
Rep. Tim Moore		Quinn Rollar			
Rep. Graig R. Meyer		Sofia Yeganian			
Rep. Tim Moore		Cole Aganad	1:00 PM	Other	State and Local Government
Rep. William O. Richardson		Gaaron Goldsmith			
Rep. Tim Moore		Patrick McElligott			
Rep. Edward Hanes, Jr.		Alyson Thompson			
Rep. Gregory F. Murphy, M.D.		Anna Lee	2:00 PM	1228/1327	Regulatory Reform
Rep. Jean Farmer- Butterfield		Hayden Savery			
Rep. Garland E. Pierce		Bailey Sloop			
Rep. Larry Yarborough		John Cooper	3:00 PM	643	Education - K-12
Rep. Becky Carney		Reilly Gallagher			
Rep. Chris Malone		Hannah Pippin			
Rep. Tim Moore		Quinn Rollar			

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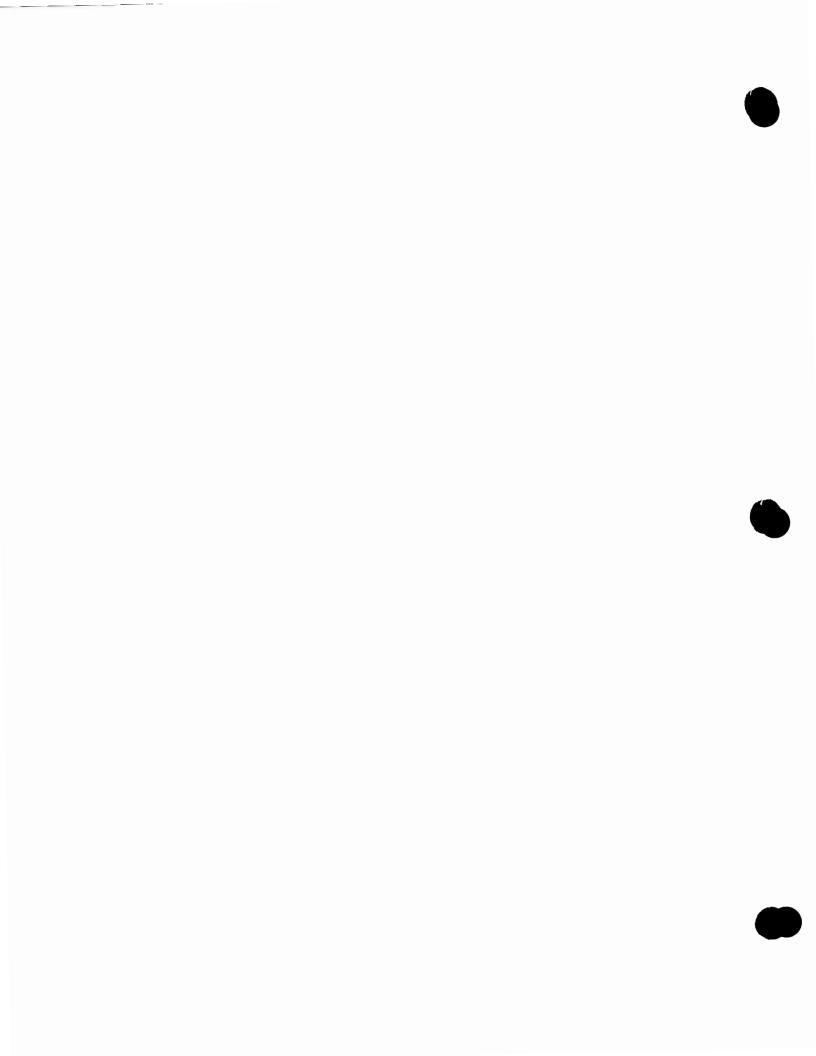
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5/30/18

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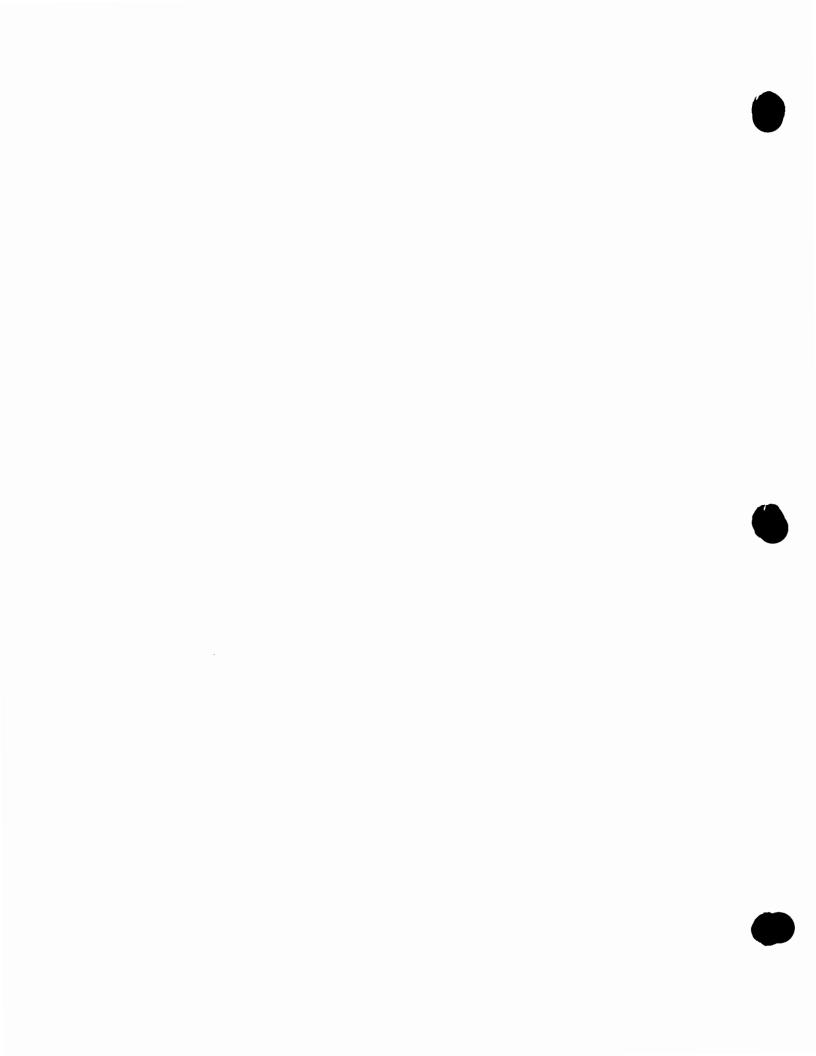
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Name of Committee

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Jamaira Phister	Ct-15
Flan	Bore : Asso.
Katharne Dlovas	NCAPA
JOHN W RUSHER	NC Peda Society
Molly Tesch	No leas society / Pediatric Dentistry
Lauren Green	NC Peds Society / Pediatric Dentistry
Kerry A. Dovc	NC Peds Society/ NC Academy



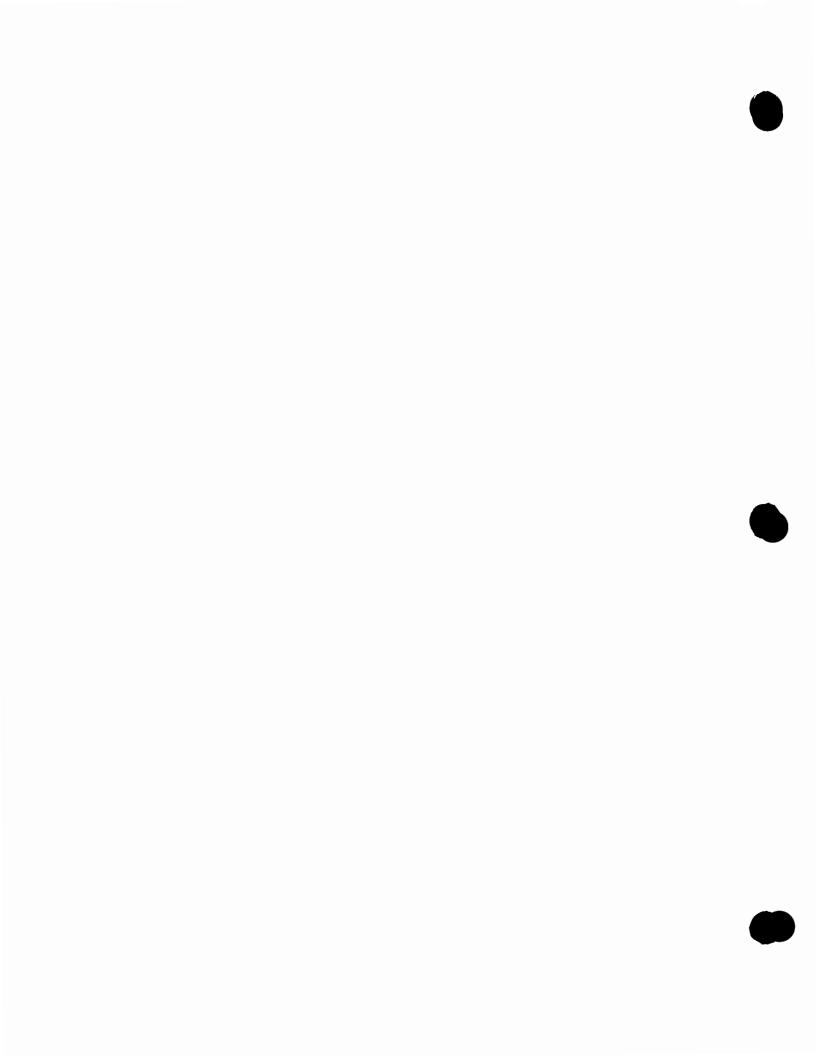
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5/30/18

Name of Committee

Date

NAME	FIRM OR AGENCY AND ADDRESS
Elmira Powell	NC Academy of Physician Assistants 1121 Slater R.J. Durham, U.C.
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Brandon Heavner	Mutual Day
Robert Rominger, PhD	NC Chapter of American Foundation Cor Suicide Prevention
Nina Rominger	NC AFSP
AMES SIMMONS	EQUALITY NC
Woodis bollong	NCAI
Yusin Elans	DRNC
Nick Oravetz	NCAPA
bok Montana	ECU Michaelog Mary Schol.
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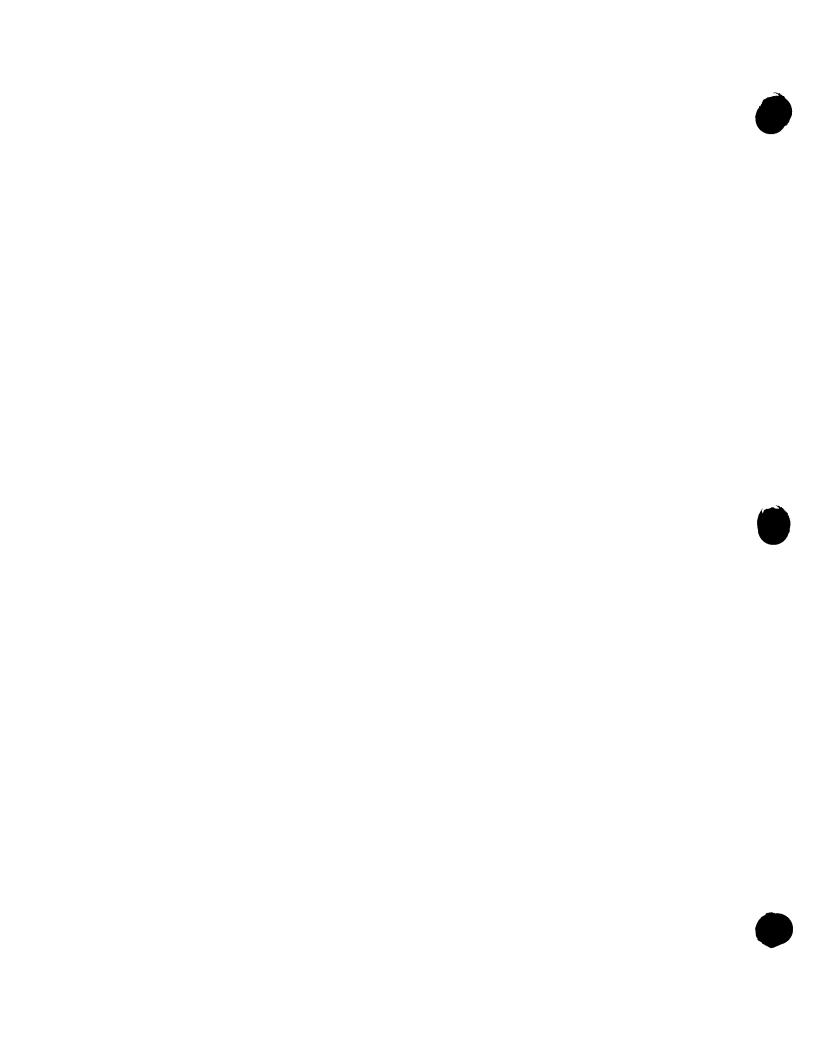


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NAME	FIRM OR AGENCY AND ADDRESS
Tanya Darrow	MARAGI
Handa Hancock, PA-C	NCAPA 1221 States Dr., Durham, NC
Jettrey Katz PA-C	NAPA
Morgan Danley	MCAPA
Emily Adams	NCAPA
Alexis Perm	NCAPA
FRANK STOOKSBURY	NCAPA
Carly Armato	NCAPA
Chris Barry, PA-C	NCAPA
Laura Gerstner, PA-C	
Truett Smith PAC	NCAPA



HEALTH

5/30/14

Name of Committee

Date

NAME	FIRM OR AGENCY AND ADDRESS
Jessica Leuritenlang	UNC Medical School & MC Medical Society
Molly Crenshaw	L
JasmineSinkhada	13
Jasnine Gornell	NCAPA
Anna Reavis	Rep. Zachary Intern
Betty Hone Johnson	NCAPA
Joshua F. Smith	NCAPA
Marc Kate	NEAPH
April Stouder	NCAPA
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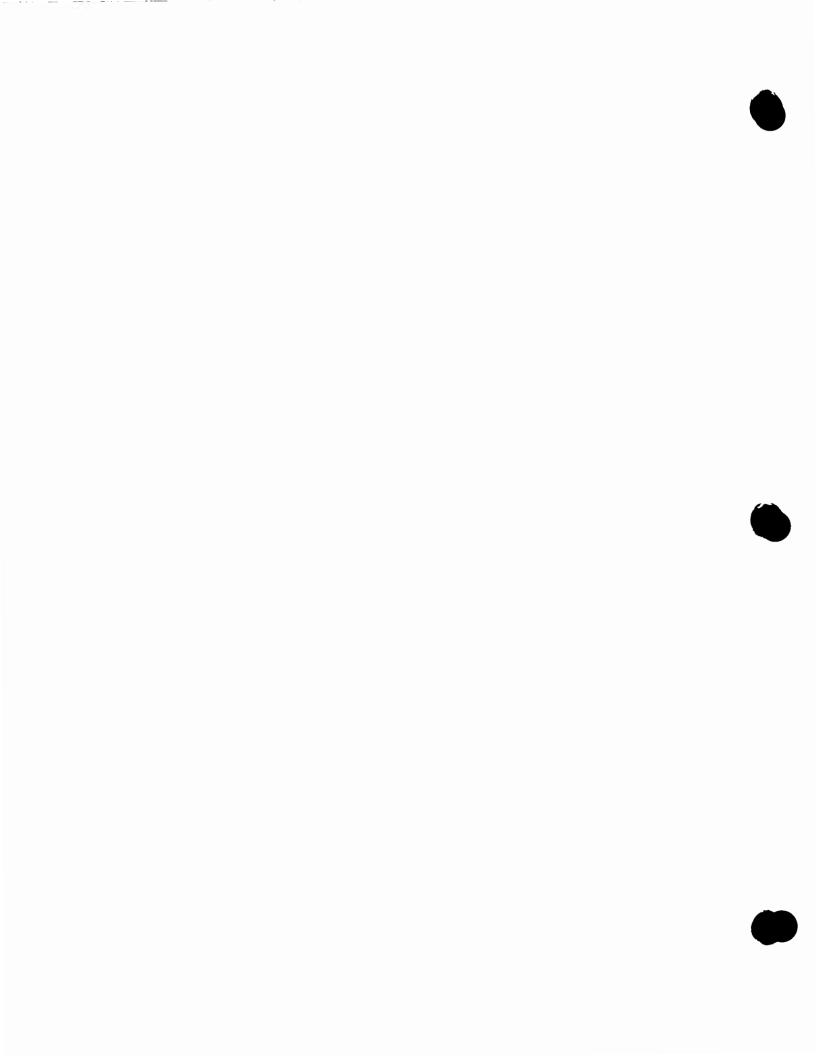
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Name of Committee

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Matt Gras	104179
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Jesse Powell	National ms society
ALEC Parker	National ms society NC Deutel Society
JAMES BIALLE	XC 013 642 500-
Kara Weislaan	SX



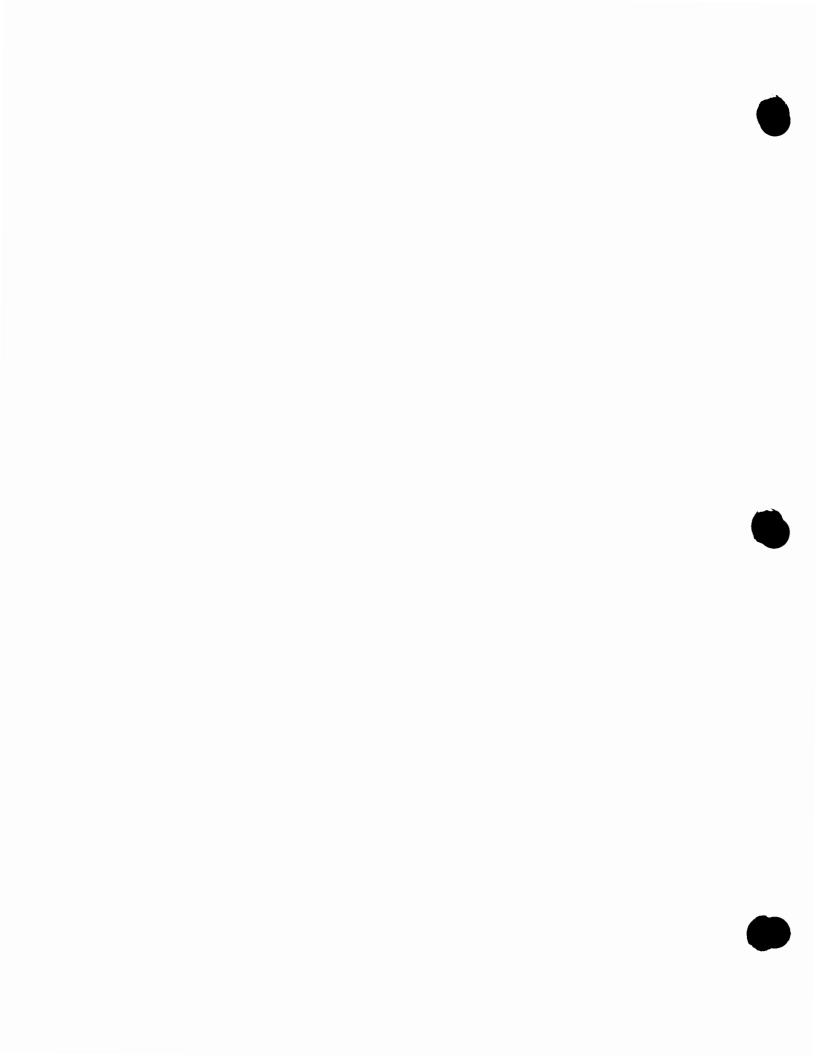
HEALTH

5/30/18

Name of Committee

Date

NAME	FIRM OR AGENCY AND ADDRESS
Mary Carr Allen	NCAPA
Jasmine Hommings	MCAPA
Muly Calabria	NCAPA
Stefanie Reed	NC Prots Society
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Kelli Wheeler	NC Peds Society
Elizabeth Mers	NC Pedanics Secrety
Krista Sirois	NC Pediatrics Society
Jennifer Smith	NC Pediatrics Society



House Committee on Health Wednesday, June 6, 2018 at 10:00 AM Room 643 of the Legislative Office Building

MINUTES

The House Committee on Health met at 10:00 AM on June 6, 2018 in Room 643 of the Legislative Office Building. Representatives Adcock, Ball, Blackwell, Boswell, Brisson, Carney, Cunningham, Dobson, Dollar, Dulin, Howard, Hunter, Insko, Bert Jones, Lambeth, Lucas, Murphy, Potts, Setzer, Shepard, Szoka, White, Yarborough, and Zachary attended.

Representative Nelson Dollar, Chair, presided.

The following bills were considered:

SB 616 Heroin & Opioid Prevention & Enforcement Act. (Senator J. Davis)

Chairman Dollar asked for a motion for the PCS for SB616 to be before the committee. Representative Howard made the motion and the motion passes.

Representative Horn and Murphy were recognized to explain the bill. The PCS to Senate Bill 616 does the following: Amends laws pertaining to the North Carolina Controlled Substances Act and the North Carolina Controlled Substances Reporting System Act, and revises and creates penalties for certain violations. It expresses the intent to appropriate additional funds in the future for community-based substance use disorder treatment and recovery services, the purchase of overdose medications, Operation Medicine Drop, and a special agent position within the State Bureau of Investigations (SBI).

After discussion from the committee Representative Lucas motioned for a favorable report to the PCS, unfavorable to the original bill and re-referred to Judiciary 1. The motion passes.

HB 967 Telemedicine Policy. (Representatives Lambeth, Dobson)

Chairman Dollar asked for a motion for the PCS for HB967 to be before the committee. Representative Jones made the motion and the motion passes.

Chairman Dollar recognized Representative Lambeth and Dobson to explain the Bill. The Proposed Committee Substitute to House Bill 967 would require the Department of Health and Human Services to study and report on requirements for insurance reimbursement of telemedicine, a broadband policy to ensure all North Carolina residents have access to telemedicine, standards for assessing the quality of telemedical care, and licensing requirements for telemedicine providers. The PCS removes the codified language from the original bill and leaves the study requirements.

After the explanation of the bill Representative Lambeth sent forth an amendment. The amendment was adopted. (Attachment 1)



After discussion from the committee Representative Lambeth motions for a favorable report to the PCS as amended and rolled into a new PCS, unfavorable to the original bill. The motion passes.

HB 981 State as a Model Employer/IDD. (Representatives Bradford, Dollar, Lambeth, Sauls)

Chairman Dollar recognized Representative Bradford to explain HB981. The bill requires the Department of Health and Human Services (DHHS), in consultation with the Office of State Human Resources (OSHR), to study the development and implementation of a statewide program that establishes the State as a model employer in the employment of individuals with disabilities and report to the Joint Legislative Oversight Committee on Health and Human Services by December 1, 2018. The bill is a recommendation from the Joint Legislative Research Commission, Committee on Intellectual and Developmental Disabilities.

After brief discussion from members of the committee Representative Carney made a motion for a favorable report. The motion passes.

HB 998 GME/Rural Hospital Study. (Representatives Lewis, Murphy, White, Hunter)

Chairman Dollar asked for a motion for the PCS for HB998 to be before the committee. Representative Lambeth made the motion and the motion passes.

Chairman Dollar recognized Representative Murphy to explain HB 998. The PCS for HB 998 directs the Department of Health and Human Services (DHHS) to study incentives for medical education in rural areas and assist rural hospitals in becoming designated as teaching hospitals; directs the Office of Rural Health, DHHS, to ensure the loan repayment program is targeted to benefit health care providers in rural areas, and to identify the need for dentists in rural areas; and directs DHHS to study changes to the Medicaid Program that will increase preventative health services, improve health outcomes, and lower the cost of care. The PCS for HB 998 combines HB 998, Section 2 of HB 999, and Section 2 from HB 1000, which were recommendations from the Legislative Research Commission, Committee on Access to Healthcare in Rural NC.

After the explanation of the bill 2 amendments were offered. Chairman Dollar recognized Representative Murphy to send forth his amendment. The amendment was adopted. (Attachment 2)

Chairman Dollar recognized Representative Adcock to send forth her amendment. The amendment was adopted. (Attachment 3)

Representative Insko made the motion for a favorable report to the PCS as amended and rolled into a new PCS, unfavorable to the original bill. The motion passes.

HB 1002 Medical Education & Residency Study. (Representatives Lambeth, Horn, Dobson, Johnson)



Chairman Dollar recognized Representative Lambeth to explain the bill. House Bill 1002 would allow the Joint Legislative Oversight Committee on Health and Human Services and the Joint Legislative Education Oversight Committee to appoint subcommittees, which may meet jointly or separately, to study various issues regarding state support for medical education and residency programs with the goal of developing a plan to support those programs in a manner that maximizes state support and best addresses the healthcare needs of North Carolina residents, particularly those in rural areas. It would also require the Department of Health and Human Services to study and report on Medicaid funding for medical education and residency programs. This bill was recommended by the Joint Legislative Oversight Committee on Health and Human Services and the Joint Legislative Education Oversight Committee.

After explanation of the bill Representative Lambeth sent forth an amendment. The amendment was adopted. (Attachment 4)

After discussion from the committee members Representative Lambeth made the motion for a favorable report to HB1002 as amended, unfavorable to the original bill. The motion passes.

The meeting adjourned at 10:45 PM.

elson Dollar, Chair

Presiding

Theresa Lopez, Committee Clerk



NORTH CAROLINA HOUSE OF REPRESENTATIVES COMMITTEE MEETING NOTICE AND BILL SPONSOR NOTIFICATION 2017-2018 SESSION

You are hereby notified that the House Committee on Health will meet as follows:

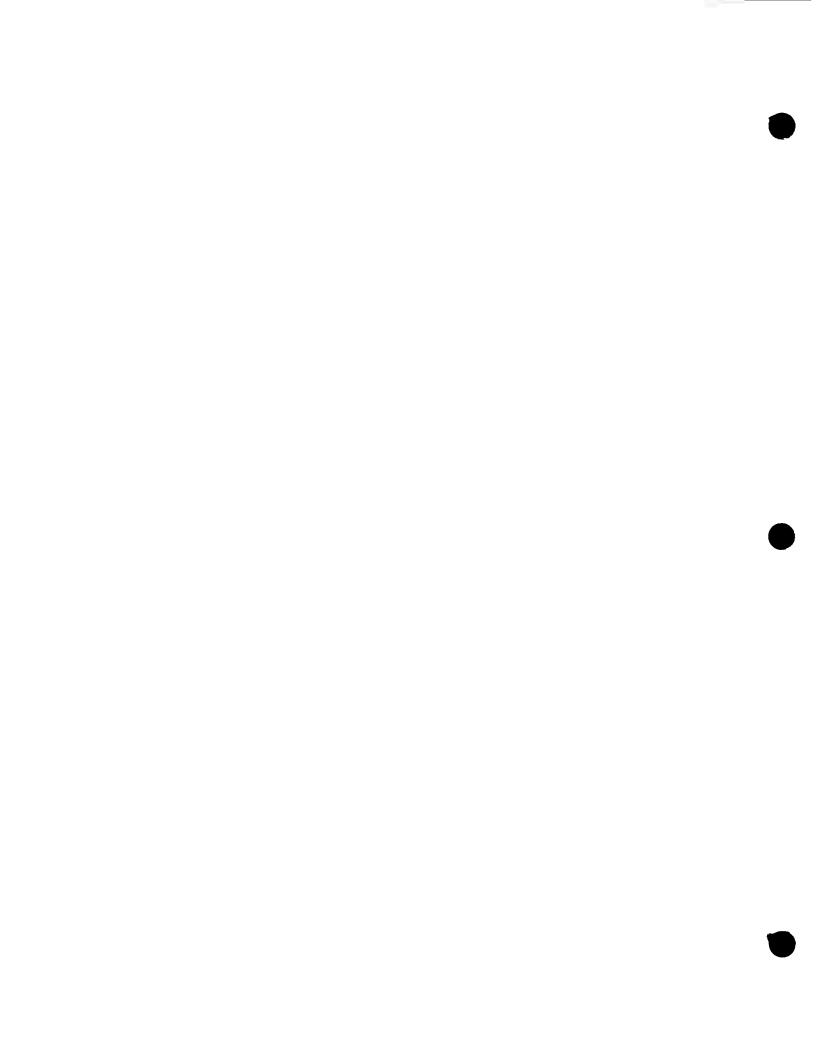
DAY & DATE: Wednesday, June 6, 2018

TIME: 10:00 AM LOCATION: 643 LOB

COMMENTS: Representative Dollar is the presiding Chair.

The following bills will be considered:

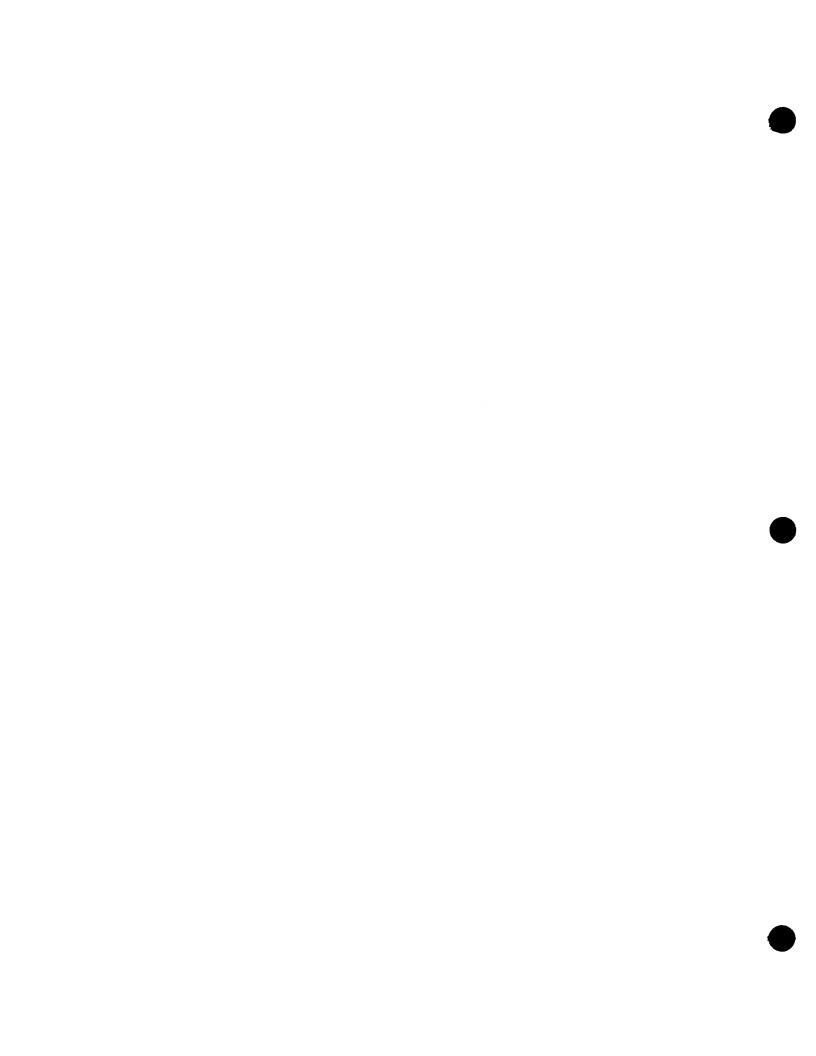
BILL NO.	SHORT TITLE	SPONSOR
<u>SB 616</u>	Heroin & Opioid Prevention &	Senator J. Davis
	Enforcement Act.	
<u>HB 967</u>	Telemedicine Policy.	Representative Lambeth
		Representative Dobson
<u>HB 981</u>	State as a Model Employer/IDD.	Representative Bradford
		Representative Dollar
		Representative Lambeth
		Representative Sauls
HB 998	Improving NC Rural Health.	Representative Lewis
		Representative Murphy
		Representative White
		Representative Hunter
HB 1002	Medical Education & Residency Study.	Representative Lambeth
		Representative Horn
		Representative Dobson
		Representative Johnson



Respectfully,

Representative Josh Dobson, Co-Chair Representative Nelson Dollar, Co-Chair Representative Bert Jones, Co-Chair Representative Donny Lambeth, Co-Chair Representative Gregory F. Murphy, MD, Co-Chair

I hereby certify this notice was filed by the committee assistant at the following offices at 8:59 AM on Tuesday, June 26, 2018.
Principal Clerk Reading Clerk – House Chamber
Theresa Lopez (Committee Assistant)



House Committee on Health Wednesday, June 6, 2018, 10:00 AM 643 Legislative Office Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

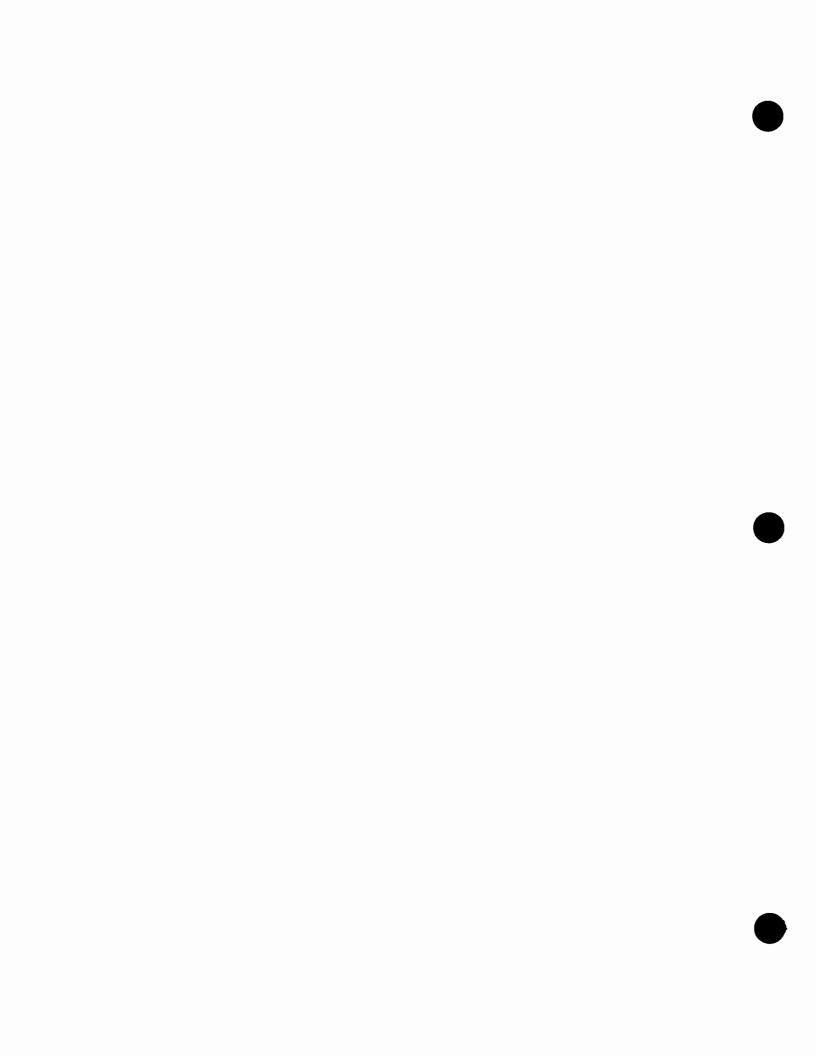
Bills

BILL NO.	SHORT TITLE	SPONSOR
SB 616	Limit Look-Back for Immaterial Irregularities.	Senator J. Davis
HB 967	e e e e e e e e e e e e e e e e e e e	Danna antationa I ambath
HD 907	Telemedicine Policy.	Representative Lambeth
		Representative Dobson
HB 981	State as a Model Employer/IDD.	Representative Bradford
		Representative Dollar
		Representative Lambeth
		Representative Sauls
HB 998	GME/Rural Hospital Study.	Representative Lewis
		Representative Murphy
		Representative White
		Representative Hunter
HB 1002	Medical Education & Residency Study.	Representative Lambeth
		Representative Horn
		Representative Dobson
		Representative Johnson

Presentations

Other Business

Adjournment



NORTH CAROLINA GENERAL ASSEMBLY **HOUSE OF REPRESENTATIVES**

HEALTH COMMITTEE REPORT

Representative Josh Dobson, Co-Chair Representative Nelson Dollar, Co-Chair Representative Bert Jones, Co-Chair Representative Donny Lambeth, Co-Chair Representative Gregory F. Murphy, MD, Co-Chair

FAVORABLE HOUSE COM SUB, UNFAVORABLE SENATE COM SUB AND RE-REFERRED

SB616 (CS#1) Limit Look-Back for Immaterial Irregularities.

Draft Number:

S616-PCS35363-TTa-42

Serial Referral:

JUDICIARY I

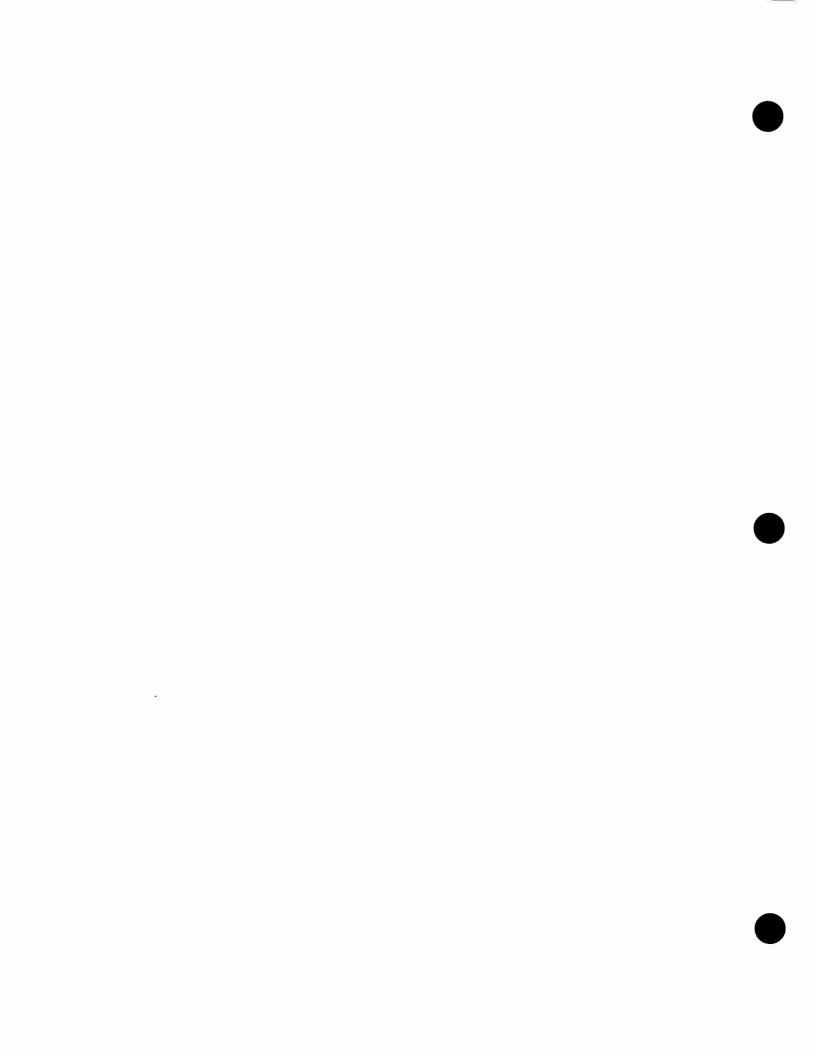
Recommended Referral: None Long Title Amended:

Yes

Floor Manager: Murphy

TOTAL REPORTED: 1





NORTH CAROLINA GENERAL ASSEMBLY HOUSE OF REPRESENTATIVES

HEALTH COMMITTEE REPORT

Representative Josh Dobson, Co-Chair Representative Nelson Dollar, Co-Chair Representative Bert Jones, Co-Chair Representative Donny Lambeth, Co-Chair Representative Gregory F. Murphy, MD, Co-Chair

FAVORABLE

НВ 981 State as a Model Employer/IDD.

> Draft Number: Serial Referral:

Recommended Referral: None Long Title Amended:

Bradford Floor Manager:

FAVORABLE COM SUB, UNFAVORABLE ORIGINAL BILL

HB 967 Telemedicine Policy.

Draft Number:

H967-PCS40751-BC-38

Serial Referral: Recommended Referral: None Long Title Amended:

Yes

None

None

None

No

Floor Manager:

Lambeth

GME/Rural Hospital Study. HB 998

Draft Number:

H998-PCS10484-SH-35

Serial Referral: Recommended Referral: None

None Yes

Long Title Amended: Floor Manager:

Murphy

HB 1002 Medical Education & Residency Study.

Draft Number:

H1002-PCS40750-BC-39

Serial Referral:

None

Recommended Referral: None Long Title Amended:

No

Floor Manager:

Lambeth

TOTAL REPORTED: 4



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NORTH CAROLINA GENERAL ASSEMBLY **AMENDMENT** House Bill 967*

AMENDMENT NO. (to be filled in by Principal Clerk) H967-ABC-34 [v.1] Page 1 of 1 Date 6/4/18 Amends Title [NO] First Edition Representative Lambeth moves to amend the bill on page 1, line 25 by rewriting the line to read: 1 The projected budget impact result if Medicaid and North Carolina Health Choice reimbursed for care provided via telemedicine in accordance with licensure regulations for appropriate existing covered services. Any other issues the Department deems appropriate." (8) 6 SIGNED mendment Sponsor **SIGNED** Committee Chair if Senate Committee Amendment

FAILED

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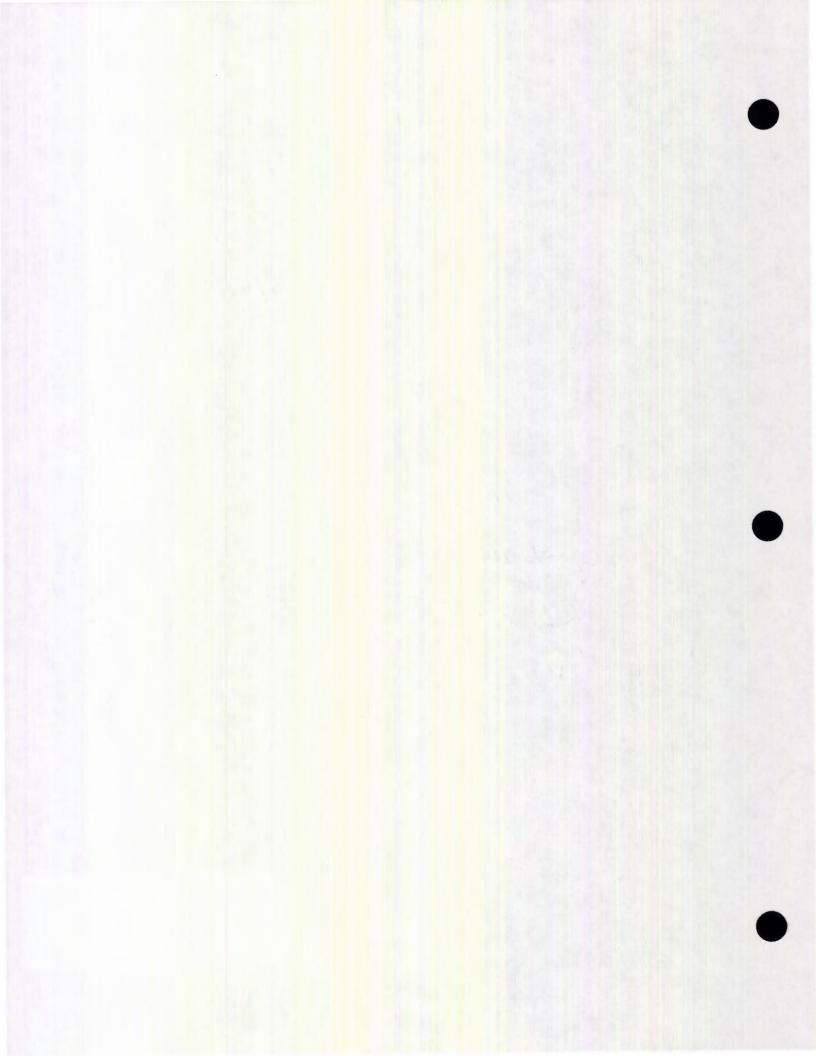
7

ADOPTED

Attachment 1

TABLED







NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT House Bill 998*

H998-ASH-34 [v.2] (to be filled in by Principal Clerk)

Page 1 of 2

Amends Title [NO] H998-CSSH-998 AMENDMENT NO.

Representative

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moves to amend the PCS on page 1, line 11-14, by rewriting the lines to read:

"RURAL AREAS; AND TO DIRECT THE PROGRAM EVALUATION DIVISION TO STUDY THE STATE HEALTH PLAN AND TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO STUDY CHANGES TO THE MEDICAID PROGRAM, THAT WILL INCREASE PREVENTATIVE HEALTH SERVICES, IMPROVE HEALTH OUTCOMES, AND LOWER THE COST OF CARE.",

And on page 3, lines 4-5, by rewriting the lines to read:

"PART III. STUDY STATE HEALTH PLAN AND MEDICAID

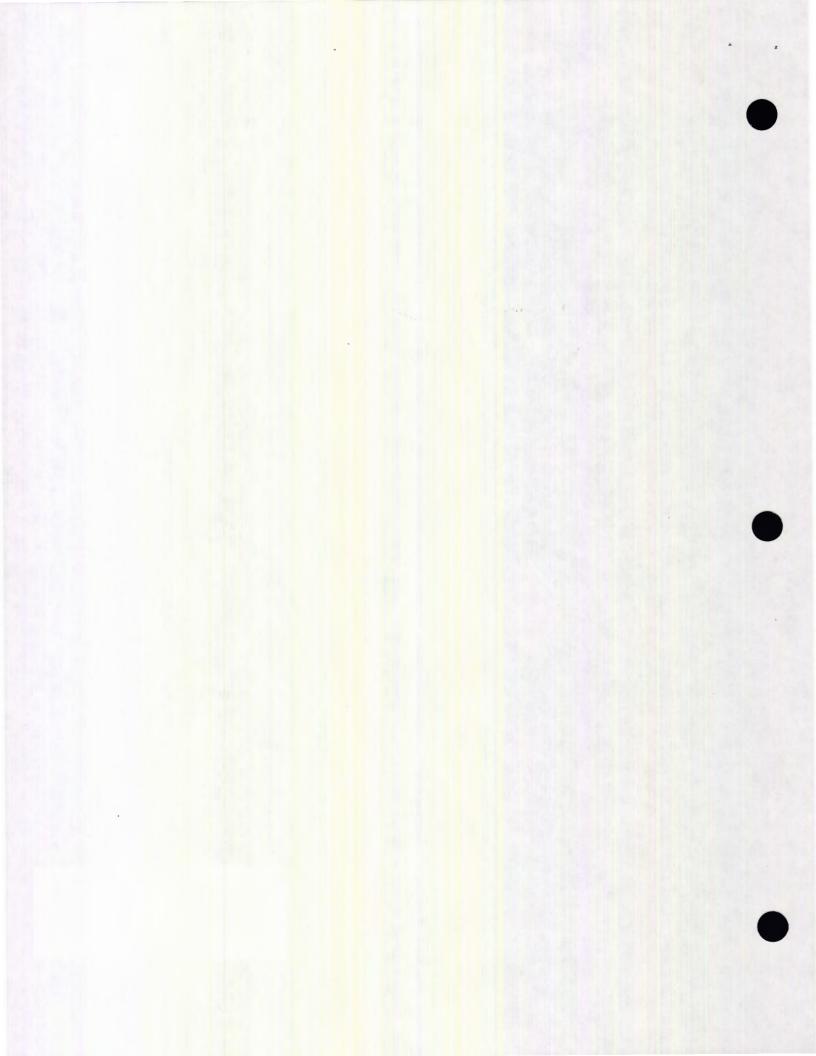
SECTION 4. The Joint Legislative Program Evaluation Oversight Committee shall include in the work plan of the Program Evaluation Division an evaluation of the State Health Plan to determine whether there are changes that will increase preventative health services, improve health outcomes, and lower the overall cost of care. The alternatives studied should include evaluation of the direct primary care model. The study shall determine the following: (i) the contract options for improving primary care physician quality of life in a rural setting that include, but are not limited to, a direct primary care type payment model and (ii) the total cost implications and legislation needed to implement recommendations. The Program Evaluation Division shall report its findings and recommendations to the Joint Legislative Program Evaluation Oversight Committee on or before March 1, 2019.

SECTION 5. The Department of Health and Human Services shall study whether";

And by renumbering the remaining section..

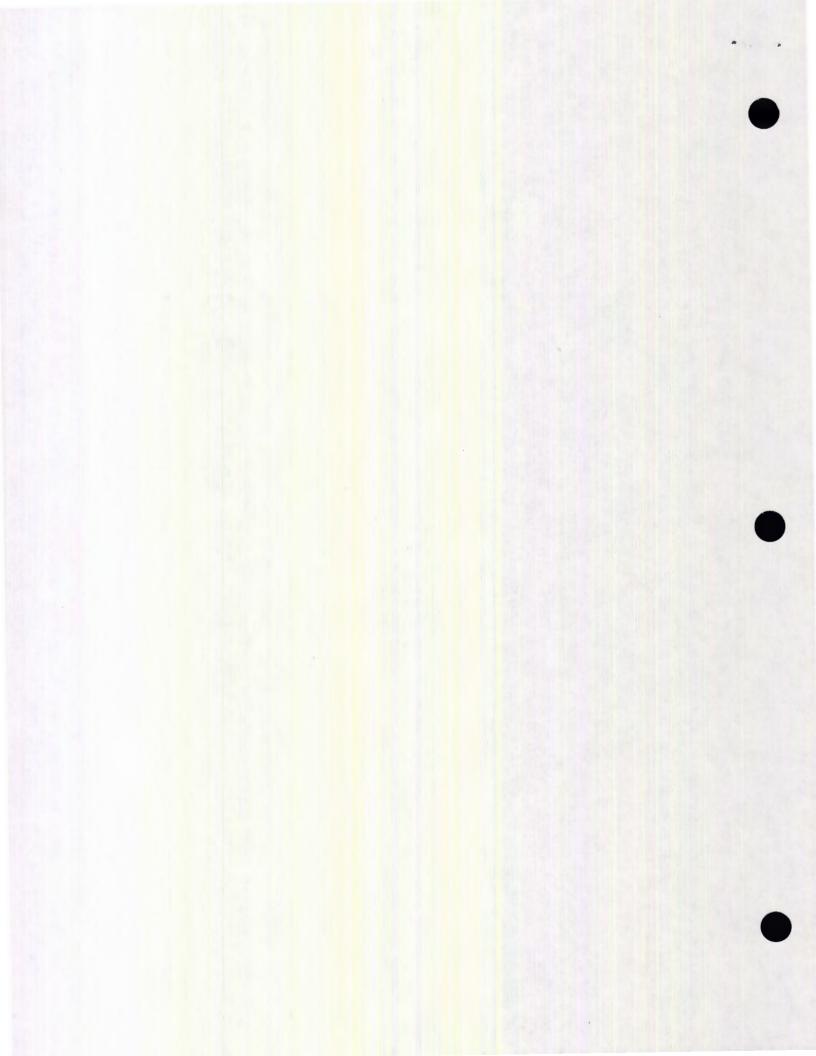
Attachment 2





NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT House Bill 998*

(to	ENDMENT NO. be filled in by incipal Clerk)	
		Page 2 of 2
SIGNED Amendment Sponsor		
SIGNED Committee Chair if Senate Committee Amendment		
Committee Chair II Senate Committee Amendment		
ADOPTED FAILED	TABLED	



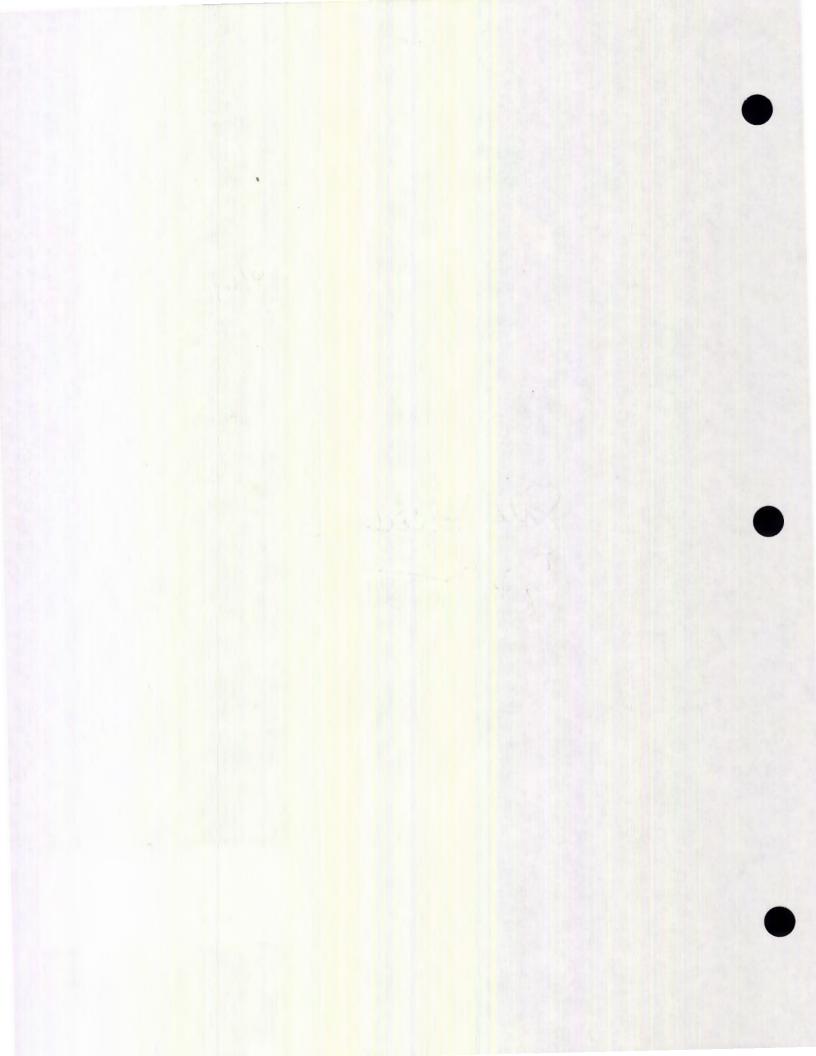


NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT House Bill 998*

	H998-ASH-33 [v.2]	(to be filled in by Principal Clerk)	Page 1 of 1
	Amends Title [NO] H998-CSSH-998	Date6/6/	,2018
	Representative Adcock		
1	moves to amend the PCS on page 3, line 1	1, by rewriting the line to read:	
2 3 4 5	"primary care provider quality of life in a direct".	a rural setting that include, but are no	t limited to, a
	SIGNED Amendment S	Sponsor	
	SIGNED Committee Chair if Senate C	committee Amendment	
	ADOPTED FAILER	TABLED	

Attachment 3







NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT House Bill 1002*

H1002-ABC-30 [v.3]

AMENDMENT NO. (to be filled in by Principal Clerk)

Page 1 of 2

Amends Title [NO]
First Edition

LAMBETH

Representative Lewis

Date 6/6/18 ,2018

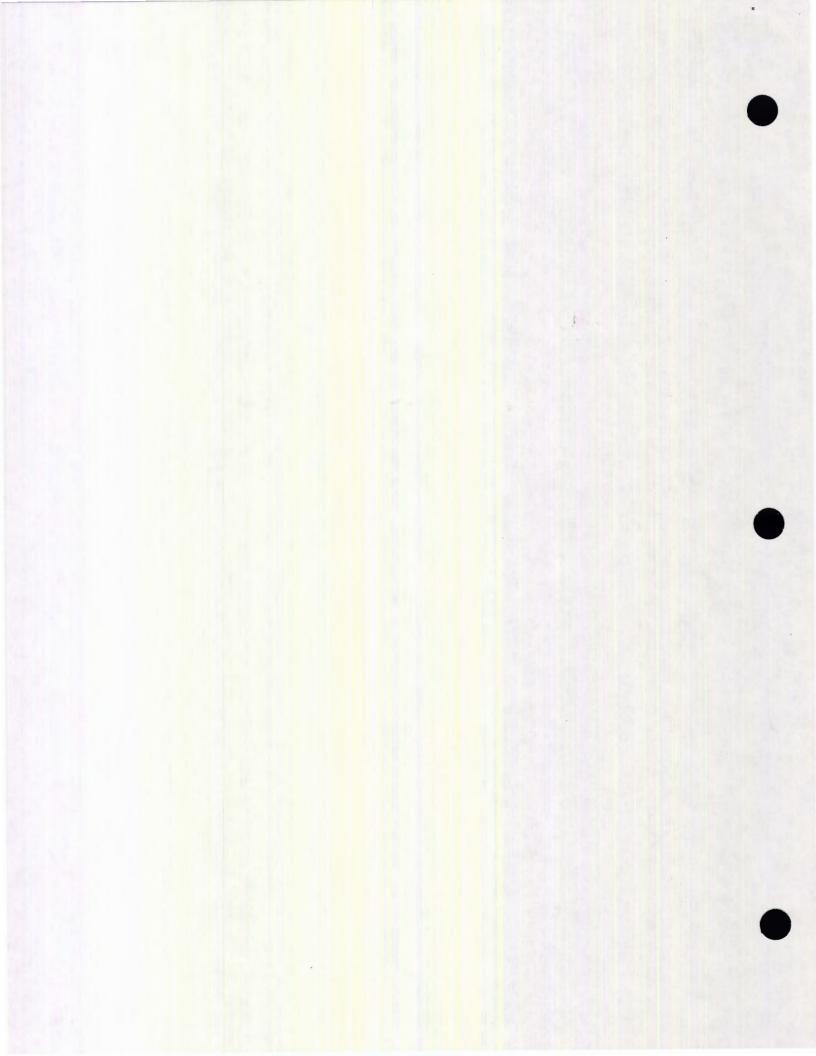
moves to amend the bill on page 2, lines 34 and 35 by rewriting the lines to read:

"Medicine, the University of North Carolina at Chapel Hill School of Medicine, the Brody School of Medicine at East Carolina University, the Duke University School of Medicine, the Wake Forest School of Medicine, and the Campbell University Jerry M. Wallace School of Osteopathic Medicine. The report shall be used to facilitate the";

and on page 2, lines 40-48 by rewriting the lines to read:

 "(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 medical residency program and how these slots have changed over time. The report shall also contain detailed information about caps for Medicare-funded graduate medical education positions. This information shall include the caps set by Medicare and other agencies, the methodology used to establish those caps, information on how medical school student slots, residency slots, and intern slots have changed over time, and how changes to medical school student slots, residency slots, and intern slots, and caps for Medicare-funded graduate medical education positions may be accomplished in the future. This information shall also include an assessment of the effect of medical school student slots, residency slots, and intern slots,

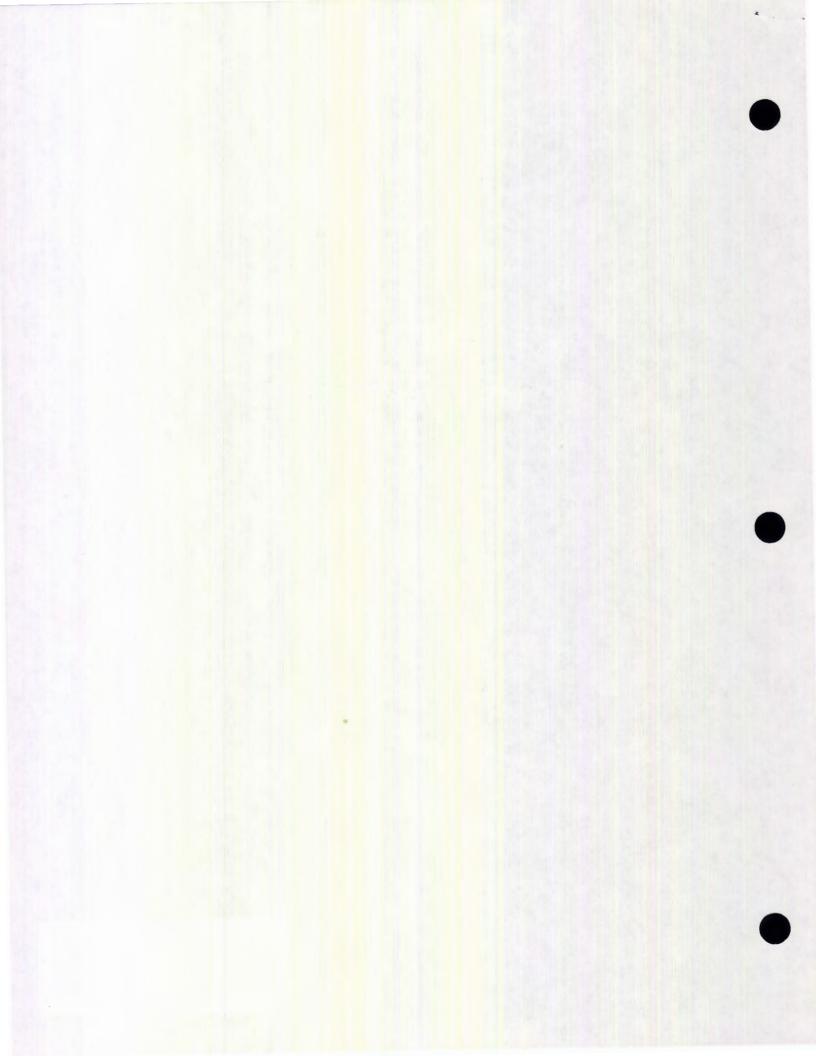




NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT House Bill 1002*

AMENDMENT NO.

H1002-ABC-	30 [v.3]		(to be filled in by Principal Clerk)	
				Page 2 of 2
	-		graduate medical education s in North Carolina."	positions or
SIGNED	Doy C.	Faulth Indiant Sponsor		
SIGNED	Committee Chair if	Senate Committee	Amendment	
ADOPTED	U	FAILED	TABLED	





SENATE BILL 616: Heroin & Opioid Prevention & Enforcement Act.

2017-2018 General Assembly

Committee:

House Health. If favorable, re-refer to Date:

June 5, 2018

Judiciary I

Introduced by: Sen. J. Davis

Prepared by: Jessica Boney*

Analysis of:

PCS to Second Edition

Staff Attorney

S616-CSTT-42

OVERVIEW: The PCS to Senate Bill 616 does the following:

- Amends laws pertaining to the North Carolina Controlled Substances Act and the North Carolina Controlled Substances Reporting System Act, and revises and creates penalties for certain violations.
- Expresses the intent to appropriate additional funds in the future for community-based substance use disorder treatment and recovery services, the purchase of overdose medications, Operation Medicine Drop, and a special agent position within the State Bureau of Investigations (SBI).

BILL ANALYSIS:

The PCS makes the changes outlined below:

Part I. TITLE OF ACT

Section 1 sets forth the title of the act as the Heroin and Opioid Prevention and Enforcement (HOPE) Act of 2018.

Part II. AMENDMENTS TO THE NORTH CAROLINA CONTROLLED SUBSTANCES ACT

Under current law, it is a felony to sell, manufacture, deliver, transport or possess 28 grams or more of MDPV or mephedrone.

Section 2 and Section 3 make grammatical changes to the chemicals referenced in G.S. 90-89.

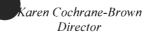
Section 4 adds the immediate precursor chemical required for the manufacture of fentanyl as a Schedule II Controlled Substance under G.S. 90-90.

Section 5 adds the precursor chemical used in the manufacturing process of fentanyl to the list of immediate precursor chemicals.

Section 6 make a grammatical correction to the chemical name.

Section 7 creates a felony offense for selling, manufacturing, delivering, transporting or possessing 28 grams or more of any substituted cathinone. Section 7 consolidates and streamlines the felony offensies pertaining to MDPV and mephedrone into a felony offense for substituted cathinone. Section 7 also adds opioid to the list of substances included in the felony offense of trafficking in opium, opiate or heroin, unless excepted otherwise, and makes a technical change.

Section 8 adds a new section to Article 5 of Chapter 90 of the General Statutes which:





Legislative Analysis Division 919-733-2578

Senate PCS 616

Page 2

- Allows a certified diversion investigator associated with a qualified law enforcement agency to request and receive copies of prescriptions records in connection with an investigation by providing the name and certification number of the certified diversion investigator, name of the qualified law enforcement agency for whom the investigator works, the case number, the purpose of the request, the name and date of birth of the individual whose prescription records are sought.
- Requires the request to be sent to the North Carolina SBI, Diversion & Environmental Crimes Unit, who will conduct audits of the requests.
- Requires a pharmacy to provide the requested prescriptions records within 2 business days.
- Prohibits a certified diversion investigator from divulging any knowledge of the prescription record unless by virtue of his office or otherwise allowed by law.
- Provides a pharmacist who complies in good faith with this section is not liable for improper use of information divulged to a certified diversion investigator.

Section 9 makes the following a Class G felony if commmitted intentionally:

- For a registrant or a practitioner to willfully misapply or divert a controlled substance under the registrant's or practitioner's care for his or her own use or other illegal use.
- For individuals who by profession provide medical care, aid emergency treatment or any combination of these to a person who is prescribed a controlled substance, but are not a registrant, a practitioner, or an employee of a registrant or practitioner, to willfully misapply or divert a controlled substances of another for his or her own use or other illegal use.

Section 9 creates a Class E felony if either of the above mentioned individuals divert a controlled substance by means of dilution or substitution. Section 9 also makes technical changes to the statute.

<u>Part III. AMENDMENTS PERTAINING TO THE NORTH CAROLINA CONTROLLED</u> SUBSTANCES REPORTING SYSTEM ACT

The Controlled Substances Reporting System (CSRS) is a database maintained by DHHS that tracks prescriptions for Schedule II through Schedule V controlled substances. Dispensers are required to report certain information on prescriptions they fill within close of the next business day after the prescription is delivered, but are encouraged to report such information within 24 hours of delivery. Such information is confidential and may only be accessed by certain persons for specific purposes set forth by statute. Current law allows DHHS to release CSRS data to persons authorized to prescribe controlled substances, special agents of the North Carolina SBI, as well as others.

In addition to the information currently required by law, Section 10 requires the dispenser to report the prescriber's national provider identification number.

Section 11(a) allows DHHS to release data in the CSRS to the Attorney General of North Carolina or a designee who is a full-time employee in the North Carolina Department of Justice, in order to monitor requests for inspection of records, and the Tactical Diversion Squad in North Carolina.

In addition to existing civil penalties and any other applicable civil or criminal penalties, Section 11(a) creates a Class I felony for certain individuals who access or disclose prescription information in the CSRS for an unauthorized purpose. An individual who accesses or discloses prescription information for an unauthorized purpose with an intent to use the information for commercial advantage, personal gain or to harm any person, is guilty of a Class H felony under Section 11(a). Section 11(a) permanently bars any person convicted of a criminal offenses under this subsection from accessing the CSRS, allows the SBI, Diversion & Environmental Crimes Unit, to investigate violations of this section and requires the SBI, Diversion & Environmental Crimes Unit, to notify DHHS of any charges or convictions.

Senate PCS 616

Page 3

Section 11(b) governs how DHHS releases information to local law enforcement officers. Section 11(b) only allows DHHS to release data to a local law enforcement officer when the local law enforcement officer is a certified diversion investigator, the agency supervising the investigator is a qualified law enforcement agency, the request is reasonably related to a bona fide active investigation involving a specific violation of state or federal law and the request has been approved by the SBI, Diversion & Environmental Crimes Unit.

Section 11(b) does the following:

- Provides immunity from civil or criminal liability for a special agent of the SBI, Diversion &
 Environmental Crimes Unit, in the event action is taken upon a request by a certified diversion
 investigator for access to data in the CSRS.
- Creates an audit trail that may be used to investigate or prosecute violations of this section, grants the
 Attorney General of North Carolina and Special Agents of the SBI access to the audit trail for
 reviewing purposes, and requires the SBI to conduct periodic audits.
- Requires data obtained from certified diversion investigators from the CSRS may only be shared with law enforcement personnel or prosecutorial officials (i) upon the direction of the certified diversion investigator who originally requested the information, and (ii) in the case of law enforcement personnel from other law enforcement agencies, only with law enforcement personnel directly participating in an official joint investigation outlined in 90-113.74(i)(5).
- Requires referring the matter to the SBI, Diversion & Environmental Crimes Unit, or a certified diversion investigator if the data indicates transactions solely out of local law enforcement officer's jurisdiction.
- Prohibits certified diversion investigator from requesting or receiving prescription data from other states through PMP Interconnect or any other mechanism.
- Defines the following terms:
 - "certified diversion investigator" as an officer affiliated with a qualified law enforcement agency who also has certain certifications.
 - "certified diversion supervisor" as the head of a municipal or county police department, a sheriff's
 office, or the designee of the agency head with supervisory authority over that agency's diversion
 investigators with certain certifications.
 - "qualified law enforcement agency" as either a municipal or a county police department or a sheriff's office, whose head is a certified diversion investigator or an entity that employs at least one certified diversion investigator and certified diversion supervisor.
 - "active investigation" as one conducted of one or more persons, for which probably cause exists for the release of the information, including a likelihood that it could lead to criminal proceedings.
- Requires DHHS to enable:
 - Each certified diversion investigator associated with a qualified law enforcement agency to register name, certification number, the qualified law enforcement agency the investigator works for, and the name and certification number of each certified diversion supervisor with whom the investigator works with the CSRS.
 - Each certified diversion investigator associated with a qualified law enforcement agency to request and receive data in connection with an investigation involving a specific violation of law involving a monitored prescription by providing the case number, a description of the purpose of the request, the name and birth date of the individual whose prescription data the investigator seeks and requires

Senate PCS 616

Page 4

acknowledgment the certified diversion investigator is aware of penalties of disclosing data from CSRS.

- SBI, Diversion & Environmental Crimes Unit to review data requests for approval, denial or delay.
- Requires DHHS to create an audit trail and allows the Attorney General of North Carolina or a
 designee and Special Agents of the North Carolina SBI assigned to the Diversion & Environmental
 Crimes Unit access to it.

Section 11(c) requires DHHS to begin developing the capabilities necessary to implement Section 11(b).

Section 12 clarifies a person assessed a civil penalty for misusing CSRS is temporarily barred from accessing CSRS until further findings by DHHS. Notwithstanding current law, Section 12 grants civil and criminal immunity to a practitioner, dispenser or other person required to transmit data under this Article, who incurs criminal or civil liability from a good faith transmission of data or subsequent actual or attempted access to, use or disclosure of such data.

Section 13 adds a section that requires the NC Criminal Justice Education and Training Standards Commission and the NC Sheriffs' Education and Training Standards Commission to facilitate education of certified diversion investigators and supervisors.

Section 14(a) amends Chapter 17C pertaining to the powers of the NC Criminal Justice Education and Training Standards Commission. Section 14(b) amends Chapter 17E pertaining to the powers of the NC Sheriffs' Education and Training Standards Commission. Both Commissions are required to establish minimum standards and levels of training for certification of diversion investigators and diversion supervisors, as defined in G.S. 90 113.74(i). Additionally, each Commission is required to ensure diversion investigators receive specified training and each Commission is required to certify and recertify at least once every three years, suspend, revoke, or deny, pursuant to the standards that it has established for the purpose, persons as qualified to be employed at entry level and retained as diversion investigators and diversion supervisors.

Part IV. APPROPRIATIONS

Section 15 makes it the intent of the General Assembly to appropriate: \$10 million in recurring funds for the 2019-2020 fiscal year from the General Fund to the Division of Mental Health, DHHS for use solely to increase the availability of community-based treatment and recovery services for substance abuse disorders; \$1 million in recurring funds for the 2019-2020 fiscal year from the General Fund to the Division of Mental Health, DHHS to purchase opioid antagonists for use by North Carolina law enforcement agencies; appropriate \$160,000 in recurring funds for the 2019-2020 fiscal year to the State Bureau of Investigation to fund Operation Medicine Drop; \$122,000 in recurring funds for the 2019-2020 fiscal year and \$58,000 in non-recurring funds for the 2019-2020 fiscal year to the SBI to create one full-time special agent position to enhance drug investigations.

Part V. SEVERABILITY CLAUSE AND EFFECTIVE DATE

Section 16 makes any provisions of the bill held to be invalid by a court severable from the other provisions of the bill, which would remain in effect.

Section 17 contains the effective date which provides that Sections 8 and 11(b) would become effective July 1, 2019 and the remainder of the bill would become effective July 1, 2018.

* Theresa Matula and Jason Moran-Bates contributed to this Bill Summary.

GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2017

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SENATE BILL 616

Finance Committee Substitute Adopted 5/9/17 PROPOSED HOUSE COMMITTEE SUBSTITUTE S616-PCS35363-TTa-42

Short Title: Heroin & Opioid Prevention & Enforcen	ment Act. (Public
Sponsors:	
Referred to:	
April 5, 2017	
A BILL TO BE ENTI	ITLED
AN ACT AMENDING LAWS PERTAINING TO THE	E NORTH CAROLINA CONTROLLED
SUBSTANCES ACT AND THE NORTH CARO	LINA CONTROLLED SUBSTANCES
REPORTING SYSTEM ACT, INCLUDING THE	
OF PENALTIES FOR CERTAIN VIOLATIONS,	
APPROPRIATE ADDITIONAL FUNDS IN THE	
SUBSTANCE USE DISORDER TREATMENT	
PURCHASE OF OVERDOSE MEDICATIONS, O A SPECIAL AGENT POSITION WITHIN THE ST	
A SPECIAL AGENT POSITION WITHIN THE ST	ATE BUREAU OF INVESTIGATION
The General Assembly of North Carolina enacts:	
PART I. TITLE	
SECTION 1. This act shall be known and a	may be cited as "The Heroin and Opioio
Prevention and Enforcement (HOPE) Act of 2018."	
	TH CAROLINA CONTROLLED
SUBSTANCES ACT SECTION 2. G.S. 90-89(3)ee. reads as rew	vritten
"ee.	Artica.
	tryptamine.5-Methoxy-N,N-diisopropyl
ryptamine."	
SECTION 3. For each NBOMe compound	d listed in G.S. 90-89(6)a. through l., the
Revisor of Statutes is authorized to replace the hyphen	
"2" with a space.	
SECTION 4. G.S. 90-90(2) is amended by	
"h1. Fentanyl immediate precurso	
4-anilino-N-phenethyl-4-pipe	
SECTION 5. G.S. 90-95(d2) is amended by	
"(29a) N-phenethyl-4-piperidinone (NPP)."	
SECTION 6. G.S. 90-95(d2)(31) reads as r	
"(31) Phenyl-2-propane.Phenyl-2-propano: SECTION 7. G.S. 90-95(h) reads as rewritten	
"(h) Notwithstanding any other provision of law,	
otherwise provided in this Article.	the following provisions apply except as
onici wise provided in this Article.	



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- (3d)Any person who sells, manufactures, delivers, transports, or possesses 28 grams or more of MDPV any substituted cathinone or any mixture containing such substance shall be guilty of a felony, which felony shall be known as "trafficking in MDPV," substituted cathinones," and if the quantity of such substance or mixture involved:
 - Is 28 grams or more, but less than 200 grams, such person shall be punished as a Class F felon and shall be sentenced to a minimum term of 70 months and a maximum term of 93 months in the State's prison and shall be fined not less than fifty thousand dollars (\$50,000);
 - b. Is 200 grams or more, but less than 400 grams, such person shall be punished as a Class E felon and shall be sentenced to a minimum term of 90 months and a maximum term of 120 months in the State's prison and shall be fined not less than one hundred thousand dollars (\$100,000):
 - Is 400 grams or more, such person shall be punished as a Class C felon c. and shall be sentenced to a minimum term of 225 months and a maximum term of 282 months in the State's prison and shall be fined at least two hundred fifty thousand dollars (\$250,000).
- Any person who sells, manufactures, delivers, transports, or possesses 28 (3e) grams or more of mephedrone or any mixture containing such substance shall be guilty of a felony, which felony shall be known as "trafficking in mephedrone," and if the quantity of such substance or mixture involved:
 - Is 28 grams or more, but less than 200 grams, such person shall be punished as a Class F felon and shall be sentenced to a minimum term of 70 months and a maximum term of 93 months in the State's prison and shall be fined not less than fifty thousand dollars (\$50,000);
 - Is 200 grams or more, but less than 400 grams, such person shall be b. punished as a Class E felon and shall be sentenced to a minimum term of 90 months and a maximum term of 120 months in the State's prison and shall be fined not less than one hundred thousand dollars (\$100,000);
 - Is 400 grams or more, such person shall be punished as a Class C felon e. and shall be sentenced to a minimum term of 225 months and a maximum term of 282 months in the State's prison and shall be fined at least two hundred fifty thousand dollars (\$250,000).
- Any person who sells, manufactures, delivers, transports, or possesses four (4) grams or more of opium or opiate, opium, opiate, or opioid, or any salt, compound, derivative, or preparation of opium or opiate opium, opiate, or opioid (except apomorphine, nalbuphine, analoxone and naltrexone and their respective salts), including heroin, or any mixture containing such substance, shall be guilty of a felony which felony shall be known as "trafficking in opium opium, opiate, opioid, or heroin" and if the quantity of such controlled substance or mixture involved:
 - Is four grams or more, but less than 14 grams, such person shall be punished as a Class F felon and shall be sentenced to a minimum term of 70 months and a maximum term of 93 months in the State's prison and shall be fined not less than fifty thousand dollars (\$50,000);
 - Is 14 grams or more, but less than 28 grams, such person shall be b. punished as a Class E felon and shall be sentenced to a minimum term of 90 months and a maximum term of 120 months in the State's prison

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and shall be fined not less than one hundred thousand dollars (\$100,000);

- c. Is 28 grams or more, such person shall be punished as a Class C felon and shall be sentenced to a minimum term of 225 months and a maximum term of 282 months in the State's prison and shall be fined not less than five hundred thousand dollars (\$500,000).
- (4b) Any person who sells, manufactures, delivers, transports, or possesses 100 or more tablets, capsules, or other dosage units, or 28 grams or more of 3,4-methylenedioxyamphetamine (MDA), including its salts, isomers, and salts of isomers, or 3,4-methylenedioxymethamphetamine (MDMA), including its salts, isomers, and salts of isomers, or any mixture containing such substances, shall be guilty of a felony, which felony shall be known as "trafficking in MDADMA." MDA/MDMA." If the quantity of the substance or mixture involved:
 - a. Is 100 or more tablets, capsules, or other dosage units, but less than 500 tablets, capsules, or other dosage units, or 28 grams or more, but less than 200 grams, the person shall be punished as a Class G felon and shall be sentenced to a minimum term of 35 months and a maximum term of 51 months in the State's prison and shall be fined not less than twenty-five thousand dollars (\$25,000);
 - b. Is 500 or more tablets, capsules, or other dosage units, but less than 1,000 tablets, capsules, or other dosage units, or 200 grams or more, but less than 400 grams, the person shall be punished as a Class F felon and shall be sentenced to a minimum term of 70 months and a maximum term of 93 months in the State's prison and shall be fined not less than fifty thousand dollars (\$50,000);
 - c. Is 1,000 or more tablets, capsules, or other dosage units, or 400 grams or more, the person shall be punished as a Class D felon and shall be sentenced to a minimum term of 175 months and a maximum term of 222 months in the State's prison and shall be fined not less than two hundred fifty thousand dollars (\$250,000).

SECTION 8. Article 5 of Chapter 90 of the General Statutes is amended by adding a new section to read:

"§ 90-107.1. Certified diversion investigator access to prescription records.

- (a) A certified diversion investigator associated with a qualified law enforcement agency, as those terms are defined in G.S. 90-113.74(i), shall request and receive from a pharmacy copies of prescriptions and records related to prescriptions in connection with a bona fide active investigation related to the enforcement of laws governing licit or illicit drugs by providing in writing or electronically all of the following:
 - (1) The certified diversion investigator's name and certification number.
 - (2) The name of the qualified law enforcement agency for whom the investigator works.
 - (3) The case number associated with the request.
 - (4) A description of the nature and purpose of the request.
 - (5) The first name, last name, and date of birth of each individual whose prescription and records related to the prescription the investigator seeks, including, when appropriate, any alternative name, spelling, or date of birth associated with each such individual.

- - (b) When a certified diversion investigator transmits such a request to a pharmacy, the certified diversion investigator shall also transmit a copy of the request to the North Carolina State Bureau of Investigation, Diversion and Environmental Crimes Unit. The North Carolina State Bureau of Investigation shall conduct periodic audits of a random sample of these requests.
 - (c) A pharmacy shall provide copies of requested prescriptions and records related to prescriptions as soon as practicable and no later than two business days after receipt of the request from the certified diversion investigator.
 - (d) No certified diversion investigator having knowledge by virtue of his office of any such prescription or record related to prescriptions shall divulge such knowledge other than to other law enforcement officials or agencies involved in the bona fide active investigation, except in connection with a prosecution or proceeding in court or before a licensing board or officer to which prosecution or proceeding the person to whom such prescriptions, orders, or records relate is a party, or as provided in G.S. 90-113.74 (i)(4), or as otherwise allowed by law.
 - (e) A pharmacy or pharmacist that in good faith complies with this section and provides copies of prescriptions and records related to prescriptions to a certified diversion investigator shall have no liability for improper use of information divulged to the certified diversion investigator."

SECTION 9. G.S. 90-108 reads as rewritten:

"§ 90-108. Prohibited acts; penalties.

- (a) It shall be unlawful for any person:
 - (1) Other than practitioners licensed under Articles 1, 2, 4, 6, 11, 12A of this Chapter to represent to any registrant or practitioner who manufactures, distributes, or dispenses a controlled substance under the provision of this Article that he <u>or she</u> is a licensed practitioner in order to secure or attempt to secure any controlled substance as defined in this Article or to in any way impersonate a practitioner for the purpose of securing or attempting to secure any drug requiring a prescription from a practitioner as listed above and who is licensed by this State; State.
 - (2) Who is subject to the requirements of G.S. 90-101 or a practitioner to distribute or dispense a controlled substance in violation of G.S. 90-105 or 90-106; G.S. 90-106.
 - (3) Who is a registrant to manufacture, distribute, or dispense a controlled substance not authorized by his <u>or her</u> registration to another registrant or other authorized <u>person; person.</u>
 - (4) To omit, remove, alter, or obliterate a symbol required by the Federal Controlled Substances Act or its successor; successor.
 - (5) To refuse or fail to make, keep, or furnish any record, notification, order form, statement, invoice or information required under this Article; Article.
 - (6) To refuse any entry into any premises or inspection authorized by this Article; Article.
 - (7) To knowingly keep or maintain any store, shop, warehouse, dwelling house, building, vehicle, boat, aircraft, or any place whatever, which is resorted to by persons using controlled substances in violation of this Article for the purpose of using such substances, or which is used for the keeping or selling of the same in violation of this Article; Article.
 - (8) Who is a registrant or a practitioner to distribute a controlled substance included in Schedule I or II of this Article in the course of his <u>or her</u> legitimate business, except pursuant to an order form as required by G.S. 90-105; G.S. 90-105.

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Provided, that if the criminal pleading alleges that the violation was committed intentionally, and upon trial it is specifically found that the violation was committed intentionally, such violations shall be a Class I felony unless one of the following applies:

(1)A person who violates subdivision (7) of subsection (a) of this section and also fortifies the structure, with the intent to impede law enforcement entry, (by barricading windows and doors) shall be punished as a Class I felon.

A person who violates subdivision (14) or (15) of subsection (a) of this section (2) shall be punished as a Class G felon.

- A person who violates subdivision (14) or (15) of subsection (a) of this section (3) and intentionally diverts any controlled substance by means of dilution or substitution or both shall be punished as a Class E felon. As used in this subdivision, the following terms have the following meanings:
 - Dilution. The act of diluting or the state of being diluted; the act of a. reducing the concentration of a mixture or solution.

<u>b.</u> <u>Substitution. – To take the place of or replace."</u>

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PART III. AMENDMENTS PERTAINING TO THE NORTH CAROLINA CONTROLLED SUBSTANCES REPORTING SYSTEM ACT

SECTION 10. G.S. 90-113.73(b) reads as rewritten:

- "(b) The Commission shall adopt rules requiring dispensers to report the following information. The Commission may modify these requirements as necessary to carry out the purposes of this Article. The dispenser shall report:
 - (1) The dispenser's DEA number.
 - (2) The name of the patient for whom the controlled substance is being dispensed, and the patient's:
 - a. Full address, including city, state, and zip eode, code.
 - b. Telephone number, and number.
 - c. Date of birth.
 - (3) The date the prescription was written.
 - (4) The date the prescription was filled.
 - (5) The prescription number.
 - (6) Whether the prescription is new or a refill.
 - (7) Metric quantity of the dispensed drug.
 - (8) Estimated days of supply of dispensed drug, if provided to the dispenser.
 - (9) National Drug Code of dispensed drug.
 - (10) Prescriber's DEA number.
 - (10a) Prescriber's national provider identification number, for any prescriber that has a national provider identification number. A pharmacy shall not be subject to a civil penalty under subsection (e) of this section for failure to report the prescriber's national provider identification number when it is not received by the pharmacy.
 - (11) Method of payment for the prescription."

SECTION 11.(a) G.S. 90-113.74 reads as rewritten:

"§ 90-113.74. Confidentiality.

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- (c) The Department shall release data in the controlled substances reporting system to the following persons only:
 - (1) Persons authorized to prescribe or dispense controlled substances for the purpose of providing medical or pharmaceutical care for their patients. A person authorized to receive data pursuant to this paragraph may delegate the authority to receive the data to other persons working under his or her direction and supervision, provided the Department approves this delegation.

The administrator of a hospital emergency department or hospital acute care facility shall provide the Department with a list of prescribers who are authorized to prescribe controlled substances for the purpose of providing medical care for patients of the hospital emergency department or hospital acute care facility and a list of delegates who are authorized to receive data on behalf of the providers listed. The administrator acting under this paragraph shall submit the lists to the Department no later than December 1 of the calendar year preceding the year during which the delegates are to receive data and may provide updated lists at any time during the course of the year. Within one week of receiving the initial or updated lists described in this paragraph, the Department shall establish all of the delegate accounts necessary to enable each delegate listed by the administrator of the hospital emergency department or hospital acute care facility to receive data on behalf of the listed prescribers.

- Delegations made pursuant to this paragraph are valid during the calendar year for which submitted by the administrator.
- (2) An individual who requests the individual's own controlled substances reporting system information.
- (3) Special agents of the North Carolina State Bureau of Investigation who are assigned to the Diversion & Environmental Crimes Unit and whose primary duties involve the investigation of diversion and illegal use of prescription medication. SBI agents assigned to the Diversion & Environmental Crimes Unit may then provide this information to other SBI agents who are engaged in a bona fide specific investigation related to enforcement of laws governing licit drugs. The SBI shall notify the Office of the Attorney General of North Carolina of each request for inspection of records maintained by the Department. The Attorney General of North Carolina, or a designee who is a full-time employee in the North Carolina Department of Justice, shall have access to the system to monitor requests for inspection of records.
- (4) Primary monitoring authorities for other states pursuant to a specific ongoing investigation involving a designated person, if information concerns the dispensing of a Schedule II through V controlled substance to an ultimate user who resides in the other state or the dispensing of a Schedule II through V controlled substance prescribed by a licensed health care practitioner whose principal place of business is located in the other state.
- (5) To a sheriff or designated deputy sheriff or a police chief or a designated police investigator who is assigned to investigate the diversion and illegal use of prescription medication or pharmaceutical products identified in Article 5 of this Chapter of the General Statutes as Schedule II through V controlled substances and who is engaged in a bona fide specific investigation related to the enforcement of laws governing licit drugs pursuant to a lawful court order specifically issued for that purpose.
- (6) The Division of Medical Assistance for purposes of administering the State Medical Assistance Plan.
- (7) Licensing boards with jurisdiction over health care disciplines pursuant to an ongoing investigation by the licensing board of a specific individual licensed by the board.
- (8) Any county medical examiner appointed by the Chief Medical Examiner pursuant to G.S. 130A-382 and the Chief Medical Examiner, for the purpose of investigating the death of an individual.
- (9) The federal Drug Enforcement Administration's Office of Diversion Control. Control or Tactical Diversion Squad in North Carolina.
- (10) The North Carolina Health Information Exchange Authority (NC HIE Authority), established under Article 29B of this Chapter, through Web-service calls.
- (k) In addition to the civil penalties provided in G.S. 90-113.75(a) and any other applicable civil or criminal penalties, the following criminal penalties apply to any individual authorized to access data in the controlled substances reporting system when that access is authorized by subdivisions (3) through (10) of subsection (c) of this section:
 - (1) An individual who knowingly and intentionally accesses prescription information in the controlled substances reporting system for a purpose not authorized by this section shall be guilty of a Class I felony.

a designee and Special Agents of the State Bureau of Investigation who are

<u>supervisor:</u>
1. <u>A municipal police department.</u>
2. A county police department.

3. A sheriff's office.

<u>d.</u> Active investigation. – An investigation that is being conducted of one or more specific persons and for which probable cause exists for the

one certified diversion investigator and at least one certified diversion

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			release of the information, including a reasonable likelihood that it
			could lead to the filing of criminal proceedings.
	(i)		Department shall do all of the following:
		(1)	Enable each certified diversion investigator associated with a qualified law
			enforcement agency to register with the controlled substances reporting
			system by providing, at a minimum, all of the following information:
			<u>a.</u> The investigator's name and certification number.
			b. The name of the qualified law enforcement agency for whom the
			investigator works.
			c. The name and certification number of each certified diversion
			supervisor with whom the investigator works.
		<u>(2)</u>	Enable each certified diversion investigator associated with a qualified law
			enforcement agency to request and receive data in connection with a bona fide
			active investigation involving a specific violation of any state or federal law
			involving a monitored prescription by providing, at a minimum, all of the
			following:
			a. The case number associated with the request.
			b. A description of the nature and purpose of the request.
			c. The first name, last name, and date of birth of each individual whose
			prescription data the investigator seeks, including, when appropriate,
			any alternative name, spelling, or date of birth associated with each
			such individual.
			d. An acknowledgement that the certified diversion investigator is aware
			of the penalties associated with improperly obtaining, disclosing, or
			disseminating data from the controlled substances reporting system.
		(3)	Enable the State Bureau of Investigation, Diversion & Environmental Crimes
			Unit to review each request for data from a certified diversion investigator
			associated with a qualified law enforcement agency and, upon such review, to
			determine if the request is approved, denied, or delayed pending further
			review or investigation.
		(4)	Create an audit trail that may be used to investigate or prosecute violations of
			this Part and ensure that the Attorney General of North Carolina or a designee
			and Special Agents of the North Carolina State Bureau of Investigation who
			are assigned to the Diversion & Environmental Crimes Unit have access to
			the system to review the audit trail."
		SEC	TION 11.(c) The Department of Health and Human Services shall begin
	developi	ng the	capabilities necessary to implement Section 11(b) of this act.
		SEC	ΓΙΟΝ 12. G.S. 90-113.75 reads as rewritten:
	§ 90-113	.75. C	ivil penalties; other remedies; immunity from liability.
	(a)		son who intentionally, knowingly, or negligently releases, obtains, or attempts
(o obtain i	informa	ation from the system in violation of a provision of this Article or a rule adopted
)	ursuant 1	to this	Article shall be assessed a civil penalty by the Department not to exceed ten
	housand	dollars	(\$10,000) per violation. violation and shall be temporarily barred from accessing
	he syster	n until	further findings by the Department. The clear proceeds of penalties assessed
			n shall be deposited to the Civil Penalty and Forfeiture Fund in accordance with
1	Article 3	1A of	Chapter 115C of the General Statutes. The Commission shall adopt rules
71.0	establishi	ng the f	factors to be considered in determining the amount of the penalty to be assessed."
	(b)	In add	dition to any other remedies available at law, an individual whose prescription

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information has been disclosed in violation of this Article or a rule adopted pursuant to this

Article may bring an action against any person or entity who has intentionally, knowingly, or

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negligently released confidential information or records concerning the individual for either or both of the following:

- (1) Nominal damages of one thousand dollars (\$1,000). In order to recover damages under this subdivision, it shall not be necessary that the plaintiff suffered or was threatened with actual damages.
- (2) The amount of actual damages, if any, sustained by the individual.
- (c) ANotwithstanding the foregoing, G.S. 8-53, G.S. 75-65, or any other provision of international, federal, State, or local law, a practitioner as defined in G.S. 90-87, a dispenser, or other person or entity permitted access to data or required or permitted to submit or transmit reports or other records, data, or information, including, without limitation, any protected health information or any other individually identifying or personal information, under this Article that, in good faith, makes a report or transmits data submits or transmits such reports or other records, data, or information as required or allowed by this Article is immune from civil or criminal liability that might otherwise be incurred or imposed as a result of making the report or transmitting the data submitting or transmitting such reports or other records, data, or information, or as a result of any subsequent actual or attempted access to or use or disclosure of such reports or other records, data, or information, whether by the Department, any law enforcement officer or agency, or any other person or entity."

SECTION 13. Article 5E of Chapter 90 of the General Statutes is amended by adding a new section to read:

"§ 90-113.74E. Certification of diversion investigators and diversion supervisors.

Pursuant to its authority under G.S. 17C-6 and G.S. 17E-4, the North Carolina Criminal Justice Education and Training Standards Commission and the North Carolina Sheriffs' Education and Training Standards Commission, in consultation with the Department of Justice, North Carolina Justice Academy, and State Bureau of Investigation, shall ensure that educational materials are created and that training programs are conducted for the certification of diversion investigators and diversion supervisors, as defined in G.S. 90-113.74(i)."

"(18) Establish minimum standards and levels of training for certification of diversion investigators and diversion supervisors, as defined in G.S. 90-113.74(i). As part of these minimum standards, the Commission shall require that certified diversion investigators receive training in the following:

- a. Definition of drug diversion.
- b. Categories of drugs most subject to diversion and misuse.
- c. Methods used to divert drugs.
- <u>d.</u> Proper investigation of drug diversion cases.
- e. Appropriate use of the controlled substances reporting system to investigate drug diversion cases.
- f. Requests of prescriptions and records related to prescriptions pursuant to G.S. 90-107.1, including best practices for working with pharmacies in a manner that minimizes disruption of customer service and pharmacy operations.
- g. Data privacy and security provisions of the Health Insurance
 Portability and Accountability Act of 1996 (HIPAA) and other
 pertinent federal and State laws governing privacy and security of
 confidential data and records.
- <u>h.</u> Proper handling of confidential data and records from any source.
- i. <u>Criminal and civil penalties under federal and State law for improperly accessing, handling, or disclosing confidential prescription data or other confidential data or records.</u>

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1 Certify and recertify at least once every three years, suspend, revoke, or deny, (19)2 pursuant to the standards that it has established for the purpose, persons as 3 qualified to be employed at entry level and retained as diversion investigators 4 and diversion supervisors, as defined in G.S. 90-113.74(i)." SECTION 14.(b) G.S. 17E-4(a) is amended by adding two new subdivisions to read: 5 "(14) Establish minimum standards and levels of training for certification of 6 diversion investigators and diversion supervisors, as defined 7 G.S. 90-113.74(i). As part of these minimum standards, the Commission shall 8 9 require that certified diversion investigators receive training in the following: 10 Definition of drug diversion. 11 Categories of drugs most subject to diversion and misuse. b. Methods used to divert drugs. 12 C. Proper investigation of drug diversion cases. 13 d. 14 Appropriate use of the controlled substances reporting system to e. investigate drug diversion cases. 15 16 Requests of prescriptions and records related to prescriptions pursuant <u>f.</u> 17 to G.S. 90-107.1, including best practices for working with pharmacies in a manner that minimizes disruption of customer service 18 and pharmacy operations. 19 20 Data privacy and security provisions of the Health Insurance g. Portability and Accountability Act of 1996 (HIPAA) and other 21 22 pertinent federal and State laws governing privacy and security of 23 confidential data and records. Proper handling of confidential data and records from any source. 24 <u>h.</u> 25 Criminal and civil penalties under federal and State law for improperly <u>i.</u> 26 accessing, handling, or disclosing confidential prescription data or other confidential data or records. 27 28 Certify and recertify at least once every three years, suspend, revoke, or deny, (15)pursuant to the standards that it has established for the purpose, persons as 29 30 qualified to be employed at entry level and retained as diversion investigators 31 and diversion supervisors, as defined in G.S. 90-113.74(i)."

PART IV. APPROPRIATIONS

SECTION 15.(a) It is the intent of the General Assembly to appropriate from the General Fund to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, the sum of ten million dollars (\$10,000,000) in recurring funds for the 2019-2020 fiscal year. These funds shall not be used for any purpose other than to increase the availability of community-based treatment and recovery services for substance use disorders, including medication-assisted treatment. These funds shall not supplant existing funds for community-based treatment and recovery services for substance abuse disorders.

SECTION 15.(b) It is the intent of the General Assembly to appropriate from the General Fund to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, the sum of one million dollars (\$1,000,000) in recurring funds for the 2019-2020 fiscal year to purchase opioid antagonists, as defined in G.S. 90-12.7, which shall be distributed at no charge to North Carolina law enforcement agencies for the reversal of opioid-related drug overdoses.

SECTION 15.(c) It is the intent of the General Assembly to appropriate from the General Fund to the State Bureau of Investigation the sum of one hundred sixty thousand dollars (\$160,000) in recurring funds for the 2019-2020 fiscal year to fund Operation Medicine Drop.

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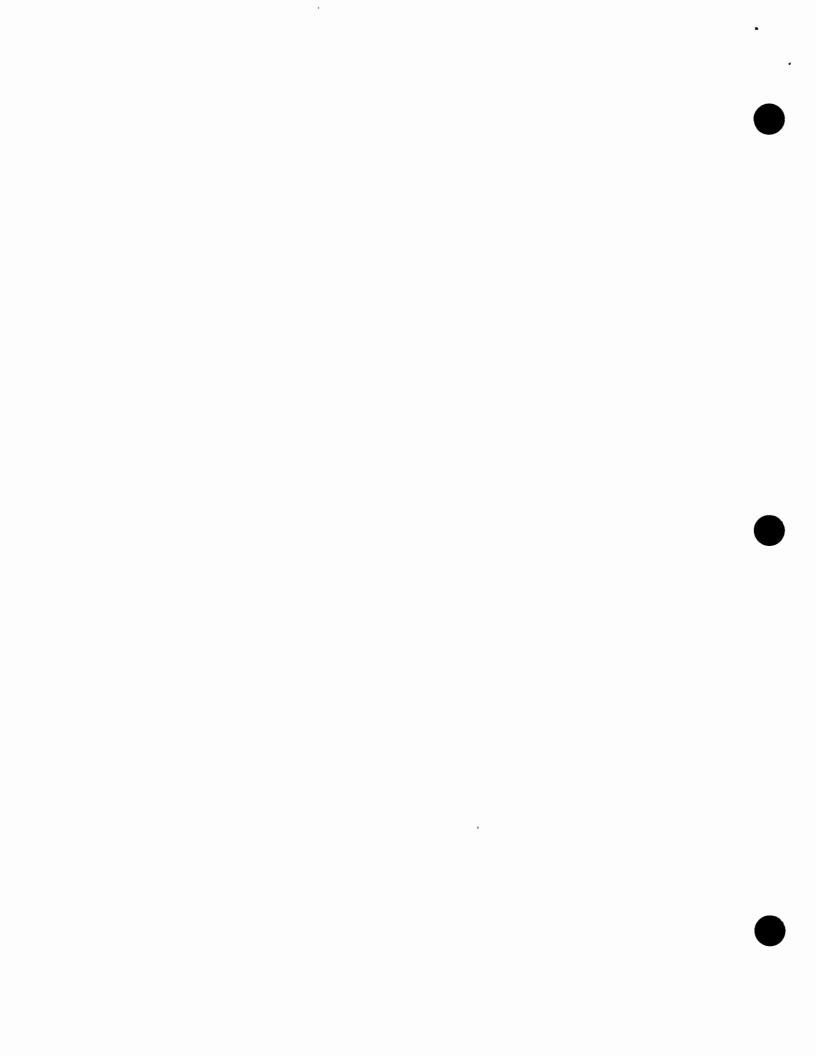
SECTION 15.(d) It is the intent of the General Assembly to appropriate from the General Fund to the State Bureau of Investigation the sum of one hundred twenty-two thousand dollars (\$122,000) in recurring funds and the sum of fifty-eight thousand dollars (\$58,000) in nonrecurring funds for the 2019-2020 fiscal year. The State Bureau of Investigation shall use these funds to create one full-time equivalent special agent position within the State Bureau of Investigation to enhance drug investigations throughout the State. These funds shall not be used to supplant any other source of funding for this position.

SECTION 15.(e) G.S. 143C-5-2 does not apply to this act.

PART V. SEVERABILITY CLAUSE AND EFFECTIVE DATE

SECTION 16. If any provision of this act or its application is held invalid, the invalidity does not affect other provisions or applications of this act that can be given effect without the invalid provisions or application, and to this end the provisions of this act are severable.

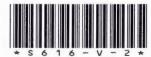
SECTION 17. Sections 8 and 11(b) of this act become effective July 1, 2019. The remainder of this act becomes effective July 1, 2018.



S

SENATE BILL 616 Finance Committee Substitute Adopted 5/9/17

Finance Committee Substitute Adopted 5/9/17				
Short Title:	Limit Look-Back for Immaterial Irregularities.	(Public)		
Sponsors:				
Referred to:				
	April 5, 2017			
IRREGU The General	A BILL TO BE ENTITLED O CONFORM THE PROCEDURES FOR PROPERTY LARITIES TO THE PROCEDURES FOR PROPERTY TO Assembly of North Carolina enacts: ECTION 1. G.S. 105-394 reads as rewritten: Immaterial irregularities.			
(a) V property for or requireme	<u>alid Tax.</u> – Immaterial irregularities in the listing, apprata and or in the levy or collection of the property tax or int of this Subchapter shall not invalidate the tax imposed upsting, appraisal, assessment, levy, collection, or any other	in any other proceeding pon any property or any		
	wing are examples of immaterial irregularities:			
taxed for the preceding five value it shows tax imposed computed unthe calendar discounts for referred to in is paid. The tax imposed to in the calendar discounts for referred to in the calendar dis	ollection. — When an immaterial irregularity is discovered by ear in which the immaterial irregularity is discovered by eyears during which it escaped proper taxation in accorded have been assigned in each of the years for with it is to in each such year. For purposes of tax collection and for this subsection is deemed to be a tax for the fiscal year year in which the immaterial irregularity was discovered prepayment and interest for late payment applicable to the the preceding sentence shall apply when the total figure of axes shall be a lien on the property as provided in G.S. 105-otice and Appeal. — Except as otherwise provided in this edures for discovered property under G.S. 105-312 applied prepare a tentative tax receipt based upon the correct as allowed under subsection (b) of this section. The assessment whose name the property is listed and the notice shall	ed and for any of the dance with the assessed be taxed and the rate of foreclosure, the amount beginning on July 1 of ered. The schedule of axes for the fiscal year on the single tax receipt -355. section, the notice and y to this section. The ction of the immaterial or shall mail a notice to		
(1		ne property is listed.		
(<u>2</u> (<u>3</u>				
(4	A brief description of the correction of the immaterial			
(5	A statement to the effect that the correction of the and the tentative tax receipt will become final ur			
	thereto is filed with the assessor within 30 days from			



General Assembly Of North Carolina

Session 2017

<u>(d)</u>	Power to Compromise After a tax receipt has been delivered and charged to th
tax collect	tor, the board of commissioners, upon the petition of the taxpayer, may compromise
settle, or a	idjust the county's claim for taxes arising from an immaterial irregularity to the sam
extent as p	provided for discovered property in G.S. 105-312(k)."

SECTION 2. This act is effective when it becomes law.



HOUSE BILL 967: Telemedicine Policy.

2017-2018 General Assembly

Committee: House Health

Introduced by: Reps. Lambeth, Dobson Analysis of: PCS to First Edition

H967-CSBC-38

Date: June 5, 2018

Prepared by: Jason Moran-Bates

Staff Attorney

OVERVIEW: The Proposed Committee Substitute to House Bill 967 would require the Department of Health and Human Services to study and report on requirements for insurance reimbursement of telemedicine, a broadband policy to ensure all North Carolina residents have access to telemedicine, standards for assessing the quality of telemedical care, and licensing requirements for telemedicine providers

[As introduced, this bill was identical to S779, as introduced by Sen. Pate, which is currently in Senate Rules and Operations of the Senate.]

BILL ANALYSIS:

The PCS removes the codified language from the original bill and leaves the study requirements.

Section 1.(a) would require DHHS to study and report on, in consultation with the Department of Insurance and relevant stakeholders, a recommended policy for reimbursement of care provided via telemedicine by private health insurance.

Section 1.(b) would require DHHS and the Department of Information Technology to study and report on a plan to ensure that all North Carolina residents have sufficiently advanced Internet connectivity to receive health care via telemedicine.

Section 1.(c) would require DHHS to study and report on performance metrics to be used by DHHS in assessing the quality of telemedicine services provided in the State.

Section 1.(d) would require DHHS to study and report on recommended standards for licensing individuals who provide healthcare via telemedicine.

EFFECTIVE DATE: This bill would be effective when it becomes law.

BACKGROUND: S.L. 2017-133 required DHHS to study and report on a telemedicine policy for North Carolina. The report recommended further study on the topics of insurance reimbursement of care provided via telemedicine, licensing standards for providers of telemedicine, and implementation of a plan to ensure all residents of North Carolina had access to sufficiently robust broadband to receive healthcare via telemedicine.







H

HOUSE BILL 967

PROPOSED COMMITTEE SUBSTITUTE H967-CSBC-967 [v.2]

06/05/2018 08:14:50 PM

Short Title: Telemedicine Policy.

(Public)

D

Sponsors:

Referred to:

May 21, 2018

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A BILL TO BE ENTITLED

AN ACT DIRECTING THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO STUDY AND REPORT RECOMMENDATIONS FOR VARIOUS TELEMEDICINE STANDARDS.

5 The General Assembly of North Carolina enacts:

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SECTION 1.(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:

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

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

16 17 (3) The areas of care for which health benefit plans should be required to provide reimbursement.
 (4) Whether private health benefit plans should be required to provide

18 19 (4) 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.

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

23 24 (6) How to best encourage market competition and ensure private health benefit plans retain sufficient flexibility to realize efficiencies.

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(7) Any other issues the Department deems appropriate.

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SECTION 1.(b) By September 1, 2019, the Department of Health and Human Services and the Department of Information Technology 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 health care via telemedicine. In conducting this study, the Departments shall and consider at least all of the following:

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

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



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- How to ensure all health care providers are connected to the North Carolina HIE Network.
- (4) Any other issues the Departments deems appropriate.

SECTION 1.(c) By September 1, 2019, the Department of Health and Human Services, in consultation with the North Carolina Institute of Medicine, the North Carolina Medical Board, and the North Carolina Board of Nursing 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.

August 2017.
(2) Guidelines established by the Agency for Healthcare Research and Quality.

(3) Any other sources the Department deems appropriate.

SECTION 1.(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 2.** This act is effective when it becomes law.

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HOUSE BILL 967*

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Short Title: Telemedicine Policy. (Public) Sponsors: Representatives Lambeth and Dobson (Primary Sponsors). For a complete list of sponsors, refer to the North Carolina General Assembly web site. Referred to: Health May 21, 2018 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: Business associate. – As defined in 45 C.F.R. § 160.103. (1)(2)Business associate contract. – As defined in 45 C.F.R. § 160.103. Covered entity. – As defined in 45 C.F.R. § 160.103. (3)(4) Department. - The North Carolina Department of Health and Human Services. (5)HIE Network. – As defined in G.S. 90-414.3(8). In-home monitoring. – The use of a nonportable medical device or equipment, (6)in combination with an Internet connection, to collect and store vital signs, or other health information, and transmit it to a health care provider. Protected health information. – As defined in 45 C.F.R. § 160.103. (7) Remote patient monitoring. - The use of a portable medical device, smart (8)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 health care provider. Store-and-forward imaging. - The acquisition and storing of clinical data, (9)including images, sound, or video, that is asynchronously transmitted to



another site for clinical evaluation.

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 health care services through audio-only telephone or teleconference, e-mail, or facsimile.

"§ 90-21.132. Practice of telemedicine.

Any individual licensed as a health care provider in the State of North Carolina under Chapter 90 of the General Statutes may provide health care 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 health care provider delivers health care via telemedicine, the health care 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 health care 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 health care 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 health care 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.

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- Each health care 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, health care 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:
 - All health care providers and their staff members who provide care via (1) telemedicine shall be trained in the use of telemedicine equipment and technology and its operation.
 - All telemedicine technology and equipment used by health care providers (2) 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 health care provider as part of the assessment.
 - All telemedicine providers shall maintain a complete record of the (3) 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.
 - No health care provider shall prescribe a controlled substance for the treatment (4) of pain unless that provider has, within the last 12 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.
- The areas of care for which health benefit plans should be required to provide (3) reimbursement.
- Whether private health benefit plans should be required to provide (4) reimbursement for health care delivered via telemedicine on the same terms as reimbursement for in-person care.
- (5)How to ensure the State's telemedicine reimbursement policy remains flexible enough to evolve with innovation.
- How to best encourage market competition and ensure private health benefit (6)plans retain sufficient flexibility to realize efficiencies.
- Any other issues the Department deems appropriate. **(7)**

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 health care 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:

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

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- How to ensure all health care providers are connected to the North Carolina

(2)

- HIE Network.(4) Any other issues the Department deems 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.

How to create community-based broadband adoption, utilization, and

(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.



HOUSE BILL 981: State as a Model Employer/IDD.

2017-2018 General Assembly

Committee: House Health Date: June 5, 2018
Introduced by: Reps. Bradford, Dollar, Lambeth, Sauls
Analysis of: First Edition Date: Theresa Matula
Legislative Analyst

OVERVIEW: House Bill 981 requires the Department of Health and Human Services (DHHS), in consultation with the Office of State Human Resources (OSHR), to study the development and implementation of a statewide program that establishes the State as a model employer in the employment of individuals with disabilities and report to the Joint Legislative Oversight Committee on Health and Human Services by December 1, 2018. The bill is a recommendation from the Joint Legislative Research Commission, Committee on Intellectual and Developmental Disabilities.

[As introduced, this bill was identical to S762, as introduced by Sens. Lee, Barringer, Edwards, which is currently in Senate Rules and Operations of the Senate.]

BILL ANALYSIS:

House Bill 981 requires DHHS, in consultation with the OSHR, to study the development and implementation of a comprehensive, statewide program that establishes the State as a model employer in the employment of individuals with disabilities. The goals of the program are as follows:

- Increasing disability inclusion and access to State agency employment.
- Specifically targeting an increase in the employment by State agencies of individuals with intellectual and developmental disabilities.
- Demonstrating to local government and private sector employers the viability and effectiveness of employing individuals with disabilities.

As part of the study, DHHS and OSHR are required to examine existing programs in other states and consider the feasibility of implementing a comprehensive program in North Carolina that contains a number of specified components.

By December 1, 2018, DHHS, in consultation with OSHR, must submit a report on the results of the study and any legislative recommendations to the Joint Legislative Oversight Committee on Health and Human Services.

EFFECTIVE DATE: The bill would become effective when it becomes law.

BACKGROUND: The bill is a recommendation from the Joint Legislative Research Commission, Committee on Intellectual and Developmental Disabilities.





Legislative Analysis Division 919-733-2578



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HOUSE BILL 981

Short Title: State as a Model Employer/IDD. (Public)

Sponsors: Representatives Bradford, Dollar, Lambeth, and Sauls (Primary Sponsors).

For a complete list of sponsors, refer to the North Carolina General Assembly web site.

Referred to: Health

May 23, 2018

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A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, IN CONSULTATION WITH THE OFFICE OF STATE HUMAN RESOURCES, TO STUDY THE DEVELOPMENT AND IMPLEMENTATION OF A PROGRAM TO ENCOURAGE THE EMPLOYMENT BY STATE AGENCIES OF INDIVIDUALS WITH DISABILITIES, INCLUDING TARGETING EMPLOYMENT OF INDIVIDUALS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES, AS RECOMMENDED BY THE LEGISLATIVE RESEARCH COMMISSION COMMITTEE ON INTELLECTUAL AND DEVELOPMENTAL DISABILITIES.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services (Department), in consultation with the Office of State Human Resources, shall study the development and implementation of a comprehensive, statewide program that establishes the State as a model employer in the employment of individuals with disabilities. The goals of the program shall include (i) increasing disability inclusion and access to State agency employment, (ii) specifically targeting an increase in the employment by State agencies of individuals with intellectual and developmental disabilities, and (iii) demonstrating to local government and private sector employers the viability and effectiveness of employing individuals with disabilities. As part of its study, the Department shall solicit the input of key stakeholders, including other relevant State agencies and organizations.

SECTION 2. In studying the development of a statewide program that establishes the State as a model employer for individuals with disabilities, the Department, in consultation with the Office of State Human Resources, shall examine existing programs in other states and shall consider the feasibility of implementing a comprehensive program in North Carolina that contains at least one or more of the following components, including expanding on existing programs:

- (1) Targeting hiring efforts through the Office of State Human Resources, including fast-track hiring policies that augment or streamline existing agency practices, trial work periods before offering permanent employment, preemployment certification through the Department for State employment, State agency internships, specific eligibility lists for hiring managers, and mandatory interview opportunities.
- (2) Focusing on recruitment and outreach efforts to identify and attract skilled individuals with disabilities for State employment.



	General Assem	bly Of North Carolina Session 2017			
1	(3)	Enhancing accessibility to State employment applications and the steps in the hiring process.			
3	(4)	Developing explicit reasonable workplace accommodation guidelines that include managing costs and providing a request process that encourages			
5	(5)	individuals with disabilities to apply for State employment.			
7	(5)	Building upon existing State personnel training programs to further encourage inclusion of individuals with disabilities in the workplace.			
8	(6)	Enabling data collection for evaluation and oversight of the State's			
9		employment practices for hiring individuals with disabilities.			
10	(7)	Increasing public and private partnerships to further develop work-based			
11		opportunities leading to State employment, such as Project SEARCH.			
12	SEC'	TION 3. By December 1, 2018, the Department, in consultation with the Office			
13	of State Human	Resources, shall submit a report to the Joint Legislative Oversight Committee			
14	on Health and Human Services on the results of the study required by this act, including any				
15	legislative recon	nmendations.			

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



HOUSE BILL 998: Improving NC Rural Health.

2017-2018 General Assembly

Committee: House Health

Introduced by: Reps. Lewis, Murphy, White, Hunter

Analysis of: PCS to First Edition

H998-CSSH-35

Date: June

June 4, 2018

Prepared by: Theresa Matula

Legislative Analyst

OVERVIEW: The PCS for HB 998 directs the Department of Health and Human Services (DHHS) to study incentives for medical education in rural areas and assist rural hospitals in becoming designated as teaching hospitals; directs the Office of Rural Health, DHHS, to ensure the loan repayment program is targeted to benefit health care providers in rural areas, and to identify the need for dentists in rural areas; and directs DHHS to study changes to the Medicaid Program that will increase preventative health services, improve health outcomes, and lower the cost of care.

The PCS for HB 998 combines HB 998, Section 2 of HB 999, and Section 2 from HB 1000, which as introduced were recommendations from the Legislative Research Commission, Committee on Access to Healthcare in Rural NC.

[As introduced, this bill was identical to S742, as introduced by Sens. Curtis, McInnis, Britt, which is currently in Senate Rules and Operations of the Senate.]

BILL ANALYSIS: <u>PART I. GME and New Teaching Hospitals</u> focuses on health care providers and hospitals in rural NC by requiring DHHS to conduct two studies.

Section 1(a) and (b) require DHHS to study options to incentivize health care providers in rural NC by identifying modifications, enhancements, and other changes to graduate medical education payments to hospitals. In conducting the study, the Department may collaborate with the North Carolina Area Health Education Centers (AHEC) Program. DHHS is required to report to the Joint Legislative Oversight Committee on Health and Human Services (JLOC-HHS) and the Joint Legislative Oversight Committee on Medicaid and NC Health Choice (JLOC-Medicaid & Health Choice) by October 1, 2018. The report must include specific, actionable steps that can be implemented, along with estimated costs and a timetable for implementation.

Section 2(a) and (b) require DHHS to conduct a study to (i) identify rural hospitals that desire to be designated as new teaching hospitals by the Centers for Medicare and Medicaid Services (CMS); (ii) determine the technical assistance those hospitals require in order to be designated as new teaching hospitals by the Centers for Medicare and Medicaid Services; and (iii) calculate the expected cost for those hospitals to be designated as new teaching hospitals by (CMS). DHHS must provide an interim report by October 1, 2018 and a final report by October 1, 2019, to the JLOC-HHS and the JLOC-Medicaid & Health Choice.

<u>PART II. Target Loan Repayment Programs</u> requires the Office of Rural Health, DHHS, to align the Program with specified goals and to identify the need for dentists in rural areas then develop a recommendation to target Program funds for dentists.





Legislative Analysis Division 919-733-2578

House PCS 998

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<u>Section 3(a)</u> directs the Office of Rural Health, DHHS, to structure the North Carolina State Loan Repayment Program to align the Program with the following goals:

- (1) Increase the number of health care providers in rural areas of the State.
- (2) Coordinate it with the National Health Service Corps and Federal Loan Repayment programs, as well as any other publicly or privately funded programs, to maximize funding in order to increase the number of health care providers in rural areas of the State.
- (3) Encourage both recruitment and retention of health care providers in rural areas of the State.

Section 3(b) directs the Office of Rural Health to work with data from the Cecil G. Sheps Center for Health Services Research, and other sources, to identify the need for dentists in rural NC and to develop a recommendation to target loan repayment funds for dentists in rural areas that have been identified as having the greatest need.

<u>Section 3(c)</u> requires the Office of Rural Health to provide an interim report by October 1, 2018, and a final report by October 1, 2019, on the requirements in this section to the JLOC-HHS.

<u>PART III. Study Medicaid</u> requires the DHHS to study Medicaid to determine methods to increase preventative health services, improve health outcomes, and lower the overall cost of care.

Section 4 requires DHHS to study whether there are changes to the State Medicaid Program that will increase preventative health services, improve health outcomes, and lower the overall cost of care. The alternatives studied should include evaluation of the direct primary care model. The study must determine the following: (i) how options will relate to the outcome measures that will be included in Prepaid Health Plan contracts under the transformed Medicaid program, (ii) the contract options for improving primary care physician quality of life in a rural setting that include, but are not limited to, a direct primary care type payment model, and (iii) the total cost implications and legislation needed to implement recommendations. DHHS is required to report to the JLOC-Medicaid & Health Choice on or before October 1, 2019.

EFFECTIVE DATE: The bill would become effective when it becomes law.

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HOUSE BILL 998

PROPOSED COMMITTEE SUBSTITUTE H998-CSSH-998 [v.4]

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Short Title: Improving NC Rural Health. (Public)

Sponsors:

Referred to:

May 24, 2018

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO

STUDY AND REPORT RECOMMENDATIONS TO CREATE INCENTIVES FOR

MEDICAL EDUCATION IN RURAL AREAS OF THE STATE AND TO ASSIST RURAL

HOSPITALS IN BECOMING DESIGNATED AS TEACHING HOSPITALS BY THE

CENTERS FOR MEDICARE AND MEDICAID SERVICES; TO DIRECT THE OFFICE

OF RURAL HEALTH, DEPARTMENT OF HEALTH AND HUMAN SERVICES, TO

ENSURE ITS LOAN REPAYMENT PROGRAM IS TARGETED TO BENEFIT HEALTH

CARE PROVIDERS IN RURAL NORTH CAROLINA, INCLUDING IDENTIFYING

AND MAKING RECOMMENDATIONS TO ADDRESS THE NEED FOR DENTISTS IN

RURAL AREAS: AND TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN

SERVICES TO STUDY CHANGES TO THE MEDICAID PROGRAM THAT WILL

INCREASE PREVENTATIVE HEALTH SERVICES, IMPROVE HEALTH OUTCOMES,

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The General Assembly of North Carolina enacts:

PART I. GME AND NEW TEACHING HOSPITALS

AND LOWER THE COST OF CARE.

SECTION 1.(a) The Department of Health and Human Services shall conduct a study to identify options for modification, enhancements, and other changes to graduate medical education payments to hospitals, as well as any other reimbursements, to incentivize health care providers in rural areas of the State to (i) participate in medical education programs exposing residents to rural areas, programs, and populations and (ii) support medical education and medical residency programs in a manner that addresses the health needs in the State. In conducting the study, the Department may collaborate with the North Carolina Area Health Education Centers Program. The study shall examine at least all of the following:

- Changes in Medicaid graduate medical education reimbursement and funding (1)sources after the 1115 Medicaid waiver submitted by the Department to the Centers for Medicare and Medicaid Services is approved, including how the changes vary from the current model, the rationale for the changes, and the specific incentives the new structure creates for urban and rural hospitals.
- (2)Options to coordinate North Carolina Area Health Education Centers funding to create incentives for attracting residents and students to rural areas of the State, with the goal of ensuring the maximum benefit of the funding.
- (3) Any other issues the Department deems appropriate.



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SECTION 1.(b) The Department shall report its findings to the Joint Legislative Oversight Committee on Health and Human Services and the Joint Legislative Oversight Committee on Medicaid and NC Health Choice by October 1, 2018. The report must include specific, actionable steps that can be implemented, along with estimated costs and a timetable for implementation.

SECTION 2.(a) The Department of Health and Human Services shall conduct a study to (i) identify rural hospitals that desire to be designated as new teaching hospitals by the Centers for Medicare and Medicaid Services; (ii) determine the technical assistance those hospitals require in order to be designated as new teaching hospitals by the Centers for Medicare and Medicaid Services; and (iii) calculate the expected cost for those hospitals to be designated as new teaching hospitals by the Centers for Medicare and Medicaid Services. In conducting this study, the Department shall engage external professionals with experience and expertise in the establishment of new teaching programs, expanding existing programs, and maximizing the effectiveness of funding for medical education, particularly in rural areas. The study shall examine at least all of the following:

- (1) Expansion of graduate medical education payments to outpatient costs and services.
- Modifications to cost-finding and reimbursement formulas that incentivize (2) rural hospitals to participate in education programs.
- Options in physician reimbursement to incentivize participation, including a (3) graduate medical education or geographic add-on for rural areas of the State.
- Any other issues the Department deems appropriate.

SECTION 2.(b) The Department shall provide an interim report of its findings to the Joint Legislative Oversight Committee on Health and Human Services and the Joint Legislative Oversight Committee on Medicaid and NC Health Choice by October 1, 2018. The Department shall submit a final report to the Joint Legislative Oversight Committee on Health and Human Services and the Joint Legislative Oversight Committee on Medicaid and NC Health Choice by October 1, 2019.

PART II. TARGET LOAN REPAYMENT PROGRAMS

SECTION 3.(a) The Office of Rural Health, Department of Health and Human Services, is directed to structure the North Carolina State Loan Repayment Program so that it is aligned with all of the following goals:

- The Program is targeted to increase the number of health care providers in (1)rural areas of the State.
- The Program is coordinated with the National Health Service Corps and (2) Federal Loan Repayment programs, as well as any other publicly or privately funded programs, to maximize funding in order to increase the number of health care providers in rural areas of the State.
- The Program encourages both recruitment and retention of health care (3) providers in rural areas of the State.

SECTION 3.(b) The Office of Rural Health, Department of Health and Human Services, is directed to work with data from the Cecil G. Sheps Center for Health Services Research, and other sources, to identify the need for dentists in rural areas in North Carolina and to develop a recommendation to target loan repayment funds for dentists in rural areas that have been identified as having the greatest need for dentists.

SECTION 3.(c) On or before October 1, 2018, the Office of Rural Health, Department of Health and Human Services, 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 Office of Rural Health, Department of Health and 1 2 3

Human Services, shall provide a final report to the Joint Legislative Oversight Committee on Health and Human Services on the actions required by this section.

implement recommendations. The Department of Health and Human Services shall report its

findings and recommendations to the Joint Legislative Oversight Committee on Medicaid and

SECTION 4. The Department of Health and Human Services shall study whether

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PART III. STUDY MEDICAID

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there are changes to the State Medicaid Program that will increase preventative health services, improve health outcomes, and lower the overall cost of care. The alternatives studied should include evaluation of the direct primary care model. The study shall determine the following: (i) how options will relate to the outcome measures that will be included in Prepaid Health Plan contracts under the transformed Medicaid program, (ii) the contract options for improving primary care physician quality of life in a rural setting that include, but are not limited to, a direct primary care type payment model, and (iii) the total cost implications and legislation needed to

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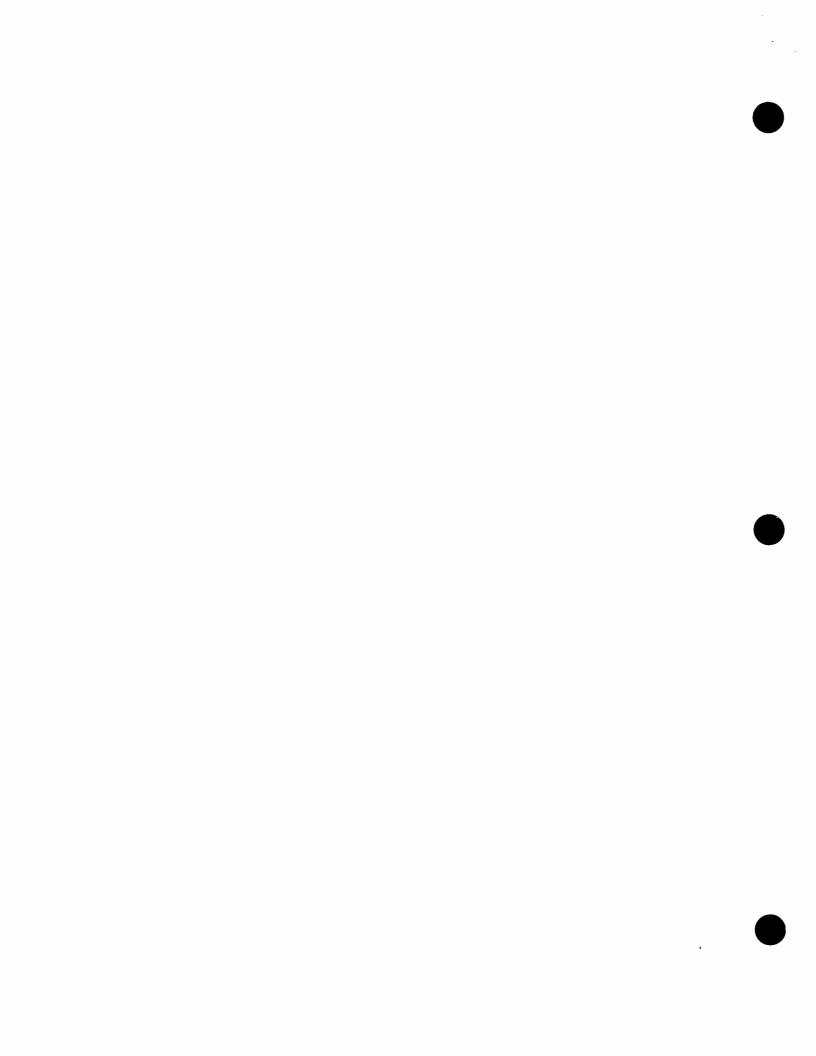
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PART IV. EFFECTIVE DATE

NC Health Choice on or before October 1, 2019.

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

H998-CSSH-998 [v.4]



HOUSE BILL 998*

(D 11')

Short Title:

GME/Rural Hospital Study.

(Public)

Sponsors:

H

Representatives Lewis, Murphy, White, and Hunter (Primary Sponsors).

For a complete list of sponsors, refer to the North Carolina General Assembly web site.

Referred to:

Health

May 24, 2018

A BILL TO BE ENTITLED

AN ACT DIRECTING THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO STUDY AND REPORT RECOMMENDATIONS TO CREATE INCENTIVES FOR MEDICAL EDUCATION IN RURAL AREAS OF THE STATE AND TO ASSIST RURAL HOSPITALS IN BECOMING DESIGNATED AS TEACHING HOSPITALS BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, AS RECOMMENDED BY THE LEGISLATIVE RESEARCH COMMISSION.

The General Assembly of North Carolina enacts:

SECTION 1.(a) The Department of Health and Human Services shall conduct a study to identify options for modification, enhancements, and other changes to graduate medical education payments to hospitals, as well as any other reimbursements, to incentivize health care providers in rural areas of the State to (i) participate in medical education programs exposing residents to rural areas, programs, and populations and (ii) support medical education and medical residency programs in a manner that addresses the health needs in the State. In conducting the study, the Department may collaborate with the North Carolina Area Health Education Centers Program. The study shall examine at least all of the following:

- (1) Changes in Medicaid graduate medical education reimbursement and funding sources after the 1115 Medicaid waiver submitted by the Department to the Centers for Medicare and Medicaid Services is approved, including how the changes vary from the current model, the rationale for the changes, and the specific incentives the new structure creates for urban and rural hospitals.
- Options to coordinate North Carolina Area Health Education Centers funding to create incentives for attracting residents and students to rural areas of the State, with the goal of ensuring the maximum benefit of the funding.
- (3) Any other issues the Department deems appropriate.

SECTION 1.(b) The Department shall report its findings to the Joint Legislative Oversight Committee on Health and Human Services and the Joint Legislative Oversight Committee on Medicaid and NC Health Choice by October 1, 2018. The report must include specific, actionable steps that can be implemented, along with estimated costs and a timetable for implementation.

SECTION 2.(a) The Department of Health and Human Services shall conduct a study to (i) identify rural hospitals that desire to be designated as new teaching hospitals by the Centers for Medicare and Medicaid Services; (ii) determine the technical assistance those hospitals require in order to be designated as new teaching hospitals by the Centers for Medicare and Medicaid Services; and (iii) calculate the expected cost for those hospitals to be designated



as new teaching hospitals by the Centers for Medicare and Medicaid Services. In conducting this study, the Department shall engage external professionals with experience and expertise in the establishment of new teaching programs, expanding existing programs, and maximizing the effectiveness of funding for medical education, particularly in rural areas. The study shall examine at least all of the following:

- (1) Expansion of graduate medical education payments to outpatient costs and services.
- (2) Modifications to cost-finding and reimbursement formulas that incentivize rural hospitals to participate in education programs.
- Options in physician reimbursement to incentivize participation, including a graduate medical education or geographic add-on for rural areas of the State.
- (4) Any other issues the Department deems appropriate.

SECTION 2.(b) The Department shall provide an interim report of its findings to the Joint Legislative Oversight Committee on Health and Human Services and the Joint Legislative Oversight Committee on Medicaid and NC Health Choice by October 1, 2018. The Department shall submit a final report to the Joint Legislative Oversight Committee on Health and Human Services and the Joint Legislative Oversight Committee on Medicaid and NC Health Choice by October 1, 2019.

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



HOUSE BILL 1002: Medical Education & Residency Study.

2017-2018 General Assembly

Committee: House Health Date: June 5, 2018
Introduced by: Reps. Lambeth, Horn, Dobson, Johnson First Edition Prepared by: Staff Attorney

OVERVIEW: House Bill 1002 would allow the Joint Legislative Oversight Committee on Health and Human Services and the Joint Legislative Education Oversight Committee to appoint subcommittees, which may meet jointly or separately, to study various issues regarding state support for medical education and residency programs with the goal of developing a plan to support those programs in a manner that maximizes state support and best addresses the healthcare needs of North Carolina residents, particularly those in rural areas. It would also require the Department of Health and Human Services to study and report on Medicaid funding for medical education and residency programs.

This bill was recommended by the Joint Legislative Oversight Committee on Health and Human Services and the Joint Legislative Education Oversight Committee.

[As introduced, this bill was identical to S733, as introduced by Sens. Curtis, Pate, Krawiec, which is currently in Senate Rules and Operations of the Senate.]

BILL ANALYSIS:

Sections 1, 2, and 4 of the bill would allow the Joint Legislative Oversight Committee on Health and Human Services and the Joint Legislative Education Oversight Committee to each appoint subcommittees to study medical education and medical residency programs. The subcommittees may meet jointly or separately, may solicit input from stakeholders, other states, and national experts, and may examine:

- Meeting the healthcare needs of the state through the support and funding of medical education and residency programs.
- The benefits of allocating funds to medical education and residency programs.
- Recommended changes to state support of medical education and residency programs.
- Protocols used to determine how much funding each medical education and residency program should receive.

The subcommittees would be required to develop proposals for a statewide plan to support medical education and residency programs in a manner that maximizes state support and best addresses the healthcare needs of North Carolina residents, particularly those in rural areas. The subcommittees would be able to issue interim reports to their respective oversight committees by November 1, 2018, and would be required to issue a final report by March 1, 2020.

Section 3 of the bill would require the Department of Health and Human Services (DHHS) to submit a report to the Joint Legislative Oversight Committee on Health and Human Services and the Joint Legislative Oversight Committee on Medicaid and NC Health Choice on medical education and residency programs. The Department may consult with stakeholders, and the report must contain the following items:

Karen Cochrane-Brown Director



Legislative Analysis Division 919-733-2578

House Bill 1002

Page 2

- Information about medical school student and residency slots.
- Suggested overall objectives for medical education and residency programs in the state.
- The total funding for the North Carolina Area Health Education Centers for the last three fiscal years.
- The total funding for the University of North Carolina at Chapel Hill School of Medicine and the East Carolina University Brody School of Medicine for the last three fiscal years.
- The total reimbursement paid to North Carolina hospitals related to graduate medical education through the Medicaid program.
- An explanation of all Medicaid graduate medical education reimbursement methodologies DHHS is using or intends to use under Medicaid transformation.
- Strategies rural hospitals communities use to attract and retain healthcare providers.
- Recommendations about forming an entity to compile and oversee data for the state's medical education and residency programs.
- An analysis of how other states use funding to recruit and retain healthcare providers in rural areas.
- Limitations set by other entities that might impact the state's ability to modify medical education and residency programs to meet the state's objectives.

EFFECTIVE DATE: This act would be effective when it becomes law.

BACKGROUND: Section 11J.2 of S.L. 2017-57 authorized the Joint Legislative Oversight Committee on Health and Human Services and the Joint Legislative Education Oversight Committee to appoint a joint subcommittee to examine the use of state funds to support medical education and residency programs. The joint subcommittee determined that additional data was needed to inform the work of future subcommittees.

H HOUSE BILL 1002*

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

Sponsors: Representatives Lambeth, Horn, Dobson, and Johnson (Primary Sponsors).

For a complete list of sponsors, refer to the North Carolina General Assembly web site.

Referred to: Health

May 24, 2018

A BILL TO BE ENTITLED

AN ACT TO STUDY MEDICAL EDUCATION PROGRAMS 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, Section 11J.2 of S.L. 2017-57 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 programs 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 programs and medical 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 programs 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 programs and medical 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 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 programs 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 programs 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 programs 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 Section 11J.2(c) of S.L. 2017-57 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 programs and medical 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 time frames for achievement, which will be used by the State when funding medical education programs and medical 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 medical 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 medical residency program in North Carolina.
- (2) Suggested overall objectives for the medical education programs and medical residency programs in the State, including identified outcomes and goals to meet the needs of rural areas.

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- (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.
- A detailed explanation of all Medicaid GME reimbursement methodologies (6) 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 S.L. 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.
- Strategies, outside of the publically funded programs, used by hospitals and (7) 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 programs and medical 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 the 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

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

House Pages Assignments Wednesday, June 06, 2018 Session: 11:00 AM

Membe	Comments	Staff	Time	Room	Committee
Rep. Darren G. Jackson		Zoe Nichols	10:00 AM	643	Health
Speaker Tim Moore		Layla Leila Samiy			
Rep. James L. Boles, Jr		Amber Ward			
Rep. Ken Goodmar		Bray Woodard			
Speaker Tim Moore		Miller Andrews	10:00 AM	544	State and Local Government
Rep. Cynthia Ba		Anne Asbill			
Rep. Tim Moore		Emily Davis			
Rep. Michael Speciale		Imari Simmons			
Rep. John Autr		Richard Asbill	1:00 PM	643	Energy Policy Commission, Jt. Leg.
Rep. George G Cleveland		Martin Kinney			
Rep. Julia C. Howard		Payton Martin			
Speaker Tim Moore		Leila Samiy			
Rep. George G Cleveland		Mitchell Messenger	1:00 PM	415	Judiciary I
Rep. Darren G. Jackson		Zoe Nichols			
Rep. Grier Martir		Emerson Replogle	•		
Rep. Rosa U. Gi		Christian Terrell			
Speaker Tim Moore		Rebecca Burkhart	1:00 PM	1425	Judiciary II
Rep. Tim Moore		Emily Davis			

Wednesday, June 06, 2018

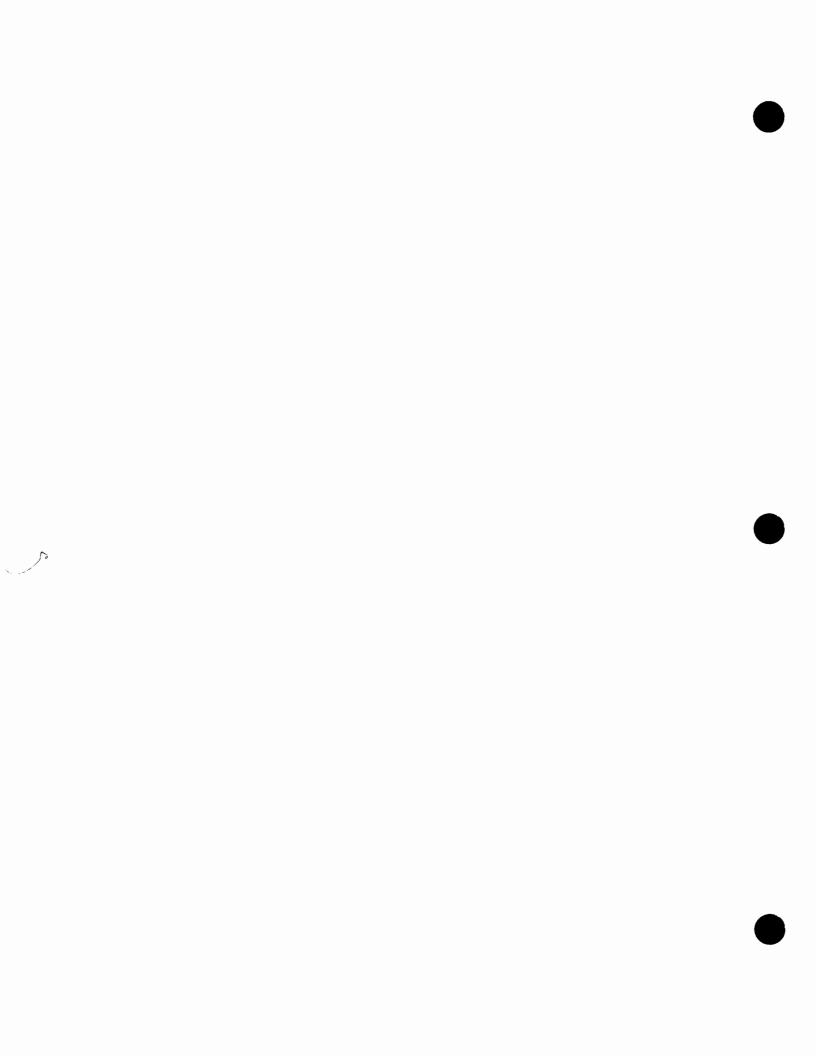
Page: 1 of 2

9:01 AM

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Committee Sergeants at Arms

NAME OF COMMITTEE House Committee on Health	
DATE: 06/06/2018 Room: 643	
House Sgt-At Arms:	
1. Name: Terry McCraw	
2. Name: Jim Moran	
Name: Rex Foster	
4. Name: Ken Gilbert	
5. Name: David Leichton Russell Salisbury	
Senate Sgt-At Arms:	
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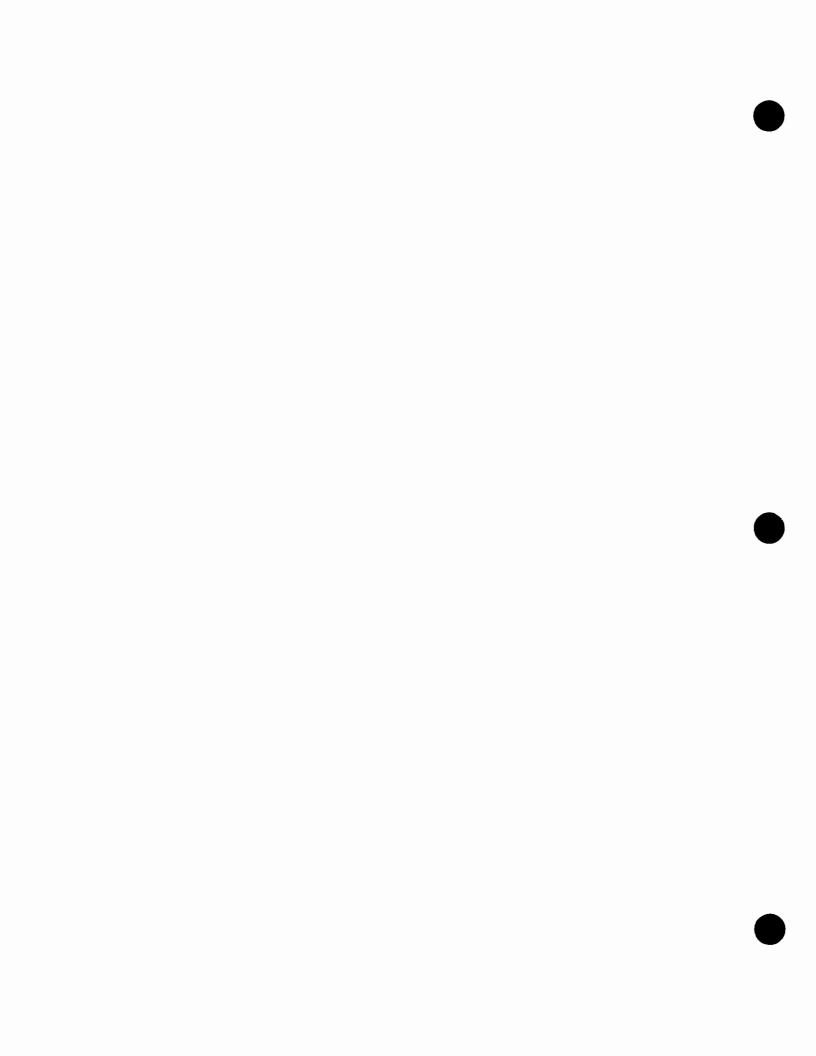
House Committee on Health

06/06/2018

Name of Committee

Date

NAME	FIRM OR AGENCY AND ADDRESS
PeyTan Magner	Gpm
Cuip BAGGETT	Med soc
Morl, Flenny	Blue Cross NC
Lindsey Drusting	FSP
- The Man	·CGA
Wendy Kelly	Four conoling
JOÉ LANIER	YROUTMAN
Kari Barsness	Coteway
NICHOUS GARAM -	NCHA.
Hyr Julian	NCA
Kary Kge	NERMA



House Committee on Health	06/06/2018
Name of Committee	Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

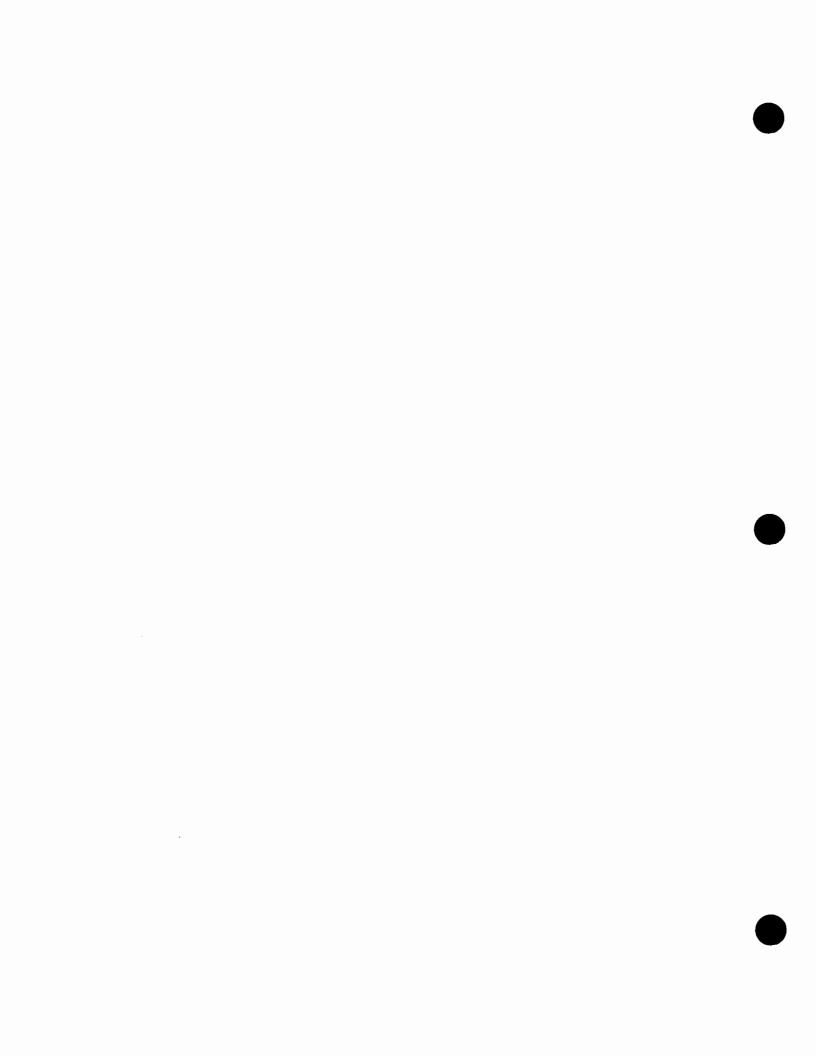
AGENCY AND ADDRESS

FIRM	OR
	FIRM

Emily Roland	NCHA
CHRISTIAN LAWSON	NCHA UNC HEATH CARE
Kara Weishaar	SA
KABUN ROBINGM	NORMA
Mis (anh)	DANC
Copy Hanp	NICHA
lori Kroll	Novant Health
Elise Herman	Novant Health
Paul Perryman	unc Hospitals
Barbara-Ann Bybel	UNE Health care
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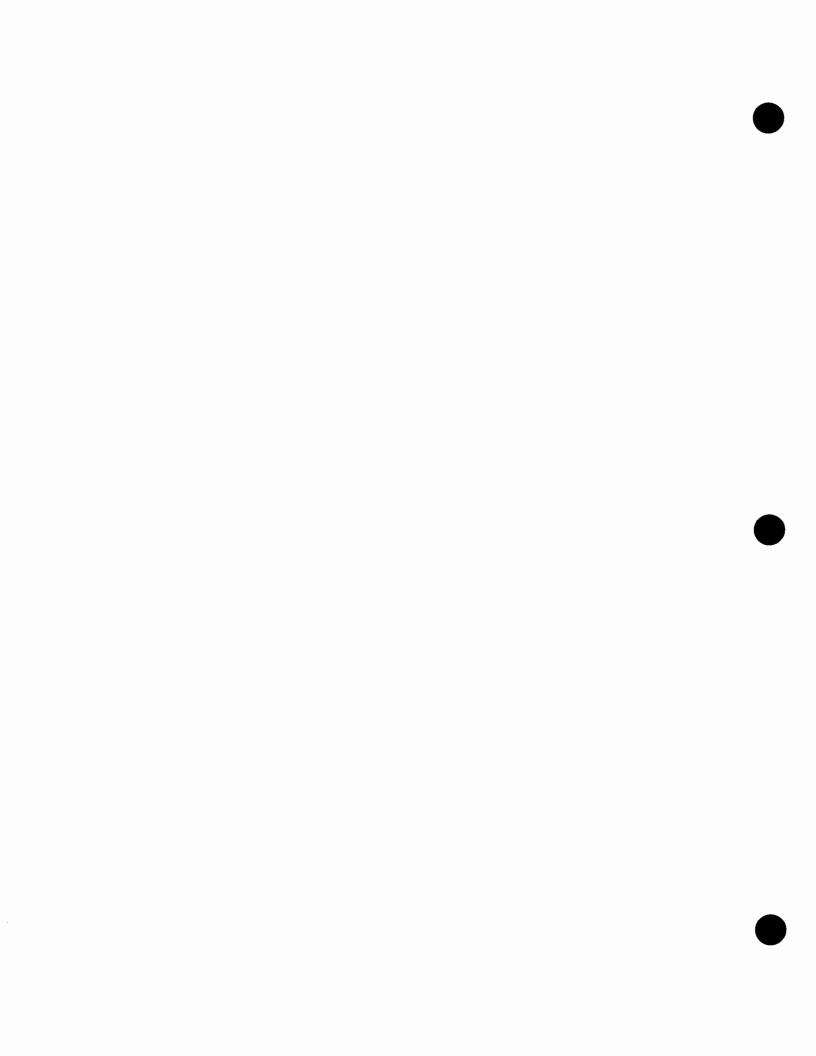
House Committee on Health	06/06/2018
Name of Committee	Date

NAME	FIRM OR AGENCY AND ADDRESS
W. Dardner Elpp	PPAB
Christine Crain	Wakehud
Dana Simpson	Smith Anderson
Amande Sin	NCDOJ
Musica Baymes	NC DUT
DAVID COWERS	PSUL
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House Committee on Health	06/06/2018
Name of Committee	Date

NAME	FIRM OR AGENCY AND ADDRESS
Evelyn (infre	NC Medical Bourd
MitneyChrastenson	Wardasmith
Caroline Duffe	Ward & Smith
Joh Pastin	NC Fanily
Sorah Palicuis	. mas mellen
Scott LASTER	KBANC
Tafari Bailey	NC House Intern
Carol maranel	Office of Governor intern
AMES SIMMONS	EQUALITY NC
Betryletter	American least Asgul
TolettarQu	MIS
Will Morgan	MES



House Committee on Health	06/06/2018
Name of Committee	Date

NAME .	FIRM OR AGENCY AND ADDRESS	*
Karen Wude	NC D+HU	
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House Committee on Health	
Name of Committee	

06/06/2018

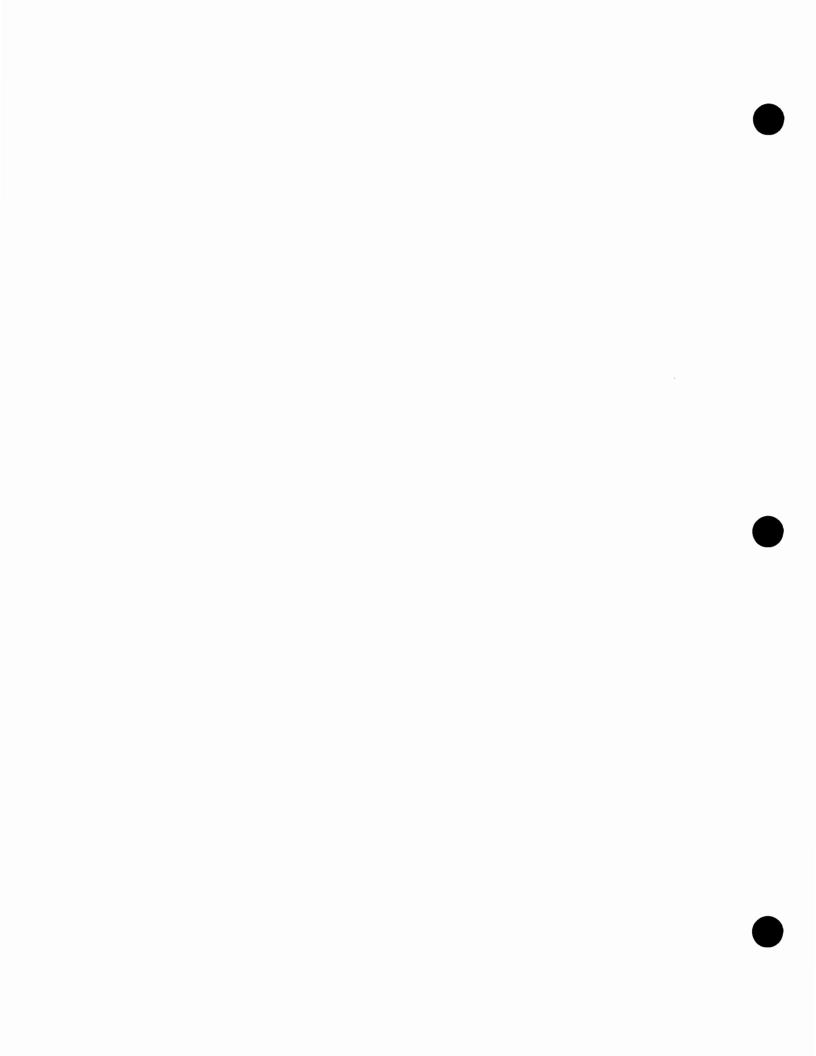
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Copinie Wilson	NCOA
Han Isl	MUC
Pacle Bealin	Polan
Lope this Larvis	LALA
amanda Donovan	KTS
Middle Frazier	119
Karen Kranbuch	NC Substance Use Disorder Federation
Kay Castillo	NASW-NC
Donald Mc Donald	APAC
Kathleen Lowe	APNC



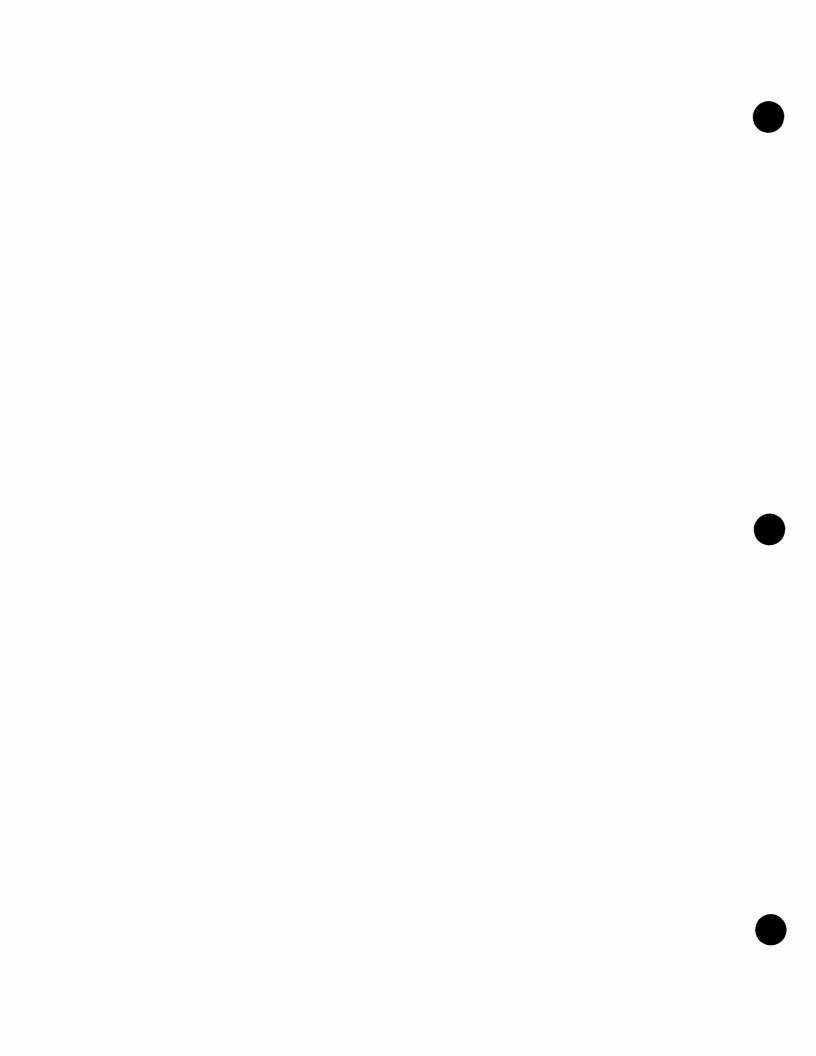
House Committee on Health	06/06/2018
Name of Committee	Date

NAME	FIRM OR AGENCY AND ADDRESS
John Markham	
Tessie Castillo	Ne Harm Ridockin Coalition
Carrilee Andreu-Neel	Eastern Ovological Associates 275 Bethesda De 783
Carrilee Andrew-Neel Soul Zolls	Eastern Urological Associates 275 Rethesta Dr 783 Bulchere 19586-
TIRvopee	·NP
Sondy Sonds	NP
Emma Shelby	TPG
Ray Riordon	The Carolinas Center
Amanda Borer	NC Eldercare Workforce Coalition/NCA
Resha Fortson	SEANC
Linnea Home	SEANC



House Committee on Health	06/06/2018
Name of Committee	Date

NAME	FIRM OR AGENCY AND ADDRESS
Mindy P. Hman	NIA
Kelly Vojel	Anthem
dela Perkinson	Pakin La
Ava Autry	Student
Mila Walker	Forward Justice
Corey Purché	Wash Away Unenployment
Sarah Gillooly	ACLU
Mike Comoly	NC DOR
TonySimpson	NCOOR.



House Committee on Health 06/06/2018

Name of Committee Date

NAME	FIRM OR AGENCY AND ADDRESS
Theres	CSS
Sarah Wolfe	MMC
Kervi Burke	NWC
Undsey Rose	NCMS
Rajari S Parilh	NCMS
Latonia Beatl.	Nems
Su Am Forress	NCMS
Ton Mayer	NCMS
Marc Carrette	NCM5
Jon Con	Tordan Pry
AndyChase	KMA



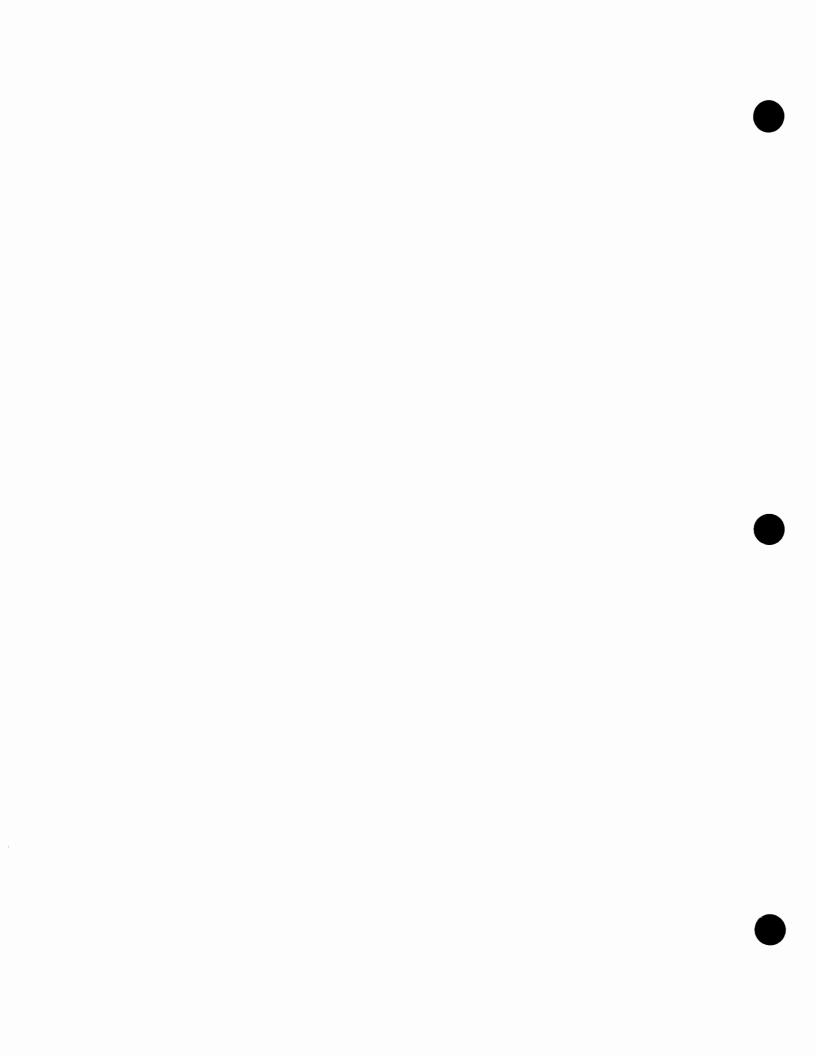
House Committee on Health

06/06/2018

Name of Committee

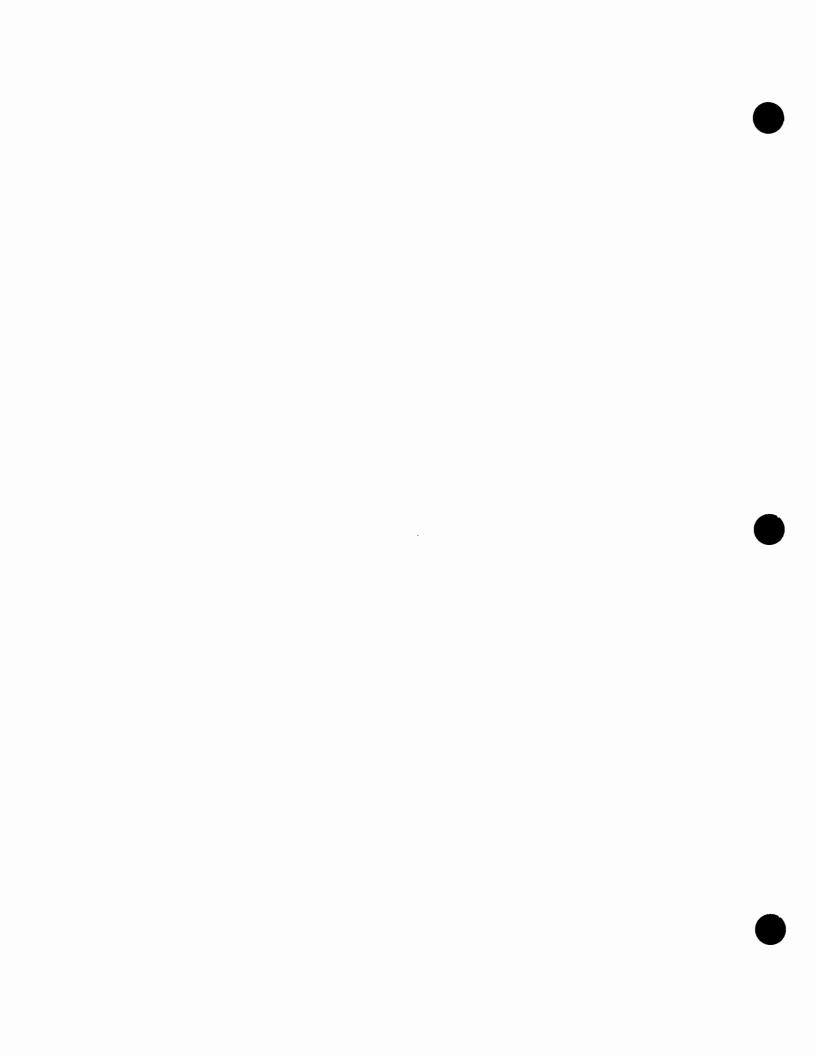
Date

NAME	FIRM OR AGENCY AND ADDRESS
Stephen Kuba	KMA
Josh Lair	5541
som West	NCICH
Susan Mayo	NCICA
Helen Power	Nems / UNC school of Medicine
Genmattson	NCH S
Bethy DOSRR	UNC charlotte
JEST BARNHART	Mwc
Julia Adams	OCGR .
REU. MAKLE CREECH	CAL
Open Royall	NCFPC



House Committee on Health	06/06/2018
Name of Committee	Date

NAME	FIRM OR AGENCY AND ADDRESS
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Tony Adams	adones and assoc.
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Will Price	. 1 04
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Lisa Martin	Cap. Ad
JAI KUMRE	NCHA
Julia Wacker	NOTA.
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House Committee on Health Wednesday, June 13, 2018 at 11:00 AM Room 643 of the Legislative Office Building

MINUTES

The House Committee on Health met at 11:00 AM on June 13, 2018 in Room 643 of the Legislative Office Building. Representatives Adcock, Ball, Blackwell, Boswell, Brisson, Carney, Cunningham, Dobson, Dollar, Dulin, Earle, Farmer-Butterfield, Ford, Howard, Hunter, Insko, Jackson, Bert Jones, Lambeth, Malone, Murphy, Potts, Rogers, Setzer, Shepard, Szoka, White, Wray, Yarborough, and Zachary attended.

Representative Donny Lambeth, Chair, presided.

The following bills were considered:

SB 368 Update False Claims Act/Rare Disease Appt/HIE. (Senators Hise, Pate, Krawiec)

Chairman Lambeth asked for a motion for the PCS for SB368 to be before the committee. Representative Dollar made the motion. The motion passes.

Chairman Lambeth recognized Representatives Dobson to explain the PCS. The PCS for SB 368 updates the False Claims Act; extends the appointments of the members for the Advisory Council on Rare Diseases; and extends the date for connection with the HIE Network for Dentists, Pharmacies, and Ambulatory Surgical Centers.

Representative Dollar asked to send forth an amendment. Chairman Lambeth recognized Representative Dollar to explain his amendment. The amendment was adopted. (Attachment 1)

Chairman Lambeth recognized Mr. Charles Hobgood, Special Deputy Attorney General Director, Medicaid Investigations Division with the North Carolina Department of Justice to assist in answering questions from the committee.

After discussion on the bill Chairman Lambeth recognized Representative Potts for a motion. Representative Potts motioned for a favorable report to the PCS for SB368 as amended and rolled into a new PCS, unfavorable to the original bill. The motion passes.

SB 630 Revise IVC Laws to Improve Behavioral Health. (Senators Hise, Krawiec, Randleman)

Chairman Lambeth asked for a motion for the PCS for SB630 to be before the committee. Representative Dobson made the motion. The motion passes.

Chairman Lambeth recognized Representative Dobson to explain the PCS. Senate Bill 630 would make changes to the laws for voluntary and involuntary commitment for the mentally ill and substance abusers, which are found in Chapter 122C of the General Statutes.



After introduction of the PCS 3 amendments were offered. Chairman Lambeth recognized Representatives Adoock to explain her amendment. The amendment was adopted. (Attachment 2)

Representative Jackson was then recognized to explain his amendment. He deferred to staff for the explanation. The amendment failed. (Attachment 3)

Chairman Lambeth then recognized Representative Insko to explain her amendment. The amendment failed. (Attachment 4)

Chairman Lambeth recognized Cody Hand with the Healthcare Association to assist with answering questions from the committee.

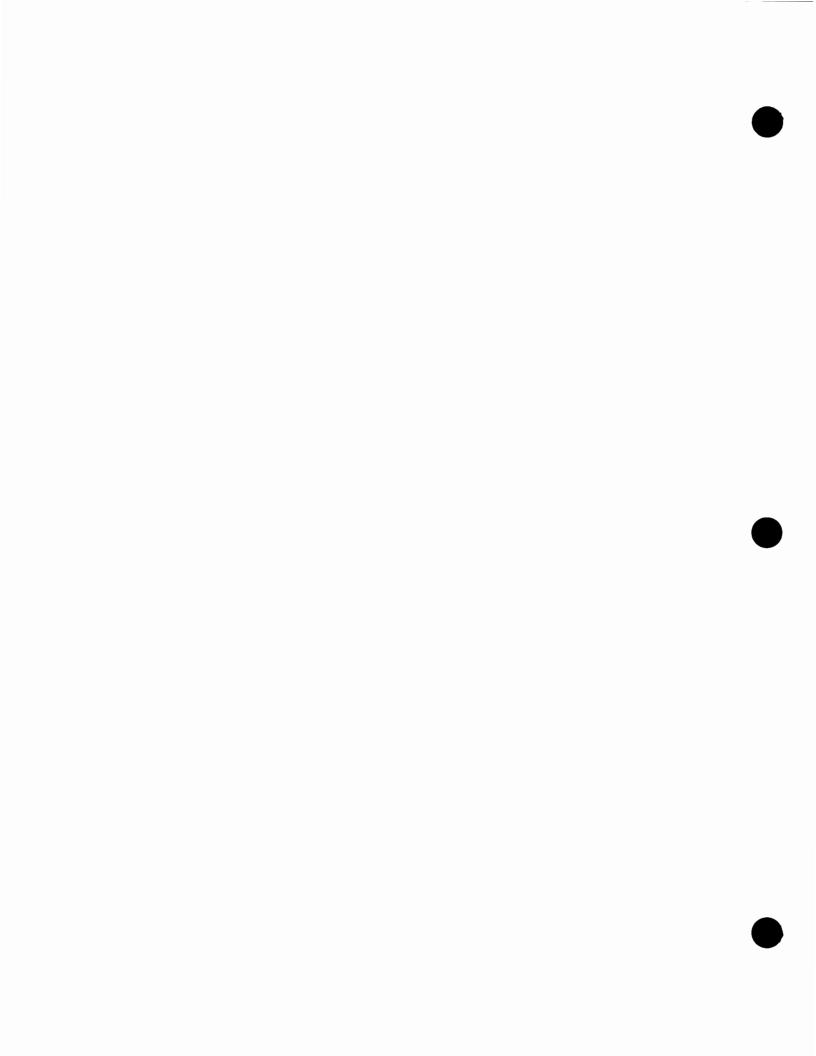
After discussion from the committee Representative Dobson motion for a favorable report to the PCS as amended and rolled into a new PCS, unfavorable to the original bill. The motion passes.

The meeting adjourned at 11:55.

Representative Donny Lambeth, Chair

Presiding

Theresa Lopez, Committee Cle



NORTH CAROLINA HOUSE OF REPRESENTATIVES COMMITTEE MEETING NOTICE AND BILL SPONSOR NOTIFICATION 2017-2018 SESSION

You are hereby notified that the House Committee on Health will meet as follows:

DAY & DATE: Wednesday, June 13, 2018

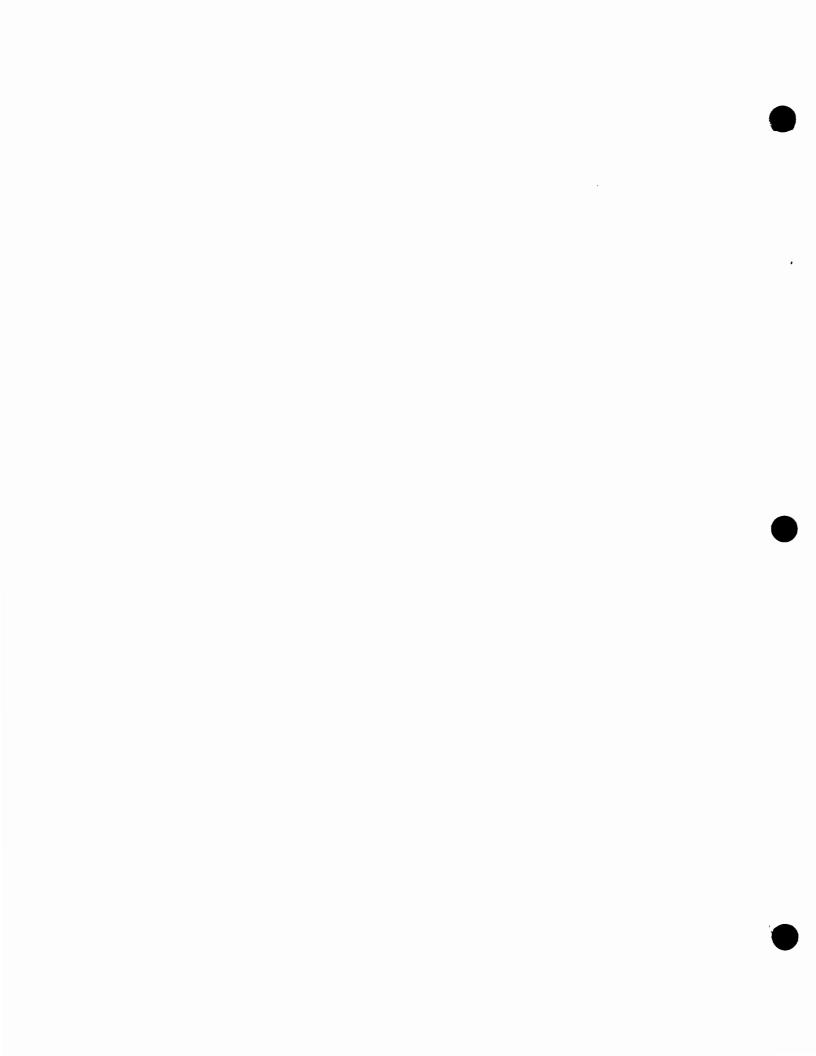
11:00 AM

643 LOB

TIME:

LOCATION:

COMMENT	S: Representative Lambeth will be	chairing.
The following	g bills will be considered:	
BILL NO.	SHORT TITLE	SPONSOR
SB 368	Update False Claims Act/Rare Diseas	
	Appt/HIE.	Senator Pate
SB 630	Device IVC Leve to Improve	Senator Krawiec
<u>3D 030</u>	Revise IVC Laws to Improve Behavioral Health.	Senator Hise Senator Krawiec
	Denavioral Fleatur.	Senator Randleman
	Respe	ectfully,
		sentative Josh Dobson, Co-Chair
	•	sentative Nelson Dollar, Co-Chair
		sentative Bert Jones, Co-Chair
		sentative Donny Lambeth, Co-Chair
	керге	sentative Gregory F. Murphy, MD, Co-Chair
hereby certif Tuesday, June	· ·	e assistant at the following offices at 9:00 AM or
	Principal Clerk	
	Reading Clerk – House Chamber	
Theresa Lope:	z (Committee Assistant)	



House Committee on Health Wednesday, June 13, 2018, 11:00 AM 643 Legislative Office Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

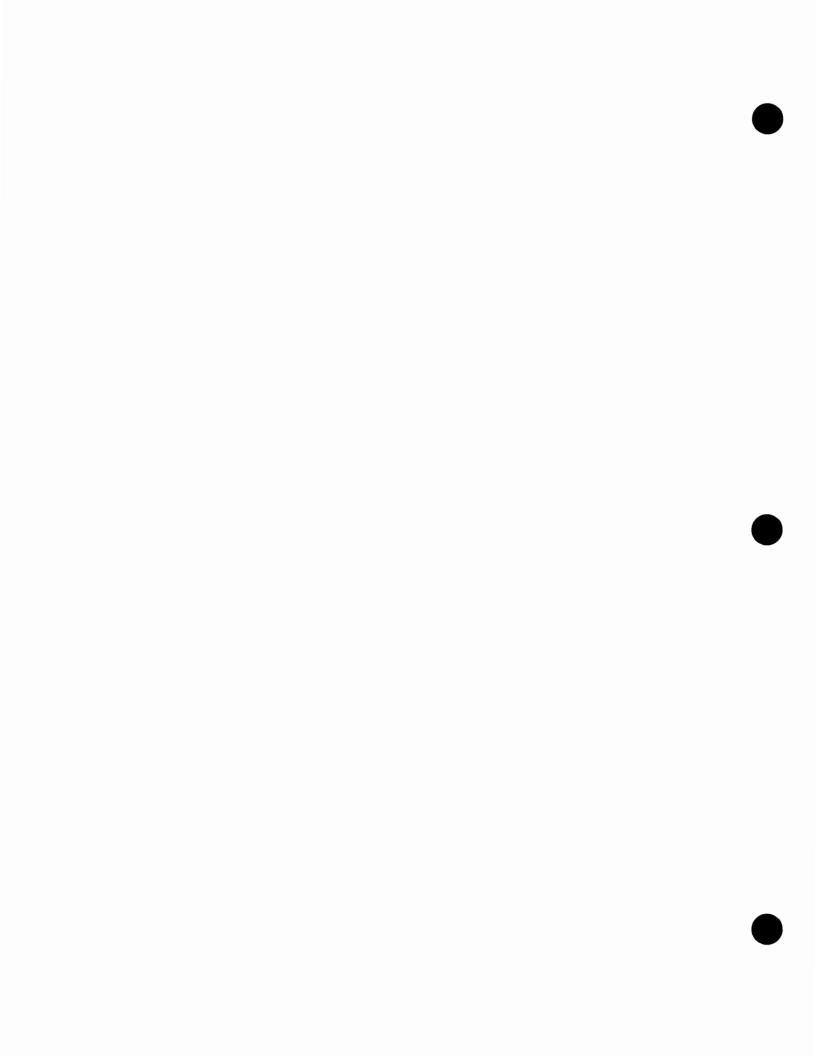
Bills

BILL NO.	SHORT TITLE	SPONSOR
SB 368	Notice of Medicaid SPA Submissions.	Senator Hise
		Senator Pate
		Senator Krawiec
SB 630	Revise IVC Laws to Improve	Senator Hise
	Behavioral Health.	Senator Krawiec
		Senator Randleman

Presentations

Other Business

Adjournment



NORTH CAROLINA GENERAL ASSEMBLY HOUSE OF REPRESENTATIVES

HEALTH COMMITTEE REPORT

Representative Josh Dobson, Co-Chair Representative Nelson Dollar, Co-Chair Representative Bert Jones, Co-Chair Representative Donny Lambeth, Co-Chair Representative Gregory F. Murphy, MD, Co-Chair

FAVORABLE HOUSE COM SUB, UNFAVORABLE ORIGINAL BILL

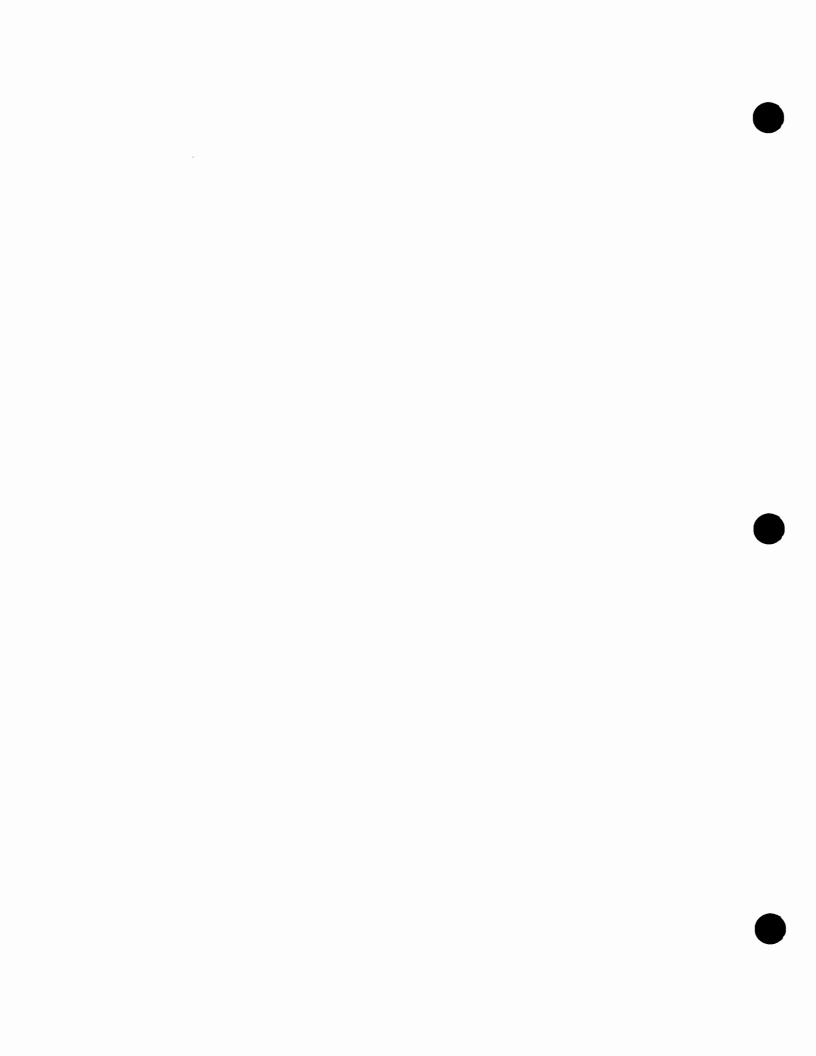
SB 368 Notice of Medicaid SPA Submissions.

Draft Number: S368-PCS15318-SH-42

Serial Referral: None Recommended Referral: None Long Title Amended: Yes Floor Manager: Dobson

TOTAL REPORTED: 1





NORTH CAROLINA GENERAL ASSEMBLY HOUSE OF REPRESENTATIVES

HEALTH COMMITTEE REPORT

Representative Josh Dobson, Co-Chair Representative Nelson Dollar, Co-Chair Representative Bert Jones, Co-Chair Representative Donny Lambeth, Co-Chair Representative Gregory F. Murphy, MD, Co-Chair

FAVORABLE HOUSE COM SUB, UNFAVORABLE ORIGINAL BILL

SB 630 Revise IVC Laws to Improve Behavioral Health.

Draft Number: S630-PCS45576-BC-49

Serial Referral: None Recommended Referral: None Long Title Amended: No Floor Manager: Dobson

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TOTAL REPORTED: 1





NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT Senate Bill 368

S368-ASH-53 [v.1]

AMENDMENT NO. (to be filled in by Principal Clerk)

Page 1 of 2

Amends Title [NO] S368-CSSH-37

Representative Dollar

moves to amend the bill on page 4, line 44, by rewriting the line to read:

"(2) Except as provided in subdivision subdivisions (3), (4) and (5)(3) of this subsection,":

and on page 5, lines 5-11, by rewriting the lines to read:

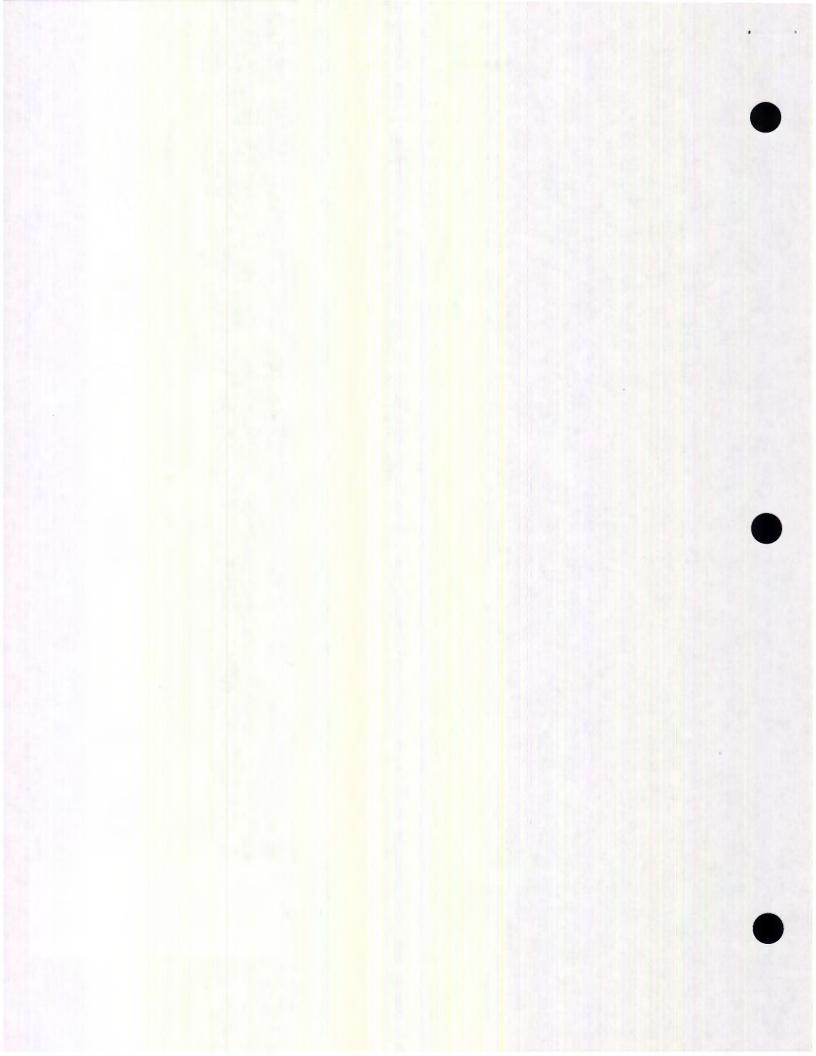
- "(4) The following entities shall begin submitting demographic and clinical data by June 1, 2021:
 - a. Ambulatory surgical centers as defined in G.S. 131E-146.
 - b. Dentists licensed under Article 2 of Chapter 90 of the General Statutes.
- (5) The following entities shall begin submitting claims data by June 1, 2021:
 - a. Pharmacists registered with the North Carolina Board of Pharmacy and pharmacists licensed under Article 4A of Chapter 90 of the General Statutes.";

and on page 5, lines 25-27, by rewriting the lines to read:

"as required by this section later than June 1, 2020,2020, or (iii) that would result in any provider or entity specified in subdivisions (4) and (5) of subsection (a1) of this section connecting to the HIE Network and commencing data submission as required by this section later than June 1, 2021. The Department of Information";

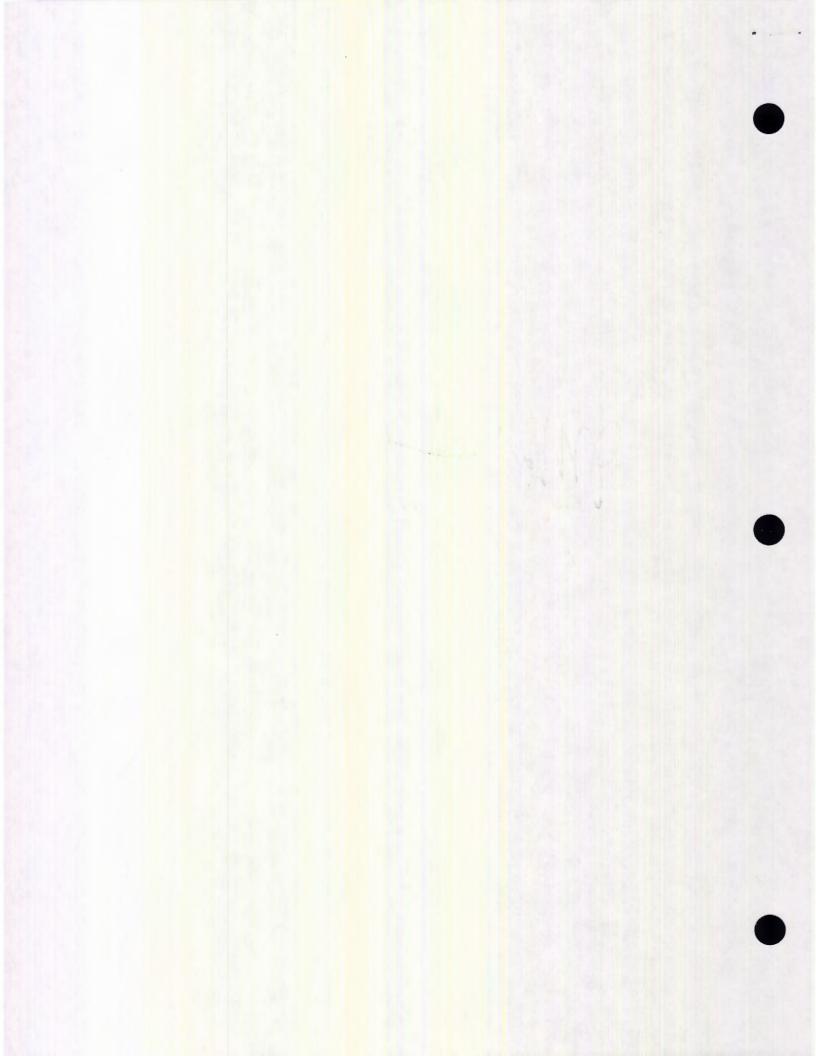
Attachment 1





AMENDMENT NO._

S368-ASH-53 [v.1]	(to be filled in by Principal Clerk)
	Page 2 of 2
And on page 5, line 48, by rewriting the line to read:	
"other patient records. A pharmacy or pharmacist	
pertaining to services rendered to Medicaid and	
beneficiaries and paid for with Medicaid or other State (c1) Exemption from Twice Daily Submission.	
required to submit claims data once daily through the	
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SIGNED X	
Amendment Sponsor	
0000 1 171	
SIGNED Committee Chair if Senate Committee	A mandmant
Committee Chair II Senate Committee A	Amendment
ADOPTED FAILED	TABLED





AMENDMENT NO. ____

	S630-ABC-42 [v.2]		(to be filled in by Principal Clerk)	
,			1	Page 1 of 1
	Amends Title [NO] PCS S630-CSBC-36 v.16	Date _	el13	,2018
	Representative Adcock			
	moves to amend the bill on page 25, lines 10-11, by runder the waiver. To certify a licensed clinical social nurse practitioner, a licensed professional counsellor, and on page 26, line 2 by rewriting the line to read: "worker, master's or higher level degree psychiatric results."	l worker or a";	, a master's or highe	
	SIGNED SIGNED Committee Chair if Senate Committee	S Amendm	ent	
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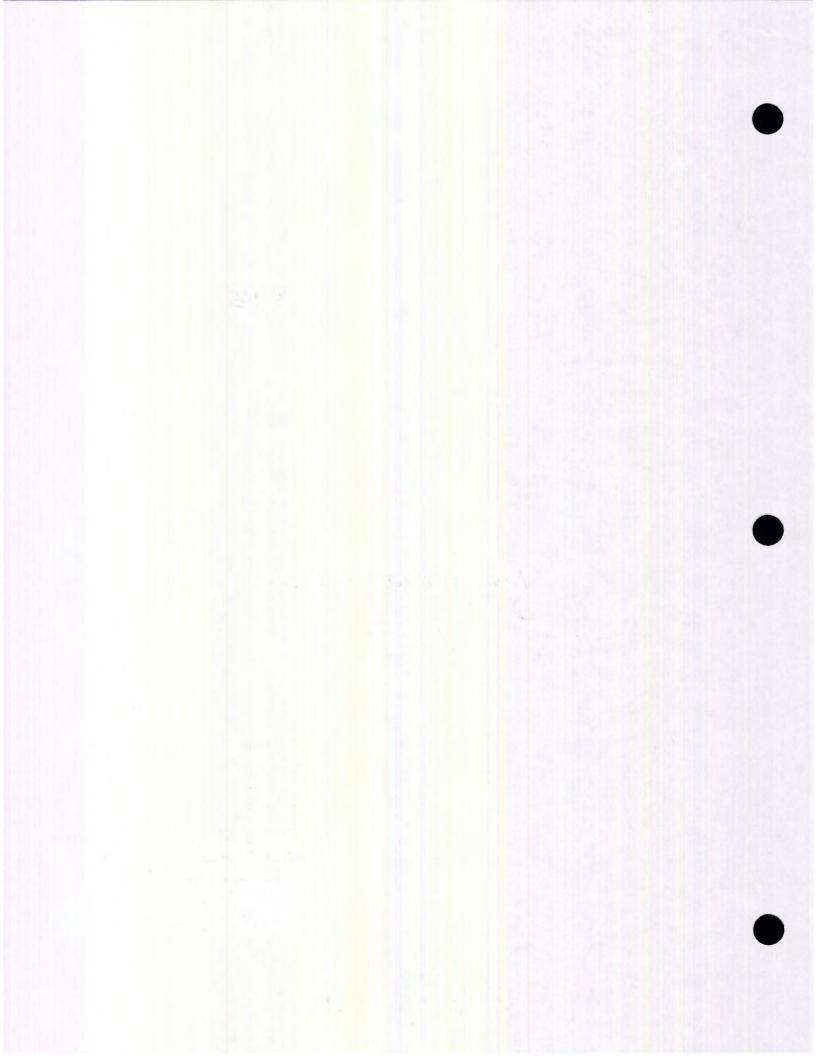
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Attachment 2







AMENDMENT NO.
(to be filled in by
Principal Clerk)

Page 1 of 3

Amends Title [NO] First Edition

Date	,20	18

Representative Jackson

moves to amend the bill on page 1, lines 25-26, by inserting a line between the lines to read:

"(18a) "Involuntary Commitment First Examination Crisis Center" means a facility that is operated under contract with the area authority or county program and is accredited by the Joint Commission, CARF, or URAC for the purpose of performing a health screening and involuntary commitment determination.

...";

and on page 7, line 11, by rewriting the line to read:

"or more involuntary commitment first examination crisis centers or other locations described in G.S. 122C-263 and";

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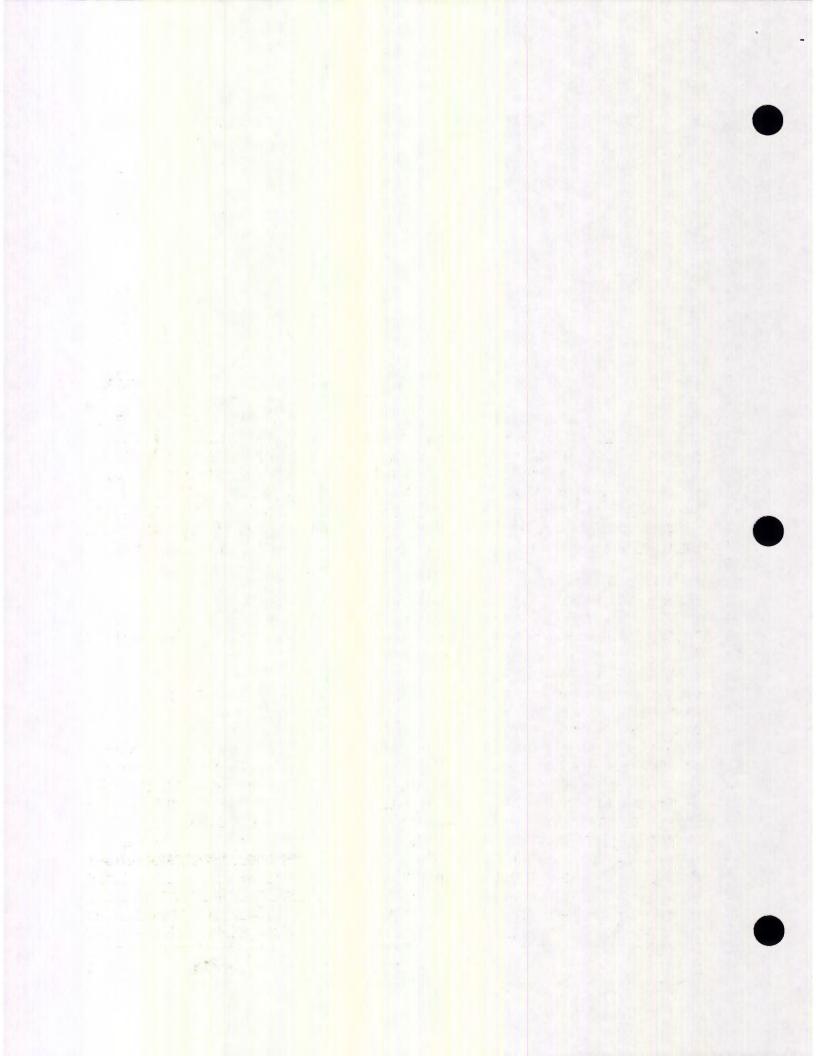
And on page 20, line 27, through page 21, line 13 by rewriting the lines to read:

"SECTION 24. G.S. 122C-263 reads as rewritten:

"§ 122C-263. Duties of law-enforcementlaw enforcement officer; first examination by physician or eligible psychologist.examination.

Without unnecessary delay after assuming custody, the law enforcement officer or (a) the individual designated by the clerk or magistrate under G.S. 122C-251(g) required to provide transportation pursuant to G.S. 122C-251(g) shall take the respondent to an area involuntary commitment first examination crisis center facility for examination by a physician or eligible psychologist; if a physician or eligible psychologist, or other location identified by the LME/MCO in the community crisis services plan adopted pursuant to G.S. 122C-202.2 that has an available commitment examiner and is capable of performing a first examination in conjunction with a health screening at the same location, unless exigent circumstances require the respondent be transported to an emergency department. If a commitment examiner is not availablein the area facility, available, whether on-site, on-call, or via telemedicine, at any involuntary commitment first examination crisis center or location, or if a plan has not been adopted, the person designated to provide transportation shall take the respondent to an alternative non-hospital provider or facility-based crisis center for a first examination in conjunction with a health screening at the same location. If no non-hospital provider or facility-based crisis center for a first examination in conjunction with a health screening at the same location for health screening and first examination exists, the person designated to provide transportation shall take the respondent to any physician or eligible psychologist locally





AMENDMENT NO. ____
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S630-ABC-43 [v.3]

Page 2 of 3

available a private hospital or clinic, a general hospital, an acute care hospital, or a State facility for the mentally ill. If a physician or eligible psychologistcommitment examiner is not immediately available available, the respondent may be temporarily detained in an area facility, if one is available; if an area facility is not available, the respondent may be detained under appropriate supervision in the respondent's home, in a private hospital or a clinic, in a general hospital, or in a State facility for the mentally ill, but not in a jail or other penal facility.

(1) For the purposes of this section, "non-hospital provider" means an outpatient provider that provides either behavioral health or medical services.

(a1) An involuntary commitment first examination crisis center or other location to which a respondent is transported under subsection (a) of this section shall provide a health screening of the respondent. The health screening shall be conducted by a commitment examiner or other individual who is determined by the area facility, involuntary commitment first examination crisis center, or other location to be qualified to perform the health screening. The Department will work with commitment examiner professionals to develop a screening tool for this purpose. The respondent may either be in the physical face-to-face presence of the person conducting the screen or may be examined utilizing telemedicine equipment and procedures. Documentation of the health screening required under this subsection that is completed prior to transporting the patient to any general hospital, acute care hospital, or designated facility shall accompany the patient or otherwise be made available at the time of transportation to the receiving facility.";

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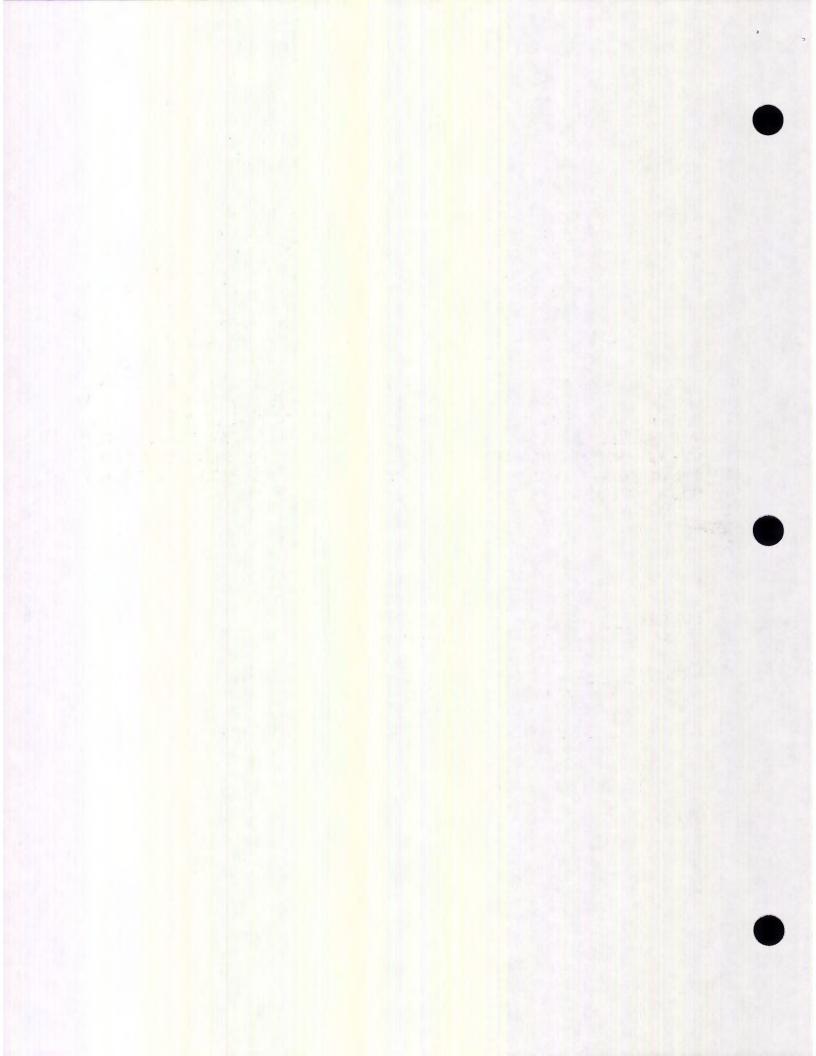
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and on page 31, line 26 through page 32, line 9, by rewriting the lines to read:

"SECTION 34. G.S. 122C-283 reads as rewritten:

"§ 122C-283. Duties of law-enforcement officer; first examination by physician or eligible psychologist.commitment examiner.

Without unnecessary delay after assuming custody, the law-enforcementlaw enforcement officer or the individual designated by the clerk or magistrateor required to provide transportation under G.S. 122C-251(g) to provide transportation shall take the respondent to an area an involuntary commitment first examination crisis center facility for examination by a physician or eligible psychologist if a physician or eligible psychologist is not available in the area facility, he shall take the respondent to any physician or eligible psychologist locally available, or other location identified by the LME/MCO in the community crisis services plan adopted pursuant to G.S. 122C 202.2 that has an available commitment examiner and is capable of performing a first examination in conjunction with a health screening in the same location. unless exigent circumstances require the respondent be transported to an emergency department. If a commitment examiner is not available, whether on-site, on-call or via telemedicine, at any involuntary commitment first examination crisis center or location, or if a plan has not been adopted, the person designated to provide transportation shall take the respondent to an alternative non-hospital provider or facility-based crisis center for a first examination in conjunction with a health screening at the same location. If no non-hospital provider or facility-based crisis center for a first examination in conjunction with a health screening at the same location, the person designated to provide transportations shall take the respondent to a private hospital or clinic, a general hospital, and acute care hospital, or a State facility for the



AMENDMENT NO. ______
(to be filled in by
Principal Clerk)

S630-ABC-43 [v.3]

 Page 3 of 3

mentally ill. If a physician or eligible psychologistcommitment examiner is not immediately available, the respondent may be temporarily detained in an area facility if one is available; if an area facility is not available, he may be detained under appropriate supervision, in his home, in a private hospital or a clinic, or in a general hospital, but not in a jail or other penal facility.

(1) For the purposes of this section, "non-hospital provider" means an outpatient provider that provides either behavioral health or medical services.

(a1) An involuntary commitment first examination crisis center, or other location to which a respondent is transported under subsection (a) of this section, shall provide a health screening of the respondent. The health screening shall be conducted by a physician or other individual who is determined by the area facility, involuntary commitment first examination crisis center, or other location to be qualified to perform the health screening. The respondent may either be in the physical face-to-face presence of the health screening examiner or may be examined utilizing telemedicine equipment and procedures. Documentation of the health screening required under this subsection that is completed prior to transporting the patient to any general or acute care hospital shall accompany the patient or otherwise be made available at the time of transportation to the receiving facility."."

SIGNED

Amendment Sponsor

SIGNED

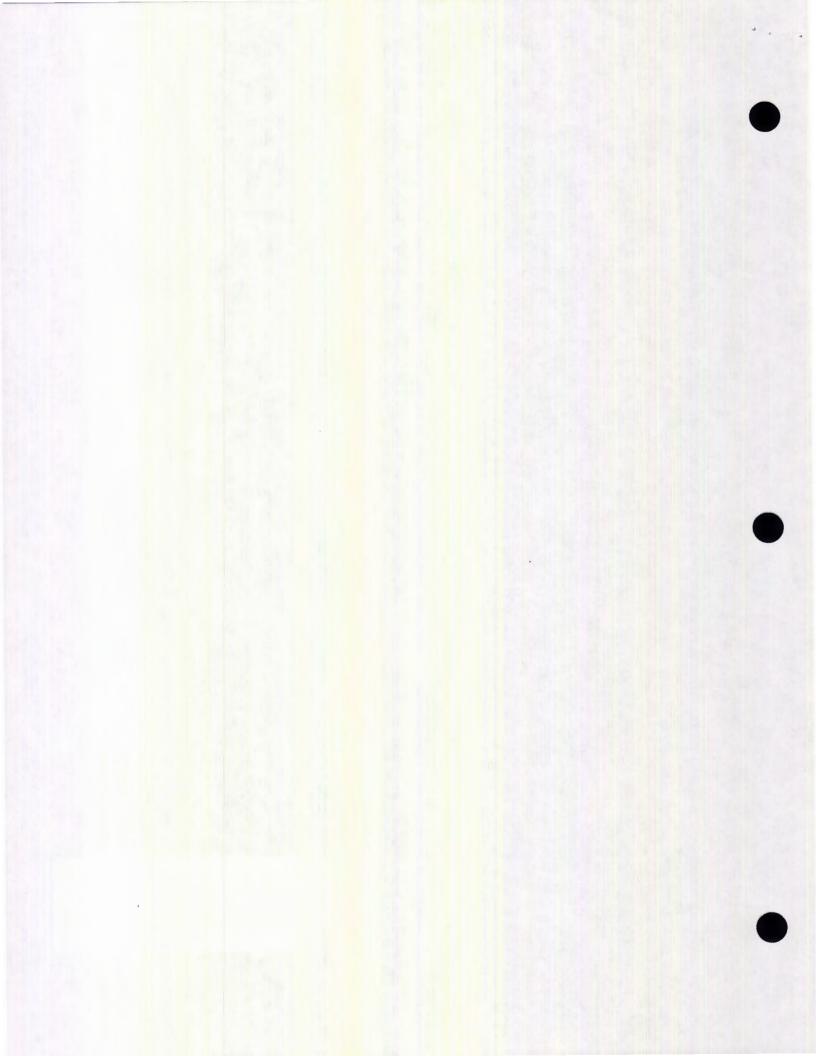
Committee Chair if Senate Committee Amendment

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Attachment 3



NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

(Please type or use ballpoint pen)

Н.	B. No. <u>630</u>	DATE
S	B. No	Amendment No.
CO	DMMITTEE SUBSTITUTE # 630-CSBC-36	(to be filled in by Principal Clerk)
	Rep.) Insko	
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mo	oves to amend the bill on page/ ¬	, line/O
•) WHICH CHANGES THE TITLE	
by.	rewriting the line to	o read:
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SENATE BILL 368: Update False Claims Act/Rare Disease Appt/HIE.

2017-2018 General Assembly

Committee: House Health

Introduced by: Sens. Hise, Pate, Krawiec

Analysis of: PCS to First Edition

S368-CSSH-37

Date:

June 12, 2018

Prepared by: Theresa Matula

Legislative Analyst

OVERVIEW: The PCS for SB 368 updates the False Claims Act; extends the appointments of the members for the Advisory Council on Rare Diseases; and extends the date for connection with the HIE Network for Dentists, Pharmacies, and Ambulatory Surgical Centers.

BILL ANALYSIS:

Sections 1-6 of the PCS for SB 368 amend Chapter 1, Article 51 of the False Claims Act.

Section 1 repeals G.S. 1-606(7) which contains a definition of "public employee," "public official," and "public employment."

Section 2 amends G.S. 1-607(a) to allow a civil penalty to be adjusted in accordance with federal law (Section 5 of the Federal Civil Penalties Inflation Adjustment act of 1990, P.L. 101-410, as amended).

Section 3 amends G.S. 1-608(b) to provide that for actions brought by private persons, the action may be dismissed only if the court and the Attorney General have given written consent to the dismissal and the reasons for consenting.

Section 4 amends G.S. 1-610(b) makes technical and clarifying changes.

Section 5 amends G.S. 1-611 pertaining to certain actions that are barred. Subsections (c) and (d) are being removed and subsections (e) and (f) are being added. Subsection (e) provides that unless opposed by the State, the court is required to dismiss an action or claim under the False Claims Act if substantially the same allegations or transactions as alleged in the action or claim were publicly disclosed by any of the following:

- o A State criminal, civil, or administrative hearing in which the State or its agent is a party.
- o A State legislative, Office of the State Auditor, or other State report, hearing, audit, or investigation.
- o The news media.

This subsection does not apply to any action brought by the Attorney General or when the person bringing the action is an original source of the information.

Subsection (f) provides that for purposes of this section, the term "original source" means an individual who meets one of the following descriptions:

- o Prior to public disclosure under subsection (e) of this section, the individual has voluntarily disclosed to the State the information on which allegations or transactions in a claim are based.
- The individual (i) has knowledge that is independent of, and materially adds to, the publicly disclosed allegations or transactions and (ii) has voluntarily provided the information to the State before filing an action under the False Claims Act

Section 6 amends G.S. 1-613 pertaining to private action for retaliation to provide that a civil action under the section may not be brought more than three years after the date when the retaliation occurred.

Karen Cochrane-Brown Director



Legislative Analysis
Division
919-733-2578

Page 2

Section 7 amends G.S. 126-84 which is the a policy statement section in the State Human Resources Act providing protection for reporting improper government activities. The change provides that State employees are no longer simply encouraged to report improper government activities, but in fact have a duty to report them.

Section 8 pertains to the Advisory Council on Rare Diseases created pursuant to G.S. 130A-33.65 in Part 6 of Chapter 130A. Section 8(a) extends the terms of the current members of the Advisory Council on Rare Diseases through July 31, 2023. Section 8(b) provides that this section of the bill is effective when it becomes law.

Section 9 amends G.S. 90-414.4 to **extend the date for connection with the HIE** network to June 1, 2021, for pharmacists, ambulatory surgical centers, and dentists. This section is effective when it becomes law.

EFFECTIVE DATE: Except as otherwise provided, the bill is effective when it becomes law and applies to actions brought on or after that date.

GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2017

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SENATE BILL 368 PROPOSED HOUSE COMMITTEE SUBSTITUTE S368-CSSH-37 [v.4]

06/12/2018 08:07:37 PM

Short Title:	Update False Claims Act/Rare Disease Appt/HIE.	(Public)
Sponsors:		
Referred to:		

March 27, 2017

A BILL TO BE ENTITLED 1 2 AN ACT TO ALIGN THE NORTH CAROLINA FALSE CLAIMS ACT WITH THE 3 FEDERAL FALSE CLAIMS ACT; TO EXTEND THE TERMS FOR THE CURRENT 4 MEMBERS OF THE ADVISORY COUNCIL ON RARE DISEASES: AND TO EXTEND 5 PARTICIPATION IN THE HIE NETWORK FOR CERTAIN PROVIDERS. 6 The General Assembly of North Carolina enacts: 7 **SECTION 1.** G.S. 1-606(7) is repealed. 8

SECTION 2. G.S. 1-607(a) reads as rewritten:

"§ 1-607. False claims; acts subjecting persons to liability for treble damages; costs and civil penalties; exceptions.

(a) Liability. – Any person who commits any of the following acts shall be liable to the State for three times the amount of damages that the State sustains because of the act of that person. A person who commits any of the following acts also shall be liable to the State for the costs of a civil action brought to recover any of those penalties or damages and shall be liable to the State for a civil penalty of not less than five thousand five hundred dollars (\$5,500) and not more than eleven thousand dollars (\$11,000) (\$11,000), as may be adjusted by Section 5 of the Federal Civil Penalties Inflation Adjustment Act of 1990, P.L. 101-410, as amended, for each violation:

SECTION 3. G.S. 1-608(b) reads as rewritten:

- Actions by Private Persons. A person may bring a civil action for a violation of G.S. 1-607 for the person and for the State, as follows:
 - The action shall be brought in the name of the State, and the person bringing (1) the action shall be referred to as the qui tam plaintiff. Once filed, the The action may be dismissed voluntarily by the person bringing the action-only if the court and Attorney General have given written consent to the dismissal. dismissal and the reasons for consenting.
 - (2) A copy of the complaint and written disclosure of substantially all material evidence and information the person possesses shall be served on the Attorney General pursuant to applicable rules of the North Carolina Rules of Civil Procedure. The complaint shall be filed in camera, shall remain under seal for at least 120 days, and shall not be served on the defendant until the court so orders. The State may elect to intervene and proceed with the action within 120 days after it receives both the complaint and the material evidence and information.



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- (3) The State may, for good cause shown, move the court for extensions of the time during which the complaint remains under seal under subdivision (2) of this subsection. Any such motions may be supported by affidavits or other submissions in camera. The defendant shall not be required to respond to any complaint filed under this section until 30 days after the complaint is unsealed and served upon the defendant pursuant to the North Carolina Rules of Civil Procedure.
- (4) Before the expiration of the 120-day period or any extensions obtained under subdivision (3) of this subsection, the State shall:
 - a. Proceed with the action, in which case the action shall be conducted by the State; or
 - b. Notify the court that it declines to take over the action, in which case the person bringing the action shall have the right to conduct the action.
- (5) When a person brings an action under this subsection, the federal False Claims Act, 31 U.S.C. § 3729 et seq., or any similar provision of law in any other state, no person other than the State may intervene or bring a related action based on the facts underlying the pending action; provided, however, that nothing in this subdivision prohibits a person from amending a pending action in another jurisdiction to allege a claim under this subsection.

When a person brings an action under this subsection, no person other than the State may intervene or bring a related action based on the facts underlying the pending action."

SECTION 4. G.S. 1-610(b) reads as rewritten:

"(b) Where the action is one which the court finds to be based primarily on disclosures of specific information, other than information provided by the qui tam plaintiff, relating to allegations or transactions (i) in a <u>State</u> criminal, civil, or administrative hearing at the <u>State</u> or <u>federal level</u>, <u>hearing</u>, (ii) in a <u>congressional</u>, <u>State</u> legislative, <u>administrative</u>, <u>General Accounting Office</u>, or <u>Office</u> of the State <u>Auditor's Auditor</u>, or other <u>State</u> report, hearing, audit, or investigation, or (iii) from the news media, the court may award such sums as it considers appropriate, but in no case more than ten percent (10%) of the proceeds, taking into account the significance of the information and the role of the qui tam plaintiff in advancing the case to litigation."

SECTION 5. G.S. 1-611 reads as rewritten:

"§ 1-611. Certain actions barred.

- (a) No court shall have jurisdiction over an action brought under G.S. 1-608(b) against a member of the General Assembly, a member of the judiciary, or a senior executive branch official acting in their official capacity if the action is based on evidence or information known to the State when the action was brought.
- (b) In no event may a person bring an action under G.S. 1-608(b) that is based upon allegations or transactions that are the subject of a civil suit or an administrative civil money penalty proceeding in which the State is already a party.
- (c) No civil action may be brought under this Article by a person who is or was a public employee or public official if the allegations of such action are based substantially upon either of the following:
 - (1) Allegations of wrongdoing or misconduct which such person had a duty or obligation to report or investigate within the scope of his or her public employment or office.
 - (2) Information or records to which the person had access as a result of his or her public employment or office.
- (d) No court shall have jurisdiction over an action under G.S. 1-608(b) based upon the public disclosure of allegations or transactions (i) in a criminal, civil, or administrative hearing

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at the State or federal level, (ii) in a congressional, legislative, administrative, General Accounting Office, or State Auditor's report, hearing, audit, or investigation, or (iii) from the news media, unless the action is brought by the Attorney General, or the person bringing the action is an original source of the information. For purposes of this section, "original source" means an individual who has direct and independent knowledge of the information on which the allegations are based and has voluntarily provided the information to the State before filing an action under G.S. 1-608(b) that is based on the information.

- Unless opposed by the State, the court shall dismiss an action or claim under this Article if substantially the same allegations or transactions as alleged in the action or claim were publicly disclosed by any of the following:
 - (1) A State criminal, civil, or administrative hearing in which the State or its agent is a party.
 - A State legislative, Office of the State Auditor, or other State report, hearing, (2) audit, or investigation.
 - (3) The news media.

This subsection shall not apply to any action brought by the Attorney General or when the person bringing the action is an original source of the information.

- For the purposes of this section, the term "original source" means an individual who meets one of the following descriptions:
 - Prior to public disclosure under subsection (e) of this section, the individual (1) has voluntarily disclosed to the State the information on which allegations or transactions in a claim are based.
 - The individual (i) has knowledge that is independent of, and materially adds (2)to, the publicly disclosed allegations or transactions and (ii) has voluntarily provided the information to the State before filing an action under this Article."

SECTION 6. G.S. 1-613 reads as rewritten:

"§ 1-613. Private action for retaliation action.

Any employee, contractor, or agent who is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment because of lawful acts done by the employee, contractor, or agent on behalf of the employee, contractor, or agent or agent, or associated others in furtherance of an action under this Article, or in furtherance of Article or other efforts to stop one or more violations of G.S. 1-607, including investigation for, initiation of, testimony for, or assistance in an action filed or to be filed under this Article, G.S. 1-607 shall be entitled to all relief necessary to make the employee employee, contractor, or agent whole. Such relief shall include reinstatement with the same seniority status the employee, contractor, or agent would have had but for the discrimination, two times the amount of back pay, interest on the back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees. An employee, contractor, or agent may bring an action may be brought in North Carolina superior court for the relief provided in this section. A civil action under this section may not be brought more than three years after the date when the retaliation occurred."

SECTION 7. G.S. 126-84(a) reads as rewritten:

"§ 126-84. Statement of policy.

- It is the policy of this State that State employees shall be encouraged have a duty to report verbally or in writing to their supervisor, department head, or other appropriate authority, evidence of activity by a State agency or State employee constituting:constituting any of the following:
 - (1) A violation of State or federal law, rule or regulation; regulation.
 - (2) Fraud: Fraud.
 - Misappropriation of State resources; resources. (3)

- (4) Substantial and specific danger to the public health and safety; or safety.
- (5) Gross mismanagement, a gross waste of monies, or gross abuse of authority."

SECTION 8.(a) Notwithstanding the provisions of G.S. 130A-33.65(c) or any other provision of law, the terms of the current members of the Advisory Council on Rare Diseases are extended until July 31, 2023.

SECTION 8.(b) This section is effective when it becomes law.

SECTION 9.(a) G.S. 90-414.4 reads as rewritten:

"§ 90-414.4. Required participation in HIE Network for some providers.

- (a) Findings. The General Assembly makes the following findings:
 - (1) That controlling escalating health care costs of the Medicaid program and other State-funded health services is of significant importance to the State, its taxpayers, its Medicaid recipients, and other recipients of State-funded health services.
 - (2) That the State needs timely access to certain demographic and clinical information pertaining to services rendered to Medicaid and other State-funded health care program beneficiaries and paid for with Medicaid or other State-funded health care funds in order to assess performance, improve health care outcomes, pinpoint medical expense trends, identify beneficiary health risks, and evaluate how the State is spending money on Medicaid and other State-funded health services.
 - (3) That making demographic and clinical information available to the State by secure electronic means as set forth in subsection (b) of this section will, with respect to Medicaid and other State-funded health care programs, improve care coordination within and across health systems, increase care quality for such beneficiaries, enable more effective population health management, reduce duplication of medical services, augment syndromic surveillance, allow more accurate measurement of care services and outcomes, increase strategic knowledge about the health of the population, and facilitate health care cost containment.
- (a1) Mandatory Connection to HIE Network. Notwithstanding the voluntary nature of the HIE Network under G.S. 90-414.2, the following providers and entities shall be connected to the HIE Network and begin submitting data through the HIE Network pertaining to services rendered to Medicaid beneficiaries and to other State-funded health care program beneficiaries and paid for with Medicaid or other State-funded health care funds in accordance with the following time line:
 - (1) The following providers of Medicaid services that have an electronic health record system shall begin submitting demographic and clinical data by June 1, 2018:
 - a. Hospitals as defined in G.S. 131E-176(13).
 - b. Physicians licensed to practice under Article 1 of Chapter 90 of the General Statutes.
 - c. Physician assistants as defined in 21 NCAC 32S.0201.
 - d. Nurse practitioners as defined in 21 NCAC 36.0801.
 - (2) Except as provided in subdivision (3) and subdivision (4) of this subsection, all other providers of Medicaid and State-funded health care services shall begin submitting demographic and clinical data by June 1, 2019.
 - (3) The following entities shall submit encounter and claims data, as appropriate, in accordance with the following time line:
 - a. Prepaid Health Plans, as defined in S.L. 2015-245, by the commencement date of a capitated contract with the Division of

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Health Benefits for the delivery of Medicaid and NC Health Choice services as specified in S.L. 2015-245.

- b. Local management entities/managed care organizations, as defined in G.S. 122C-3, by June 1, 2020.
- (4) The following entities shall begin submitting demographic and clinical data by June 1, 2021:
 - a. Pharmacists licensed under Article 4A of Chapter 90 of the General Statutes and pharmacies registering with the North Carolina Board of Pharmacy.
 - b. Ambulatory surgical centers as defined in G.S. 131E-146.
 - c. Dentists licensed under Article 2 of Chapter 90 of the General Statutes.
- Extensions of Time for Establishing Connection to the HIE Network. The Department of Information Technology, in consultation with the Department of Health and Human Services, may establish a process to grant limited extensions of the time for providers and entities to connect to the HIE Network and begin submitting data as required by this section upon the request of a provider or entity that demonstrates an ongoing good-faith effort to take necessary steps to establish such connection and begin data submission as required by this section. The process for granting an extension of time must include a presentation by the provider or entity to the Department of Information Technology and the Department of Health and Human Services on the expected time line for connecting to the HIE Network and commencing data submission as required by this section. Neither the Department of Information Technology nor the Department of Health and Human Services shall grant an extension of time (i) to any provider or entity that fails to provide this information to both Departments or Departments, (ii) that would result in the provider or entity connecting to the HIE Network and commencing data submission as required by this section later than June 1, 2020. 2020, or (iii) that would result in any provider or entity specified in subsection (a1)(4) connecting to the HIE Network and commencing data submission as required by this section later than June 1, 2021. The Department of Information Technology shall consult with the Department of Health and Human Services to review and decide upon a request for an extension of time under this section within 30 days after receiving a request for an extension.
- (b) Mandatory Submission of Demographic and Clinical Data. Notwithstanding the voluntary nature of the HIE Network under G.S. 90-414.2 and, except as otherwise provided in subsection (c) of this section, as a condition of receiving State funds, including Medicaid funds, the following entities shall submit at least twice daily, through the HIE network, demographic and clinical information pertaining to services rendered to Medicaid and other State-funded health care program beneficiaries and paid for with Medicaid or other State-funded health care funds, solely for the purposes set forth in subsection (a) of this section:
 - (1) Each hospital, as defined in G.S. 131E-176(13) that has an electronic health record system.
 - (2) Each Medicaid provider.
 - (3) Each provider that receives State funds for the provision of health services.
 - (4) Each local management entity/managed care organization, as defined in G.S. 122C-3.
- (c) Exemption for Certain Records. Providers with patient records that are subject to the disclosure restrictions of 42 C.F.R. § 2 are exempt from the requirements of subsection (b) of this section but only with respect to the patient records subject to these disclosure restrictions. Providers shall comply with the requirements of subsection (b) of this section with respect to all other patient records.
- (d) Method of Data Submissions. The data submissions required under this section shall be by connection to the HIE Network periodic asynchronous secure structured file transfer or any other secure electronic means commonly used in the industry and consistent with document

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General Assembly Of North Carolina								Sessi	ion 2017
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exchange and data submission standards established by the Office of the National Coordinator for Information Technology within the U.S. Department of Health and Human Services."

SECTION 9.(b). This section is effective when it becomes law.

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SECTION 10. Except as otherwise provided, this act is effective when it becomes law and applies to actions brought on or after that date.

Page 6 Senate Bill 368 S368-CSSH-37 [v.4]

GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2017

SENATE BILL 368

(Public)

Senators Hise, Pate, Krawiec (Primary Sponsors); and Rabin. Sponsors:

Notice of Medicaid SPA Submissions.

Rules and Operations of the Senate Referred to:

March 27, 2017

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO PROVIDE NOTIFICATION TO THE GENERAL ASSEMBLY UPON SUBMISSION OR NON-SUBMISSION OF A MEDICAID STATE PLAN AMENDMENT.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 108A-54.1A reads as rewritten:

"§ 108A-54.1A. Amendments to Medicaid State Plan and Medicaid Waivers.

- The Department of Health and Human Services is expressly authorized and required to take any and all necessary action to amend the State Plan and waivers in order to keep the program within the certified budget, except as provided in G.S. 108A-54(f). For purposes of this section, the term "amendments to the State Plan" includes State Plan amendments, Waivers, and Waiver amendments.
 - (b), (c) Repealed by Session Laws 2015-245, s. 18, effective September 23, 2015.
- No fewer than 10 days prior to submitting an amendment to the State Plan to the federal government, the Department shall post the amendment on its Web site and notify the members of the Joint Legislative Oversight Committee on Medicaid and NC Health Choice and the Fiscal Research Division that the amendment has been posted. For any amendments to the State Plan that add or eliminate an optional service, the notice required by this subsection shall be 90 days. This notice requirement shall not apply to draft or proposed amendments submitted to the federal government for comments but not submitted for approval.
- Upon the submission of an amendment to the State Plan to the federal government, the Department shall notify the Joint Legislative Oversight Committee on Medicaid and NC Health Choice and the Fiscal Research Division that the amendment has been submitted.

If the Department determines that an amendment posted on its Web site in accordance with subsection (d) of this section will not be submitted to the federal government, then the Department shall notify the Joint Legislative Oversight Committee on Medicaid and NC Health Choice and the Fiscal Research Division upon making that determination.

- Repealed by Session Laws 2015-245, s. 18, effective September 23, 2015. (e)
- (f) Any public notice required under 42 C.F.R. 447.205 shall, in addition to any other posting requirements under federal law, be posted on the Department's Web site. Upon posting such a public notice, the Department shall notify the members of the Joint Legislative Oversight Committee on Medicaid and NC Health Choice and the Fiscal Research Division that the public notice has been posted. Public notices shall remain posted on the Department's Web site."



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Short Title:

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SECTION 2. This act is effective when it becomes law and applies to amendments to the State Plan posted on the Department of Health and Human Services Web site on or after that date.



SENATE BILL 630: Revise IVC Laws to Improve Behavioral Health.

2017-2018 General Assembly

Committee:

House Health

Introduced by:

Sens. Hise, Krawiec, Randleman

Analysis of:

PCS to First Edition

S630-CSBC-36

Date:

June 2, 2018

Prepared by: Jason Moran-Bates

Staff Attorney

OVERVIEW: The proposed committee substitute to Senate Bill 630 would make changes to the laws for voluntary and involuntary commitment for the mentally ill and substance abusers, which are found in Chapter 122C of the General Statutes.

BILL ANALYSIS:

Section 1 of the PCS would amend G.S. 122C-3 to:

- Add definitions for "commitment examiner," "incapable," "medical screening," "outpatient treatment physician," and "outpatient treatment center."
- Clarify that a "legally responsible person" for an individual without a health care power of attorney includes an attorney-in-fact under a general power of attorney, spouse, parents and children, siblings, or any other person with a relationship to that individual. This list mirrors the list of people who can provide consent for medical treatment under G.S. 90-21.13(c)
- Eliminate the definition of "program director."

Section 2 of the PCS would amend G.S. 122C-4 to clarify that "legally responsible person" for an incapable adult is a:

- Person named under a healthcare power of attorney.
- Person named in an advance instruction for mental health treatment.
- Any of the other individuals listed in the new definition for "legally responsible person."

Section 3 of the PCS would make conforming changes to G.S. 122C-55.

Section 4 of the PCS would amend G.S. 122C-54 to allow the facility conducting an examination of the respondent to furnish records pertinent to the proceedings to the court, respondent's counsel, and the state's attorney. Non-pertinent medical records could only be disclosed pursuant to a court order.

Section 5 of the PCS would add definitions for "facility," "area facility," and "secretary" to G.S. 122C-55. It would also add a new subsection permitting a facility to provide confidential information to a county Sheriff on clients in need of treatment for mental illness, developmental disabilities, or substance abuse when the Sheriff requests that information. The Sheriff may also provide the same information on former inmates to any facility in which those inmates seek treatment. All information may be disclosed without consent of the client or inmate.

Section 6 of the PCS would add community crisis services planning to the list functions of Local Management Entities (LME) in G.S. 122C-115.4.

Karen Cochrane-Brown Director



Legislative Analysis Division 919-733-2578

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Section 7 of the PCS would amend G.S. 122C-117 to require a Local Management Entity/Managed Care Organization (LME/MCO) to develop, obtain agreement to, and adopt a community crisis services plan under G.S. 122C-202.2.

Section 8 of the PCS would amend G.S. 122C-202.2 to require LME/MOCs to create a community crisis services plan, with the purpose of facilitating a first examination in conjunction with a medical screening. This plan would be required to:

- Incorporate the IVC transportation agreement adopted pursuant to G.S. 122C-251(g), which identifies the law enforcement organization responsible for custody and transportation of respondents.
- Identify the facility responsible for providing the first screening of respondents.
- Identify training for law enforcement officers and designated individuals who take custody of and transport respondents.

County commissioners, law enforcement agencies, acute care hospitals, area facilities, and other affected agencies would be required to participate in creating the plan, and the LME/MCOs would be able to invite community partners and other stakeholders in formulating the plan, which may address additional topics those stakeholders deem necessary.

This section represents a substantive change from the bill as originally filed as it separates the transportation agreement (described in Section 19) below from the community crisis services plan. The transportation agreement was part of the community crisis services plan in the original bill.

Section 9 of the PCS would amend G.S. 122C-206 to:

- Require notification to be given to the legally responsible person when a minor or incapable adult is transferred from one facility to another.
- Require a facility transferring a voluntary client to an acute care hospital solely for an unrelated medical condition to hold that individual's bed slot for at least 12 hours, unless both the transferring and the receiving facility agree return in that time is not reasonable.

The PCS adds the requirement that the original facility hold the patient's bed for a specified time.

Section 10 of the PCS would amend G.S. 122C-201.1 to make all individuals involved in the custody, transportation, assessment, examination, supervision, treatment, or release of a respondent or voluntary client immune from civil and criminal liability, except in the case of gross negligence.

Section 11 of the PCS would amend G.S. 122C-210.3 to allow any individual designated to transport a voluntary client under G.S. 122C-251(g) to receive an order for transport from the court.

Section 12 of the PCS would amend G.S. 122C-211 to allow information in an advanced directive for mental health treatment to be reviewed at a first evaluation.

Section 13 would make conforming changes to G.S. 122C-212.

Section 14 of the PCS would add a new part to Article 5 of Chapter 122C regarding the admission and discharge of incapable adults.

- Incapable adults may be voluntarily admitted pursuant to an advance directive for mental health treatment or the request of an individual holding a healthcare power of attorney.
- Admitted individuals can be held for up to 15 days.
- An individual must be discharged within 72 hours if:

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- The individual is no longer incapable and either does not consent to further treatment, or requests discharge.
- o The legally responsible person for an incapable individual requests discharge.

Section 15 of the PCS would amend G.S. 122C-221 to require the legally responsible person for a minor to sign an application for admission of that minor.

Section 16 of the PCS would amend G.S. 122C-224 to require a minor's application for admission to be sent to the court.

Section 17 of the PCS would clarify that Part 4 of Article 5 of Chapter 122C only applies to adults who are adjudicated incompetent, not those who are only incapable.

Section 18 of the PCS would amend G.S. 122C-232 to:

- Require the court to provide a written description of the admission and discharge process to incompetent adult respondents.
- Require the facility to notify the clerk of court that an incompetent adult has been admitted and that a hearing must be scheduled.
- Limit the maximum length of admission to 90 days.

Section 19 of the PCS would amend G.S. 122C-251 to require cities and counties to formulate involuntary commitment (IVC) transportation agreements, which must:

- Be developed in coordination with acute care hospitals, law enforcement agencies, and area authorities.
- Allow trained law enforcement officers and other trained individuals to be designated to transport IVC respondents.
- Require individuals designated to transport IVC respondents to consent to providing transportation before being designated.
- Require cities and counties to carry out all their custody and transportation responsibilities.

This section represents a substantive change from the bill as originally filed. The PCS separates the transportation agreement from the community crisis services plan in Section 9. It removes the considerations law enforcement was to take into consideration before using restraints. It removes the requirement that a minor's caretaker be consulted before a minor is retrained.

In addition, force and restraint could not be used in transporting a respondent unless deemed reasonably necessary by the law enforcement official for the safety of the respondent, official, or others.

Section 20 of the PCS would add "commitment examiners" to G.S. 122C-253.

Section 21 of the PCS would make conforming changes to G.S. 122C-255.

Section 22 of the PCS would amend G.S. 122C-261 to:

- Replace references to "physician or eligible psychologist" with "commitment examiner."
- Allow examination affidavits to be transmitted electronically.
- Provide immunity for individuals involved in the commitment process unless those individuals are grossly negligent.
- Make conforming changes.

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Section 23 of the PCS would amend G.S. 122C-262 to:

- Replace references to "physician or eligible psychologist" with "commitment examiner."
- Allow temporary detention of a respondent under appropriate supervision if a facility is not available.

Section 24 of the PCS would amend G.S. 122C-263 to:

- Establish a priority list of first exam sites and a process to follow if one is not available.
- Require a medical screening at the first exam and require transportation of the IVC respondent to a facility able to handle any emergent medical conditions discovered in that exam.
- Clarify when a medical screening exam is not necessary.
- Require transportation of IVC respondents within six hours of notification that transportation is necessary.
- Replace references to "physician or eligible psychologist" with "commitment examiner."

Section 25 of the PCS would amend G.S. 122C-263.1 to allow the Secretary of Health and Human Services to certify mental health professionals, other than physicians and psychologists, to perform first examinations.

Section 26 of the PCS would amend G.S. 122C-264 to replace references to "physician or eligible psychologist" with "commitment examiner."

Section 27 of the PCS would amend G.S. 122C-265 to replace references to "physician or eligible psychologist" with "commitment examiner."

Section 28 of the PCS would amend G.S. 122C-267 to replace references to "physician or eligible psychologist" with "commitment examiner."

Section 29 of the PCS would amend 122C-268 to require hearings for IVC respondents subject to a series of successive custody orders within 10 days of the most recent order. It would also establish criteria for hearings to be held via teleconference.

Section 30 of the PCS would amend G.S. 122C-271 to require the court to make specific findings that a respondent is eligible for outpatient treatment, to list the treating facility (and LME/MCO if the treating facility is contracted with one) on the order, and to send a copy of the order to the treating facility and LME/MCO.

This section represents a substantive change from the bill as originally filed. The PCS removes the requirement that outpatient treatment facilities meet specified criteria and that the court make written findings that the outpatient met those criteria.

Section 31 of the PCS would make a conforming change to G.S. 122C-276.

Section 32 of the PCS would amend G.S. 122C-281 to replace references to "physician or eligible psychologist" with "commitment examiner" and make individuals who take reasonable measures to temporarily detain a respondent civilly and criminally immune, except in cases of gross negligence.

Section 33 of the PCS would amend G.S. 122C-282 to replace references to "physician or eligible psychologist" with "commitment examiner."

Section 34 of the PCS would amend G.S. 122C-283 to:

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- Require the appropriate individual transport a respondent to a first exam site according to the criteria established in G.S. 122C-263.
- Require a medical screening at the first exam and require transportation of the IVC respondent to a facility able to handle any emergent medical conditions discovered in that exam.
- Clarify when a medical screening exam is not necessary.
- Require a facility transferring an individual in the IVC process to an acute care hospital solely for an unrelated medical condition to hold that individual's bed slot for at least 6 hours, unless both the transferring and the receiving facility agree return in that time is not reasonable.
- Replace references to "physician or eligible psychologist" with "commitment examiner."

Section 35 of the PCS would amend G.S. 122C-284 to replace references to "physician or eligible psychologist" with "commitment examiner" and allow IVC respondents and their counsel to file a waiver of the right to receive notice of a hearing.

Section 36 of the PCS would amend G.S. 122C-285 to replace references to "physician or eligible psychologist" with "commitment examiner" and require written findings in all cases.

Section 37 of the PCS would amend G.S. 122C-286 to require hearings for IVC respondents subject to a series of successive custody orders within 10 days of the most recent order and permit IVC respondents to waive personal appearance at the hearing.

Section 38 of the PCS would amend G.S. 122C-287 to require the court to follow the procedures in G.S. 122C-271(a)(3) and G.S. 122C-271(b)(4) when remanding a substance abuser who is dangerous to self or others for treatment to any non-inpatient facility.

Section 39 of the PCS would make conforming changes to G.S. 122C-290.

Section 40 of the PCS would make conforming changes to G.S. 122C-291.

Section 41 of the PCS would make conforming changes to G.S. 122C-292.

Section 42 of the PCS would make conforming changes to G.S. 122C-293.

Section 43 of the PCS would require the local plan developed under G.S. 122C-202.2 and G.S. 122C-251(g) to be submitted to the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services on or before October 1, 2019. Changes to previously filed plans would have to be filed at least 10 days before the effective date of the changes.

This section represents a substantive change from the bill as originally filed. The PCS requires the local plan to be filed with the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services.

Section 44 of the PCS would require any community crisis services plan to be filed with DHHS by the earlier of (1) 12 months after CMS approves the Medicaid and NC Health Choice transformation in S.L. 2015-245, or (2) 6 months prior to the date DHHS actually initiates capitated contracts as defined in Section 4 of S.L. 2015-245.

Section 45 of the PCS would permit a State or local human services agency or a healthcare provider to file a petition for adjudication of incompetence and present evidence at a hearing on the petition without legal counsel.

This section was not in the original bill.

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EFFECTIVE DATE: Section 44 of this act would be effective when it becomes law. The remainder of the act would be effective October 1, 2019, and apply to proceedings initiated on or after that date.



GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2017

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SENATE BILL 630 PROPOSED HOUSE COMMITTEE SUBSTITUTE \$630-CSBC-36 [v.16] 06/12/2018 06:08:53 PM

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Short Title: Revise IVC Laws to Improve Behavioral Health. (Public) Sponsors: Referred to:

April 5, 2017 A BILL TO BE ENTITLED 1 2 AN ACT REVISING THE LAWS PERTAINING TO INVOLUNTARY COMMITMENT IN 3 ORDER TO IMPROVE THE DELIVERY OF BEHAVIORAL HEALTH SERVICES IN 4 NORTH CAROLINA. 5 The General Assembly of North Carolina enacts: 6 **SECTION 1.** G.S. 122C-3 reads as rewritten: 7 "§ 122C-3. Definitions. 8 The following definitions apply in this Chapter: 9 10 "Commitment examiner" means a physician, an eligible psychologist, or any 11 (8a)health professional or mental health professional who is certified under G.S. 12 122C-263.1 to perform the first examination for involuntary commitment 13 described in G.S. 122C-263(c) or G.S. 122C-283(c) as required by Parts 7 and 14 8 of this Article. 15

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- "Incapable" with respect to an individual has the same definition set forth in (16a)G.S. 122C-72(4). An adult individual who is incapable is not the same as an incompetent adult unless the adult individual has been adjudicated incompetent under Chapter 35A of the General Statutes.
- "Incompetent adult" means an adult individual who has been adjudicated (17)incompetent.incompetent under Chapter 35A of the General Statutes.
- "Legally responsible person" means: (i) when applied to an adult, who has (20)been adjudicated incompetent, a guardian; (ii) when applied to a minor, a parent, guardian, a person standing in loco parentis, or a legal custodian other than a parent who has been granted specific authority by law or in a custody order to consent for medical care, including psychiatric treatment; or (iii) when applied to an adult who is incapable as defined in G.S. 122C-72(e)G.S. 122C-72(4) and who has not been adjudicated incompetent, a health care agent named pursuant to a valid health care power of attorney; provided that if an incapable adult does not have a health care agent or guardian, "legally responsible person" means one of the persons



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(29a) "Program director" means the director of a county program established pursuant to G.S. 122C-115.1.

center on an outpatient commitment order unless the respondent enrolled with an LME/MCO or is eligible for services through an LME/MCO, or the

respondent otherwise qualifies for the provision of services offered by the

SECTION 2. G.S. 122C-4 reads as rewritten:

provider.

"§ 122C-4. Use of phrase "client or his-the legally responsible person."

(a) Except as otherwise provided by law, whenever in this Chapter the phrase "client or his the legally responsible person" is used, and the client is a minor or an incompetent adult, the duty or right involved shall be exercised not by the client, but by the legally responsible person.

(b) Except as otherwise provided by law, whenever in this Chapter the phrase "client or the legally responsible person" is used, and the client is an incapable adult who has not been

 adjudicated incompetent under Chapter 35A of the General Statutes, the duty or right involved shall be exercised not by the client but by a health care agent named pursuant to a valid health care power of attorney, if one exists, or by the client as expressed in a valid advance instruction for mental health treatment, if one exists. If no health care power of attorney or advance instruction for mental health treatment exists, the legally responsible person for an incapable adult who has not been adjudicated incompetent under Chapter 35A of the General Statutes shall be one of the persons listed in subdivisions (3) through (7) of subsection (c) of G.S. 90 21.13, to be selected based on the priority order indicated in said subdivisions (3) through (7)."

SECTION 3. G.S. 122C-53 reads as rewritten:

"§ 122C-53. Exceptions; client.

- (a) A facility may disclose confidential information if the client or his-the legally responsible person consents in writing to the release of the information to a specified person. This release is valid for a specified length of time and is subject to revocation by the consenting individual.
- (b) A facility may disclose (i) the fact of admission or discharge of a client and (ii) the time and location of admission or discharge to the client's next of kin whenever the responsible professional determines that the disclosure is in the best interest of the client.
- (c) Upon request a client shall have access to confidential information in his client the client's record except information that would be injurious to the client's physical or mental well-being as determined by the attending physician or, if there is none, by the facility director or his the facility director's designee. If the attending physician or, if there is none, the facility director or his the facility director's designee has refused to provide confidential information to a client, the client may request that the information be sent to a physician or psychologist of the client's choice, and in this event the information shall be so provided.
- (d) Except as provided by G.S. 90-21.4(b), upon request the legally responsible person of a client shall have access to confidential information in the client's record; except information that would be injurious to the client's physical or mental well-being as determined by the attending physician or, if there is none, by the facility director or his-the facility director's designee. If the attending physician or, if there is none, the facility director or his-the facility director's designee has refused to provide confidential information to the legally responsible person, the legally responsible person may request that the information be sent to a physician or psychologist of the legally responsible person's choice, and in this event the information shall be so provided.
- (e) A client advocate's access to confidential information and his—the client's responsibility for safeguarding this information are as provided by subsection (g) of this section.
- (f) As used in subsection (g) of this section, the following terms have the meanings specified:
 - (1) "Internal client advocate" means a client advocate who is employed by the facility or has a written contractual agreement with the Department or with the facility to provide monitoring and advocacy services to clients in the facility in which the client is receiving services; and services.
 - (2) "External client advocate" means a client advocate acting on behalf of a particular client with the written consent and authorization; authorization under either of the following circumstances:
 - a. In the case of a client who is an adult and who has not been adjudicated incompetent under Chapter 35A or former Chapters 33 or 35 of the General Statutes, of the elient; orclient.
 - b. In the case of any other client, of the client and his-the-legally responsible person.
- (g) An internal client advocate shall be granted, without the consent of the client or his the legally responsible person, access to routine reports and other confidential information

necessary to fulfill his—monitoring and advocacy functions. In this role, the internal client advocate may disclose confidential information received to the client involved, to his-the legally responsible person, to the director of the facility or his-the director's designee, to other individuals within the facility who are involved in the treatment or habilitation of the client, or to the Secretary in accordance with the rules of the Commission. Any further disclosure shall require the written consent of the client and his-the legally responsible person. An external client advocate shall have access to confidential information only upon the written consent of the client and his legally responsible person. In this role, the external client advocate may use the information only as authorized by the client and his legally responsible person.

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SECTION 4. G.S. 122C-54 reads as rewritten:

"§ 122C-54. Exceptions; abuse reports and court proceedings.

(a1) Upon a determination by the facility director or his the facility director's designee that disclosure is in the best interests of the client, a facility may disclose confidential information for purposes of filing a petition for involuntary commitment of a client pursuant to Article 5 of this Chapter or for purposes of filing a petition for the adjudication of incompetency of the client and the appointment of a guardian or an interim guardian under Chapter 35A of the General Statutes.

(c) Certified copies of written results of examinations by physicians and records in the eases of clients voluntarily admitted or involuntarily committed and facing. When an individual is held at a facility under involuntary commitment or voluntary admission proceedings that require district court hearings and or rehearings pursuant to Article 5 of this Chapter-Chapter, certified copies of written results of examinations, gathered during the course of the current commitment or admission shall be furnished by the facility to the client's counsel, the attorney representing the State's interest, and the court. Upon request, the facility shall disclose to respondent's counsel, the attorney representing the State's interest, and the court confidential information collected, maintained, or used in attending or treating the respondent during the proceeding for voluntary admission or involuntary commitment. Other medical records shall be furnished only upon court order. The confidentiality of client information shall be preserved in all matters except those pertaining to the necessity for admission or continued stay in the facility or commitment under review. The relevance of confidential information for which disclosure is sought in a particular case shall be determined by the court with jurisdiction over the matter.

(d) Any individual individual, including the respondent, seeking confidential information contained in the court files or the court records of a proceeding made pursuant to Article 5 of this Chapter may file a written motion in the cause setting out why the information is needed. A district court judge may issue an order to disclose the confidential information sought if he the judge finds (i) the order is appropriate under the circumstances and if he finds (ii) that it is in the best interest of the individual admitted or committed or of the public to have the information disclosed. The respondent's legally responsible person shall exercise the respondent's right to access the court records if the respondent is a minor or an incompetent adult at the time of the request. The district court judge's decision on the order may be appealed to superior court.

(e) Upon the request of the legally responsible person or the minor admitted or committed, and after that minor has both been released and reached adulthood, the court records of that minor made in proceedings pursuant to Article 5 of this Chapter may be expunged from the files of the court. The minor and his the minor's legally responsible person shall be informed in writing by the court of the right provided by this subsection at the time that the application for admission is filed with the court.

(g) A facility may disclose confidential information to an attorney who represents either the facility or an employee of the facility, if such information is relevant to litigation, to the operations of the facility, or to the provision of services by the facility. An employee may discuss confidential information with his-the-employee attorney or with an attorney representing the facility in which he-employee is employed.

..."

SECTION 5. G.S. 122C-55 reads as rewritten:

"§ 122C-55. Exceptions; care and treatment.

- (a) Any facility may share confidential information regarding any client of that facility with any other facility when necessary to coordinate appropriate and effective care, treatment or habilitation of the client. For the purposes of this section, the following definitions apply:
 - (1) eoordinate "Coordinate" means the provision, coordination, or management of mental health, developmental disabilities, and substance abuse services and other health or related services by one or more facilities and includes the referral of a client from one facility to another.
 - (2) "Facility" and "area facility" include an area authority.
 - (3) "Secretary" includes any primary care case management programs that contract with the Department to provide a primary care case management program for recipients of publicly funded health and related services.
- (a1) Any facility may share confidential information regarding any client of that facility with the Secretary, and the Secretary may share confidential information regarding any client with a facility when necessary to conduct quality assessment and improvement activities or to coordinate appropriate and effective care, treatment or habilitation of the client. For purposes of this subsection, subsection (a6), and subsection (a7) of this section, the purposes or activities for which confidential information may be disclosed include, but are not limited to, case management and care coordination, disease management, outcomes evaluation, the development of clinical guidelines and protocols, the development of care management plans and systems, population-based activities relating to improving or reducing health care costs, and the provision, coordination, or management of mental health, developmental disabilities, and substance abuse services and other health or related services. As used in this section, "facility" includes an LME and "Secretary" includes the Community Care of North Carolina Program, or other primary care case management programs that contract with the Department to provide a primary care case management program for recipients of publicly funded health and related services.
- (a2) Any area or State facility or the psychiatric service of the University of North Carolina Hospitals at Chapel Hill may share confidential information regarding any client of that facility with any other area facility or State facility or the psychiatric service of the University of North Carolina Hospitals at Chapel Hill when necessary to conduct payment activities relating to an individual served by the facility. Payment activities are activities undertaken by a facility to obtain payment or provide receive reimbursement for the provision of services and may include, but are not limited to, determinations of eligibility or coverage, coordination of benefits, determinations of cost-sharing amounts, claims management, claims processing, claims adjudication, claims appeals, billing and collection activities, medical necessity reviews, utilization management and review, precertification and preauthorization of services, concurrent and retrospective review of services, and appeals related to utilization management and review.
- (a3) Whenever there is reason to believe that a client is eligible for benefits through a Department program, any State or area-facility or the psychiatric service of the University of North Carolina Hospitals at Chapel Hill may share confidential information regarding any client of that facility with the Secretary, and the Secretary may share confidential information regarding any client with an area facility or State facility or the psychiatric services of the University of North Carolina Hospitals at Chapel Hill. Disclosure is limited to that information necessary to

establish initial eligibility for benefits, determine continued eligibility over time, and obtain reimbursement for the costs of services provided to the client.

(c2) A facility may furnish confidential information in its possession to the Sheriff of any county when requested by the Sheriff regarding any client of that facility who is confined in the county's jail or jail annex when the inmate has been determined by the county jail medical unit to be in need of treatment for mental illness, developmental disabilities, or substance abuse. The Sheriff may furnish to a facility confidential information in its possession about treatment for mental illness, developmental disabilities, or substance abuse that the county jail medical unit has provided to any present or former inmate if the inmate is presently seeking treatment from the requesting facility or if the inmate has been involuntarily committed to the requesting facility for inpatient or outpatient treatment. Under the circumstances described in this subsection, the consent of the client or inmate shall not be required in order for this information to be furnished and the information shall be furnished despite objection by the client or inmate. Confidential information disclosed pursuant to this subsection is restricted from further disclosure.

SECTION 6. G.S. 122C-115.4 reads as rewritten:

"§ 122C-115.4. Functions of local management entities.

(b) The primary functions of an LME are designated in this subsection and shall not be conducted by any other entity unless an LME voluntarily enters into a contract with that entity under subsection (c) of this section. The primary functions include all of the following:

(7a) Community crisis services planning in accordance with G.S. 122C-202.2.

. . . **

SECTION 7. G.S. 122C-117 reads as rewritten:

"§ 122C-117. Powers and duties of the area authority.

(a) The area authority shall do all of the following:

(18) Develop and adopt community crisis services plans in accordance with G.S. 122C-202.2

SECTION 8. Part 1 of Article 5 of Chapter 122C of the General Statutes is amended by adding a new section to read:

"§ 122C-202.2. LME/MCO community crisis services plan; commitment examiners; transporting agencies; training; collaboration. Every LME/MCO shall adopt a community crisis services plan in accordance with

- (a) Every LME/MCO shall adopt a community crisis services plan in accordance with this section to facilitate first examination in conjunction with a health screening at the same location required pursuant to Parts 7 and 8 of this Article within its catchment area. The community crisis services plan for the LME/MCO's catchment area shall be comprised of separate plans, known as "local area crisis services plans" for each of the local areas or regions within the catchment area that the LME/MCO identifies as an appropriate local planning area, taking into consideration the available resources and interested stakeholders within a particular geographic area or region of the catchment area. Each LME/MCO may determine the number and geographic boundaries of the local planning areas within its catchment area. Each local area crisis services plan shall, for the local area covered by the local plan, do at least all of the following:
 - (1) Incorporate the involuntary commitment transportation agreement adopted pursuant to G.S. 122C-251(g) for the cities and counties within the local planning areas which identifies the law enforcement officers, designees under

G.S. 122C-251(g), or individuals or entities otherwise required to provide custody and transportation of a respondent for a first examination in conjunction with a health screening at the same location required by G.S. 122C-263(a) and G.S. 122C-283. Notwithstanding the foregoing, counties and cities shall retain the responsibilities for custody and transportation set forth in this Article, except as otherwise set forth in a plan developed, agreed upon, and adopted in compliance with this section and G.S. 122C-251(g).

- [2] Identify one or more area facilities or other locations in accordance with G.S. 122C-263 and G.S. 122C-283. Each LME/MCO shall contract with one or more facilities or other locations described in G.S. 122C-263 and G.S. 122C-283 for the provision of, health screenings and first examinations required by G.S. 122C-263 and G.S. 122C-283 for the provision of first examination in conjunction with a health screening required by G.S. 122C-263 and G.S. 122C-283, to meet the needs of its local planning area.
- Identify available training for law enforcement personnel and other persons (3) designated or required under G.S. 122C-251(g) to provide transportation and custody of involuntary commitment respondents. Law enforcement officers may request to participate in the training program identified by the LME/MCO. Persons who are designated in compliance with G.S. 122C-251(g) to provide all or part of the transportation and custody required for involuntary commitment proceedings under this Article and who are not law enforcement officers shall participate in the training. To the extent feasible, the identified training shall address the use of deescalation strategies and techniques, the safe use of force and restraint, respondent rights relevant to custody and transportation, the location of any area facilities identified by the LME/MCO pursuant to subdivision (1) of this subsection, and the completion and return of the custody order to the clerk of superior court. The training identified by the LME/MCO may be comprised of one or more programs, and may include a Crisis Intervention Team program or other mental health training program or a combination of these programs.
- (b) Law enforcement agencies, acute care hospitals, magistrates, area facilities with identified commitment examiners, and other affected agencies shall participate with the LME/MCO in the development of the local area crisis services plans described in this section. Other stakeholders and community partners identified by the LME/MCO may be invited to participate in the planning. No local area crisis services plan developed under this section shall be adopted or thereafter be effective or implemented unless such plan first has been mutually agreed upon in writing by all entities identified in the plan pursuant to subsection (a) of this section. If any member of the Crisis Planning Committee fails to agree to the plan in writing, the Secretary shall develop a procedure to attempt to resolve the conflict in order to achieve approval of the Plan.
- (c) The plans adopted under this section may, by mutual agreement of all entities identified in the plan, address any other matters necessary to facilitate the custody, transportation, examination, and treatment of respondents to commitment proceedings under Parts 7 and 8 of this Article."

SECTION 9. G.S. 122C-206 reads as rewritten:

"§ 122C-206. Transfers of clients between 24-hour facilities. facilities; transfer of clients from 24-hour facilities to acute care hospitals.

(a) Before transferring a voluntary adult client from one 24-hour facility to another, the responsible professional at the original facility shall: (i) get authorization from the receiving

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facility that the facility will admit the client; (ii) get consent from the client; and (iii) if consent to share information is granted by the client, or if the disclosure of information is permitted under G.S. 122C-53(b), notify the next of kin of the time and location of the transfer. The preceding requirements of this paragraph may be waived if the client has been admitted under emergency procedures to a State facility not serving the client's region of the State. Following an emergency admission, the client may be transferred to the appropriate State facility without consent according to the rules of the Commission.

- Before transferring a respondent held for a district court hearing or a committed respondent from one 24-hour facility to another, the responsible professional at the original facility shall:
 - Obtain authorization from the receiving facility that the facility will admit the (1) respondent; and
 - Provide reasonable notice to the respondent, or respondent or the legally (2) responsible person, and to the respondent's counsel, of the reason for the transfer and document the notice in the client's record.

No later that than 24 hours after the transfer, the responsible professional at the original facility shall notify the petitioner, the clerk of court, the respondent's counsel, and, if consent is granted by the respondent, or if the disclosure of the information is permitted under G.S. 122C-53 or other applicable law, the next of kin, that the transfer is completed complete. If the transfer is completed before the judicial commitment hearing, these proceedings shall be initiated by the receiving facility. If the respondent is a minor, an incompetent adult, or is deemed incapable, then the responsible professional at the original facility shall, not later than 24 hours after the transfer, notify the respondent's legally responsible person of the location of the transfer and that the transfer is complete.

- Minors and incompetent adults, admitted pursuant to Parts 3 and 4 of this Article, may be transferred from one 24-hour facility to another following the same procedures specified in subsection (b) of this section. In addition, the legally responsible person shall be consulted before the proposed transfer.transfer and notified, within 24 hours after the transfer is complete, of the location of the transfer and that the transfer is complete. If the transfer is completed before the judicial determination required in G.S. 122C-223 or G.S. 122C-232, these proceedings shall be initiated by the receiving facility.
- If a client described in subsections (b) or (c) of this section is to be transferred from one 24-hour facility to another another, or to an acute care hospital pursuant to subsection (e) of this section, and transportation is needed, the responsible professional at the original facility shall notify the clerk of court or magistrate, and the clerk of court or magistrate shall issue a custody order for transportation of the client as provided by G.S. 122C-251.
- Minors and incompetent adults, admitted pursuant to Part 5 of this Article and incapable adults admitted pursuant to Part 2A of this Article, may be transferred from one 24-hour facility to another provided that prior to transfer the responsible professional at the original facility shall:
 - Obtain authorization from the receiving facility that the facility will admit the (1) client: and
 - Provide reasonable notice to the client regarding the reason for transfer and (2) document the notice in the client's record; and
 - Provide reasonable notice to and consult with the legally responsible person (3) regarding the reason for the transfer and document the notice and consultation in the client's record.

No later than 24 hours after the transfer, the responsible professional at the original facility shall notify the legally responsible person that the transfer is completed.

The responsible professional may transfer a client from one 24-hour facility to another or to an acute care hospital for emergency medical treatment, emergency medical evaluation, or

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emergency surgery without notice to or consent from the client. Within a reasonable period of time the responsible professional shall notify the next of kin or the legally responsible person of the client of the transfer.

- (f) When a client is transferred <u>from one 24-hour facility</u> to another facility solely for medical reasons, the client shall be returned to the original facility when the medical care is completed unless the responsible professionals at both facilities concur that discharge of the client who is not subject to G.S. 122C-266(b) is appropriate.
- When a client is transferred from a 24 hour facility to an acute care hospital solely for medical reasons, the hospital shall return the client to the original facility as soon as the next client space becomes available at the original facility after completion of the client's medical care. With the exception of facility-based crisis centers, the original facility must allow at least twelve hours for the client's return before assigning the client's room or bed to another patient unless both facilities agree that return of the client in this time period is not feasible. The original facility must accept the return of the client in priority over other clients seeking admission, except in the cases of patients designated incapable to proceed to trial by court order. If the responsible professionals at both facilities concur that discharge of a client who is not subject to G.S. 122C-266(b) is appropriate, the client may be discharged. If, at the time of the transfer, a client is being held under a custody order pending a second commitment examination or a district court hearing under involuntary commitment proceedings, the custody order shall remain valid throughout the period of time necessary to complete the client's medical care and transport the client between the 24-hour facility and the acute care hospital; provided, however, that the requirement for a timely hearing under G.S. 122C-268(a) applies. Any decision to terminate the proceedings because the respondent no longer meets the criteria for commitment or because a hearing cannot be held within the time required by G.S. 122C-268(a) shall be documented and reported to the clerk of superior court in accordance with G.S. 122C-266(c).
 - (g) The Commission may adopt rules to implement this section." **SECTION 10.** G.S. 122C-201.1 reads as rewritten:

"§ 122C-210.1. Immunity from liability.

No facility facility, person, or entity, including an area facility, a facility licensed under this Chapter, an acute care hospital, a general hospital, an area authority, a law enforcement officer, an LME, or an LME/MCO, or any of its their officials, staff, or employees, or any other physician or other individual who is responsible for the custody, transportation, examination, admission, management, supervision, treatment, or release of a respondent or client and who follows accepted professional judgment, practice, and standards is not grossly negligent is civilly or criminally liable, personally or otherwise, for that person's or entity's actions or omissions arising from these responsibilities or for the actions or omissions of the a respondent or client. This immunity is in addition to any other legal immunity from liability to which these persons, entities, facilities facilities, agencies, or individuals may be entitled and applies to actions performed in connection with, or arising out of, the custody, transportation, examination, commitment, admission admission, management, supervision, treatment, or release or commitment of any individual pursuant to or under the authority of this Article. Article or otherwise."

SECTION 11. G.S. 122C-210.3 reads as rewritten:

"§ 122C-210.3. Electronic and facsimile transmission of custody orders.

A custody order entered by the clerk or magistrate pursuant to this Chapter may be delivered to the law enforcement officer or other person designated or required to provide transportation and custody pursuant to G.S. 122C-251 by electronic or facsimile transmission."

SECTION 12. G.S. 122C-211 reads as rewritten:

"Part 2. Voluntary Admissions and Discharges, Competent Adults, Facilities for the Mentally Ill and Substance Abusers.

§ 122C-211. Admissions.

provide the treatment needed by the client.

Except as provided in subsections (b) through (f1)(f) of this section, any individual, (a) including a parent in a family unit, in need of treatment for mental illness or substance abuse may seek voluntary admission at any facility by presenting himself or herself for evaluation to the facility. No physician's statement is necessary, but a written application for evaluation or admission, signed by the individual seeking admission, or the individual's legally responsible person, is required. The application form shall be available at all times at all facilities. However, no one shall be denied admission because application forms are not available. An evaluation shall determine whether the individual is in need of care, treatment, habilitation or rehabilitation for mental illness or substance abuse or further evaluation by the facility. Information provided by family members regarding the individual's need for treatment shall be reviewed in the evaluation. If applicable, information provided in an advance instruction for mental health treatment by the client or the client's legally responsible person shall be reviewed in the evaluation. An individual may not be accepted as a client if the facility determines that the individual does not need or cannot benefit from the care, treatment, habilitation, or rehabilitation available and that the individual is not in need of further evaluation by the facility. The facility shall give to an individual who is denied admission a referral to another facility or facilities that may be able to

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_(e) When an individual from a single portal area seeks admission to an area or State 24 hour facility, the admission shall follow the procedures as prescribed in the area plan. When an individual from a single portal area presents himself for admission to the facility directly and is in need of an emergency admission, the individual may be accepted for admission. The facility shall notify the area authority within 24 hours of the admission. Further planning of treatment for the client is the joint responsibility of the area authority and the facility as prescribed in the area plan.

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_(f1) An individual in need of treatment for mental illness may be admitted to a facility pursuant to an advance instruction for mental health treatment or pursuant to the authority of a health care agent named in a valid health care power of attorney, provided that the individual is incapable, as defined in G.S. 122C-72(4) at the time of the need for admission. An individual admitted to a facility pursuant to an advance instruction for mental health treatment may not be retained for more than 10 days, except as provided for in subsection (b) of this section. When a health care power of attorney authorizes a health care agent to seek the admission of an incapable individual, the health care agent shall act for the individual in applying for admission to a facility and in consenting to medical treatment at the facility when consent is required, provided that the individual is incapable.

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SECTION 13. G.S. 122C-212 reads as rewritten:

"§ 122C-212. Discharges.

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- (a) Except as provided in <u>subsections subsection</u> (b) and (c) of this section, an individual who has been voluntarily admitted to a facility shall be discharged upon <u>his the individual's</u> own request. A request for discharge from a 24-hour facility shall be in writing.
- (b) An individual who has been voluntarily admitted to a 24-hour facility may be held for 72 hours after his the individual's written application for discharge is submitted.
- (c) When an individual from a single portal area who has been voluntarily admitted to an area or State 24 hour facility is discharged, the discharge shall follow the procedures as prescribed in the area plan."

SECTION 14. Article 5 of Chapter 122C of the General Statutes is amended by adding a new Part to read:

"Part 2A. Voluntary Admissions and Discharges; Incapable Adults; Facilities for Individuals
With Mental Illness and Substance Use Disorder.

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"§ 122C-213. Voluntary admission of individuals determined to be incapable.

- (a) An individual in need of treatment for mental illness and who is incapable, as defined in G.S. 122C-3 and G.S. 122C-72, may be admitted to and treated in a facility pursuant to an advance instruction for mental health treatment executed in accordance with Part 2 of Article 3 of this Chapter or pursuant to the authority of a health care agent named in a valid health care power of attorney executed in accordance with Article 3 of Chapter 32A of the General Statutes.
- (b) Except as otherwise provided in this Part, G.S. 122C-211 applies to admissions of incapable adults under this Part.
- (c) An advance instruction for mental health treatment shall be governed by Part 2 of Article 3 of this Chapter.
- (d) When a health care power of attorney authorizes a health care agent pursuant to G.S. 32A-19 to make mental health treatment decisions for an incapable individual, the health care agent shall act for the individual in applying for admission and consenting to treatment at a facility, consistent with the extent and limitations of authority granted in the health care power of attorney for as long as the individual remains incapable.
- (e) A 24-hour facility may not hold an individual under a voluntary admission who is determined to be incapable at the time of admission and who is admitted pursuant to an advance instruction for mental health treatment for more than 15 days, except as provided in G.S. 122C 211(b); provided, however, that an individual who regains sufficient understanding and capacity to make and communicate mental health treatment decisions may elect to continue his or her admission and treatment pursuant to the individual's informed consent in accordance with G.S. 122C-211. A 24-hour facility may file a petition for involuntary commitment pursuant to Article 5 of this Chapter if an individual meets applicable criteria at the conclusion of this 15-day period.

"§ 122C-214. Discharge of individuals determined to be incapable.

- (a) The responsible professional shall unconditionally discharge an individual admitted to a facility pursuant to this Part at any time it is determined the individual is no longer mentally ill or in need of treatment at the facility.
- (b) An individual who has been voluntarily admitted to a facility pursuant to this Part and who is no longer deemed incapable shall be discharged upon his or her own request. An individual's request for discharge from a 24-hour facility shall be in writing. A facility may hold an individual who has been voluntarily admitted to a 24-hour facility pursuant to this Part for up to 72 hours after the individual submits a written request for discharge, but the facility shall release the individual upon the expiration of 72 hours following submission of the written request for discharge unless the responsible professional obtains an order under Part 7 or 8 of this Article to hold the client.
- (c) A health care agent named in a valid health care power of attorney or the legally responsible person may submit on behalf of an individual admitted to a facility under this Part a written request to have the individual discharged from the facility, provided (i) the individual remains incapable at the time of the request and (ii) the request is not inconsistent with the authority expressed in the health care power of attorney or other controlling document. A facility may hold an individual for up to 72 hours after a health care agent submits a written request for the individual's discharge but shall release the individual upon the expiration of 72 hours following submission of the written request for discharge unless the responsible professional obtains an order under Part 7 or 8 of this Article to hold the client.
- (d) If, in the opinion of a physician or eligible psychologist, an individual admitted to a facility under this Part regains sufficient understanding and capacity to make and communicate mental health treatment decisions while in treatment, and the individual refuses to sign an authorization for continued treatment within 72 hours after regaining decisional capacity, the facility shall discharge the individual unless the responsible professional obtains an order under Part 7 or 8 of this Article to hold the client.

(e) In any case in which an order is issued authorizing the involuntary commitment of an individual admitted to a facility under this Part, the facility's further treatment and holding of the individual shall be in accordance with Part 7 or 8 of this Article, whichever is applicable.

SECTION 15. G.S. 122C-221 reads as rewritten:

"§ 122C-221. Admissions.

(a) Except as otherwise provided in this Part, a minor may be admitted to a facility if the minor is mentally ill or a substance abuser and in need of treatment. Except as otherwise provided in this Part, the provisions of G.S. 122C-211 shall apply to admissions of minors under this Part. Except as provided in G.S. 90-21.5, in applying for admission to a facility, in consenting to medical treatment when consent is required, and in any other legal procedure under this Article, the legally responsible person shall act for the minor. The application of the minor shall be in writing and signed by the legally responsible person. If a minor reaches the age of 18 while in treatment under this Part, further treatment is authorized only on the written authorization of the client or under the provisions of Part 7 or Part 8 of Article 5 of this Chapter.

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SECTION 16. G.S. 122C-224(c) reads as rewritten:

"§ 122C-224. Judicial review of voluntary admission.

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(c) Within 24 hours after admission, the facility shall notify the clerk of court in the county where the facility is located that the minor has been admitted and that a hearing for concurrence in the admission must be scheduled. At the time notice is given to schedule a hearing, the facility shall (i) notify the clerk of the names and addresses of the legally responsible person and the responsible professional professional and (ii) provide the clerk with a copy of the legally responsible person's written application for admission of the minor and the facility's written evaluation of the minor, both of which are required under G.S. 122C 211(a)."

SECTION 17. Part 4 of Article 5 of Chapter 122C of the General Statutes is amended by adding a new section to read:

"§ 122C-230. Applicability of Part 4.

This Part applies to adults who are adjudicated incompetent by a court of competent jurisdiction. This Part does not apply to the admission of adults who are deemed incapable but who have not been adjudicated incompetent."

SECTION 18. G.S. 122C-232 reads as rewritten:

"§ 122C-232. Judicial determination.

- (a) When an incompetent adult is admitted to a 24-hour facility where the incompetent adult will be subjected to the same restrictions on his-freedom of movement present in the State facilities for the mentally ill, or to similar restrictions, a hearing shall be held in the district court in the county in which the 24-hour facility is located within 10 days of after the day that the incompetent adult is admitted to the facility. A continuance of not more than five days may be granted upon motion of:any of the following:
 - (1) The court; court.
 - (2) Respondent's counsel; or counsel.
 - (3) The responsible professional.

The Commission shall adopt rules governing procedures for admission to other 24-hour facilities not falling within the category of facilities where freedom of movement is restricted; these rules shall be designed to ensure that no incompetent adult is improperly admitted to or remains in a facility.

- (a1) Prior to admission, the facility shall provide the incompetent adult and the legally responsible person with written information describing the procedures for court review of the admission and the procedures for discharge.
- (a2) Within 24 hours after admission, the facility shall notify the clerk of court of the county in which the facility is located that the incompetent adult has been admitted and that a

hearing for concurrence in the admission must be scheduled. At the time the facility provides notice to the court to schedule a hearing for concurrence, the facility shall notify the clerk of the names and addresses of the legally responsible person and the responsible professional and provide a copy of the legally responsible person's written application for evaluation or admission of the incompetent adult and the facility's evaluation of the incompetent adult.

- (b) In any case requiring the hearing described in subsection (a) of this section, no petition is necessary; the written application for voluntary admission shall serve as the initiating document for the hearing. The court shall determine whether the incompetent adult is mentally ill or a substance abuser and is in need of further treatment at the facility. Further treatment at the facility should be undertaken only when lesser measures will be insufficient. If the court finds by clear, cogent, and convincing evidence that these requirements have been met, the court shall concur with the voluntary admission of the incompetent adult and set the length of the authorized admission for a period not to exceed 90 days. If the court finds that these requirements have not been met, it shall order that the incompetent adult be released. A finding of dangerousness to self or others is not necessary to support the determination that further treatment should be undertaken.
- (d) In addition to the notice of hearings and rehearings to the incompetent adult and his <u>or her</u> counsel required under Part 7 of this Article, notice shall be given by the clerk to the legally responsible <u>person</u>, <u>person</u> or <u>his a successor to the legally responsible person</u>. The legally responsible <u>person</u>, <u>or his person or a successor to the legally responsible person may also file with the clerk of court a written waiver of his to receive notice."</u>

SECTION 19. G.S. 122C-251 reads as rewritten:

"Part 6. Involuntary Commitment – General Provisions.

§ 122C-251. Transportation. Custody and transportation.

- (a) Except as provided in subsections (c), (f)(f), and (g), transportation of a respondent within a county under the involuntary commitment proceedings of this Article, including admission and discharge, shall be provided by the city or county. The city has the duty to provide transportation of a respondent who is a resident of the city or who is physically taken into custody in the city limits. The county has the duty to provide transportation for a respondent who resides in the county outside city limits or who is physically taken into custody outside of city limits. However, cities and counties may contract with each other to provide transportation.
- (b) Except as provided in subsections (f)(c), (f), and (g) or in G.S. 122C-408(b), transportation between counties under the involuntary commitment proceedings of this Article for a first examination as described in G.S. 122C-263(a) and 122C-283(a) and for admission to a 24-hour facility shall be provided by the county where the respondent is taken into custody. Transportation between counties under the involuntary commitment proceedings of this Article for respondents held in 24-hour facilities who have requested a change of venue for the district court hearing shall be provided by the county where the petition for involuntary commitment was initiated. Transportation between counties under the involuntary commitment proceedings of this Article for discharge of a respondent from a 24-hour facility shall be provided by the county of residence of the respondent. However, a respondent being discharged from a facility may use his own transportation at his own expense.
- (c) Transportation of a respondent may be (i) by city- or county-owned vehicles-vehicles, (ii) or-by private vehicle by contract with the city or eounty-county, or (iii) as provided in an agreement developed and adopted under subsection (g) of this section and G.S. 122C-202.2 To the extent feasible, law enforcement officers transporting respondents shall dress in plain clothes and shall travel in unmarked vehicles. Further, law enforcement officers, to the extent possible, shall advise respondents when taking them into custody that they are not under arrest and have not committed a crime, but are being taken into custody and transported to receive treatment and for their own safety and that of others.

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- (d) To the extent feasible, in providing transportation of a respondent, a city or county shall provide a driver or attendant who is the same sex as the respondent, unless the law-enforcement enforcement officer allows a family member of the respondent to accompany the respondent in lieu of an attendant of the same sex as the respondent.
- (e) In taking custody and providing transportation as required by this section, the law enforcement officer may use reasonable force to restrain the respondent if it appears necessary to protect himself, the law enforcement officer, the respondent, or others. Any use of restraints shall be as reasonably determined by the officer to be necessary under the circumstances for the safety of the respondent, the law enforcement officer, and other persons. Every effort to avoid restraint of a child under the age of 10 shall be made by the transporting officer unless the child's behavior or other circumstances dictate that restraint is necessary. The law enforcement officer shall respond to all inquiries from the facility concerning the respondent's behavior and the use of any restraints related to the custody and transportation of the respondent, except in circumstances where providing that information is confidential or would otherwise compromise a law enforcement investigation. No law enforcement law enforcement officer or other person designated or required to provide custody or transport of a client under G.S. 122C-251 may be held criminally or civilly liable for assault, false imprisonment, or other torts or crimes on account of reasonable measures taken under the authority of this Article.
- (f) Notwithstanding the provisions of subsections (a), (b), and (c) of this section, a clerk, a magistrate, or a district court judge, where applicable, may authorize the family or immediate friends of the respondent, if they so request, to transport the respondent in accordance with the procedures of this Article. This authorization shall only be granted in cases where the danger to the public, the family or friends of the respondent, or the respondent himself or herself is not substantial. The family or immediate friends of the respondent shall bear the costs of providing this transportation.
- (g) The governing body of a city or county may adopt shall a plan known as an "involuntary commitment transportation agreement" or "transportation agreement" for the custody and transportation of respondents in involuntary commitment proceedings in under this Article. Article as follows:
 - (1) Law enforcement and other affected agencies, including local acute care hospitals and other mental health providers, shall participate in developing the transportation agreement. The area authority may participate in developing the transportation agreement.
 - The transportation agreement may designate Law-enforcementlaw (2) enforcement officers, personnel, volunteers, or other public or private agency personnel who have agreed pursuant to subsection (g) of this section may be designated to provide all or parts of the custody and transportation required by involuntary commitment proceedings. Persons so designated or otherwise required to provide all or parts of the custody and transportation required by involuntary commitment proceedings shall be trained as set forth in G.S. 122C-202.2(a)(3), and the plan shall assure adequate safety and protections for both the public and the respondent. Any person or agency designated or required to provide all or parts of the custody and transportation required by involuntary commitment proceedings shall Law enforcement, other affected agencies, and the area authority shall participate in the planning. If any person other than a law-enforcement agency is designated by a city or county, the person so designated shall provide the transportation and follow the procedures in this Article. References in this Article to a law enforcementlaw enforcement officer apply to this person any person or entity designated to provide custody or transportation. The transportation

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agreement may provide that private personnel or agencies may contract for transportation services to transport respondents under involuntary commitment from one entity to another.

- A person shall not be designated under subsection (g) of this section without (3) that person's written consent and the written consent of his or her employer, if applicable. An agency, corporation, or entity shall not be designated without the written consent of that agency, corporation, or entity. Any person, agency, corporation, or other entity shall be designated to provide only the services which the person, agency, corporation, or other entity has previously consented in writing to provide and shall be permitted to withdraw from or discontinue providing services, in whole or in part, upon written notice to the designating governing body. The transportation agreement shall be submitted to the magistrates in the city or county's judicial district, county clerks of court, to the LME/MCO that serves the city or county, and to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services on or before January 1, 2019. If the city or county modifies the transportation agreement, it will submit the modified agreement to their magistrates in their judicial district, county clerks of court, the LME/MCO that serves the city or county, and the Division of Mental Health, Developmental Disabilities and Substance Abuse Services at least 10 days prior to the effective date of the new plan.
- (4) Counties and cities shall retain and be required to perform the responsibilities set forth in this Article, except as set forth in a plan developed, agreed upon, and adopted in compliance with this subsection.
- (h) The cost and expenses of transporting of custody and transportation of a respondent to or from a 24 hour facility as required by the involuntary commitment procedures of this Article, to the extent they are not reimbursed by a third party insurer, is are the responsibility of the county of residence of the respondent respondent, to the extent they are not reimbursed by a third-party insurer. The State (when providing transportation under G.S. 122C-408(b)), a city, or a county is entitled to recover the reasonable cost of transportation from the county of residence of the respondent. The county of residence of the respondent shall reimburse the State, another county, or a city the reasonable transportation costs incurred as authorized by this subsection. The county of residence of the respondent is entitled to recover the reasonable cost of transportation it has paid to the State, a city, or a county. Provided that the county of residence provides the respondent or other individual liable for the respondent's support a reasonable notice and opportunity to object to the reimbursement, the county of residence of the respondent may recover that cost from:
 - (1) The respondent, if the respondent is not indigent;
 - (2) Any person or entity that is legally liable for the resident's support and maintenance provided there is sufficient property to pay the cost;
 - (3) Any person or entity that is contractually responsible for the cost; or
 - (4) Any person or entity that otherwise is liable under federal, State, or local law for the cost."

SECTION 20. G.S. 122C-253 reads as rewritten:

"§ 122C-253. Fees under commitment order.

Nothing contained in Parts 6, 7, or 8 of this Article requires a private physician, private psychologist, <u>commitment examiner</u>, or private facility to accept a respondent as a client either before or after commitment. Treatment at a private facility or by a private <u>physician or private psychologistphysician</u>, <u>psychologist</u>, <u>or commitment examiner</u> is at the expense of the respondent to the extent that the charges are not disposed of by contract between the area authority and the private facility. An area authority and its contract agencies shall set and recover fees for inpatient

or outpatient treatment services provided under a commitment order in accordance with G.S. 122C-146."

SECTION 21. G.S. 122C-255 reads as rewritten:

"§ 122C-255. Report required.

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Beginning January 1, 2012, each Each 24-hour residential facility that (i) falls under the category of nonhospital medical detoxification, facility-based crisis service, or inpatient hospital treatment, (ii) is not a State facility under the jurisdiction of the Secretary of Health and Human Services, and (iii) is designated by the Secretary of Health and Human Services as a facility for the custody and treatment of individuals under a petition of involuntary commitment pursuant to G.S. 122C-252 and 10A NCAC 26C .0101 shall submit a written report on involuntary commitments each January 1 and each July 1 to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services. The report shall include all of the following:

- (1) The number and primary presenting conditions of individuals receiving treatment from the facility under a petition of involuntary commitment.
- (2) The number of individuals for whom an involuntary commitment proceeding was initiated at the facility, who were referred to a different facility or program.
- (3) The reason for referring the individuals described in subdivision (2) of this section to a different facility or program, including the need for more intensive medical supervision."

SECTION 22. G.S. 122C-261 reads as rewritten:

"Part 7. Involuntary Commitment of the Mentally III; Facilities for the Mentally III.

§ 122C-261. Affidavit and petition before clerk or magistrate when immediate hospitalization is not necessary; custody order.

- (a) Anyone who has knowledge of an individual who is mentally ill and either (i) dangerous to self, as defined in G.S. 122C-3(11)a., or dangerous to others, as defined in G.S. 122C-3(11)b., or (ii) in need of treatment in order to prevent further disability or deterioration that would predictably result in dangerousness, may appear before a clerk or assistant or deputy clerk of superior court or a magistrate and execute an affidavit to this effect, and petition the clerk or magistrate for issuance of an order to take the respondent into custody for examination by a physician or eligible psychologist commitment examiner. The affidavit shall include the facts on which the affiant's opinion is based. If the affiant has knowledge or reasonably believes that the respondent, in addition to being mentally ill, is also mentally retarded, this fact shall be stated in the affidavit. Jurisdiction under this subsection is in the clerk or magistrate in the county where the respondent resides or is found.
- If the clerk or magistrate finds reasonable grounds to believe that the facts alleged in the affidavit are true and that the respondent is probably mentally ill and either (i) dangerous to self, as defined in G.S. 122C-3(11)a., or dangerous to others, as defined in G.S. 122C-3(11)b., or (ii) in need of treatment in order to prevent further disability or deterioration that would predictably result in dangerousness, the clerk or magistrate shall issue an order to a law other designated person enforcement officer or any authorized—under G.S. 122C-251G.S. 122C-251(g) to take the respondent into custody for examination by a physician or eligible psychologist.commitment examiner. If the clerk or magistrate finds that, in addition to probably being mentally ill, the respondent is also probably mentally retarded, the clerk or magistrate shall contact the area authority before issuing a custody order and the area authority shall designate the facility to which the respondent is to be taken for examination by a physician or eligible psychologist.commitment examiner. The clerk or magistrate shall provide the petitioner and the respondent, if present, with specific information regarding the next steps that will occur for the respondent.

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- (c) If the clerk or magistrate issues a custody order, the clerk or magistrate shall also make inquiry in any reliable way as to whether the respondent is indigent within the meaning of G.S. 7A-450. A magistrate shall report the result of this inquiry to the clerk.
- (d) If the affiant is a physician or eligible psychologist, commitment examiner, all of the following apply:
 - (1) The If the affiant has examined the respondent, the affiant may execute the affidavit before any official authorized to administer oaths. This affiant is not required to appear before the clerk or magistrate for this purpose. This affiant shall file the affidavit with the clerk or magistrate by delivering to the clerk or magistrate the original affidavit oraffidavit, by transmitting a copy in paper form that is printed through the facsimile transmission of the affidavit.affidavit, or by delivering the affidavit through electronic transmission. If the affidavit is filed through electronic or facsimile transmission, the affiant shall mail the original affidavit no later than five days after the facsimile transmission of the affidavit to the clerk or magistrate to be filed by the clerk or magistrate with the facsimile copy of the affidavit.
 - (2) This affiant's examination shall comply with the requirements of the initial examination as provided in G.S. 122C-263(c). The affiant shall document in writing and file the examination findings with the affidavit delivered to the clerk or magistrate in accordance with subdivision (d)(1) of this section.
 - If the physician or eligible psychologist commitment examiner recommends (3) outpatient commitment according to the criteria for outpatient commitment set forth in G.S. 122C-263(d)(1) and the clerk or magistrate finds probable cause to believe that the respondent meets the criteria for outpatient commitment, the clerk or magistrate shall issue an order that a hearing before a district court judge be held to determine whether the respondent will be involuntarily committed. The physician or eligible psychologist shall provide the respondent with written notice of any scheduled appointment and the name, address, and telephone number of the proposed outpatient treatment physician or center. The physician or eligible psychologist The commitment examiner shall contact the local management entityLME/MCO that serves the county where the respondent resides or the local management entityLME/MCO that coordinated services for the respondent to inform the local management entityLME/MCO that the respondent has been scheduled for an appointment with an outpatient treatment physician or center. The commitment examiner shall provide the respondent with written notice of any scheduled appointment and the name, address, and telephone number of the proposed outpatient treatment physician or center.
 - If the physician or eligible psychologist commitment examiner recommends (4) inpatient commitment based on the criteria for inpatient commitment set forth in G.S. 122C-263(d)(2) and the clerk or magistrate finds probable cause to believe that the respondent meets the criteria for inpatient commitment, the clerk or magistrate shall issue an order to a law enforcement officer to take the respondent into custody for transportation to or custody at a 24-hour facility described in G.S. 122C-252, provided that if a 24-hour facility is not immediately available or appropriate to the respondent's medical condition, the respondent may be temporarily detained under appropriate supervision and, upon further examination, released in accordance G.S. 122C-263(d)(2).

- (7) If a physician or eligible psychologistcommitment examiner executes an affidavit for inpatient commitment of a respondent, a second-physician who is not the commitment examiner who performed the examination under this section shall be required to perform the examination required by G.S. 122C-266.
- (8) No commitment examiner, area facility, acute care hospital, general hospital, or other site of first examination, or its officials, staff, employees, or other individuals responsible for the custody, examination, detention, management, supervision, treatment, or release of an individual examined for commitment, who is not grossly negligent, shall be held liable in any civil or criminal action for taking measures prior to the inpatient admission of the individual to a 24-hour facility
- (e) Except as provided in subdivision (5) of subsection (d) of this section, upon receipt of the custody order of the clerk or magistrate or a custody order issued by the court pursuant to G.S. 15A-1003, a law enforcement officer or otherofficer, person designated under G.S. 122C-251(g), or other person identified in the order shall take the respondent into custody within 24 hours after the order is signed, and proceed according to G.S. 122C-263. The custody order is valid throughout the State.
- (f) When a petition is filed for an individual who is a resident of a single portal area, the procedures for examination by a physician or eligible psychologist as set forth in G.S. 122C-263 shall be carried out in accordance with the area plan. Prior to issuance of a custody order for a respondent who resides in an area authority with a single portal plan, the clerk or magistrate shall communicate with the area authority to determine the appropriate 24 hour facility to which the respondent should be admitted according to the area plan or to determine if there are more appropriate resources available through the area authority to assist the petitioner or the respondent. When an individual from a single portal area is presented for commitment at a 24-hour area or State facility directly, the individual may not be accepted for admission until the facility notifies the area authority and the area authority agrees to the admission. If the area authority does not agree to the admission, it shall determine the appropriate 24-hour facility to which the individual should be admitted according to the area plan or determine if there are more appropriate resources available through the area authority to assist the individual. If the area authority agrees to the admission, further planning of treatment for the client is the joint responsibility of the area authority and the facility as prescribed in the area plan.

Notwithstanding the provisions of this section, in no event shall an individual known or reasonably believed to be mentally retarded be admitted to a State psychiatric hospital, except as follows:

- (1) Persons described in G.S. 122C-266(b);
- (2) Persons admitted pursuant to G.S. 15A-1321;
- (3) Respondents who are so extremely dangerous as to pose a serious threat to the community and to other patients committed to non-State hospital psychiatric inpatient units, as determined by the Director of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services or his designee; and
- (4) Respondents who are so gravely disabled by both multiple disorders and medical fragility or multiple disorders and deafness that alternative care is inappropriate, as determined by the Director of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services or his designee.

Individuals transported to a State facility for the mentally ill who are not admitted by the facility may be transported by <u>appropriate</u> law enforcement officers or designated staff of the State facility in State-owned vehicles to an appropriate 24-hour facility that provides psychiatric inpatient care.

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No later than 24 hours after the transfer, the responsible professional at the original facility shall notify the petitioner, the clerk of court, and, if consent is granted by the respondent, the next of kin, that the transfer has been completed."

SECTION 23. G.S. 12C-262 reads as rewritten:

"§ 122C-262. Special emergency procedure for individuals needing immediate hospitalization.

- (a) Anyone, including a law enforcement officer, who has knowledge of an individual who is subject to inpatient commitment according to the criteria of G.S. 122C-261(a)G.S. 122C-263(d)(2) and who requires immediate hospitalization to prevent harm to self or others, may transport the individual directly to an area facility or other place, including a State facility for the mentally ill, for examination by a physician or eligible psychologistcommitment examiner in accordance with G.S. 122C-263(c).
- (b) Upon examination by the physician or eligible psychologist, commitment examiner, if the individual meets the inpatient commitment criteria required specified in G.S. 122C-261(a), the physician or eligible psychologistG.S. 122C-263(d)(2) and requires immediate hospitalization to prevent harm to self or others, the commitment examiner shall so certify in writing before any official authorized to administer oaths. The certificate shall also state the reason that the individual requires immediate hospitalization. If the physician or eligible psychologistcommitment examiner knows or has reason to believe that the individual is mentally retarded, the certificate shall so state.
- (c) If the physician or eligible psychologistcommitment examiner executes the oath, appearance before a magistrate shall be waived. The physician or eligible psychologistcommitment examiner shall send a copy of the certificate to the clerk of superior court by the most reliable and expeditious means. If it cannot be reasonably anticipated that the clerk will receive the copy within 24 hours, excluding Saturday, Sunday, and holidays, of the time that it was signed, the physician or eligible psychologist shall also communicate the findings to the clerk by telephone.
- (d) Anyone, including a law enforcement officer if necessary, may transport the individual to a 24-hour facility described in G.S. 122C-252 for examination and treatment pending a district court hearing. If there is no area 24-hour facility and if the respondent is indigent and unable to pay for care at a private 24-hour facility, the law enforcement officer or other designated person providing transportation shall take the respondent to a State facility for the mentally ill designated by the Commission in accordance with G.S. 143B-147(a)(1)a and immediately notify the clerk of superior court of this action. The physician's or eligible psychologist's commitment examiner's certificate shall serve as the custody order and the law enforcement officer or other designated person shall provide transportation in accordance with the provisions of G.S. 122C-251. If a 24 hour facility is not immediately available or appropriate to the respondent's medical condition, the respondent may be temporarily detained under appropriate supervision in accordance with G.S. 122C 263(d)(2) and released in accordance with G.S. 122C 263(d)(2).

In the event an individual known or reasonably believed to be mentally retarded is transported to a State facility for the mentally ill, in no event shall that individual be admitted to that facility except as follows:

- (1) Persons described in G.S. 122C-266(b);
- (2) Persons admitted pursuant to G.S. 15A-1321;
- (3) Respondents who are so extremely dangerous as to pose a serious threat to the community and to other patients committed to non-State hospital psychiatric inpatient units, as determined by the Director of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services or his designee; and

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Respondents who are so gravely disabled by both multiple disorders and medical fragility or multiple disorders and deafness that alternative care is inappropriate, as determined by the Director of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services or his designee.

Individuals transported to a State facility for the mentally ill who are not admitted by the facility may be transported by law enforcement officers or designated staff of the State facility in State-owned vehicles to an appropriate 24-hour facility that provides psychiatric inpatient care.

No later than 24 hours after the transfer, the responsible professional at the original facility shall notify the petitioner, the clerk of court, and, if consent is granted by the respondent, the next of kin, that the transfer has been completed.

- (f) If, upon examination of a respondent presented in accordance with subsection (a) of this section, the commitment examiner finds that the individual meets the criteria for inpatient commitment specified in G.S. 122C-263(d)(2) but does not require immediate hospitalization to prevent harm to self or others, the commitment examiner may petition the clerk or magistrate in accordance with G.S. 122C-261(d) for an order to take the individual into custody for transport to a 24-hour facility described in G.S. 122C-252. If the commitment examiner recommends inpatient commitment and the clerk or magistrate finds probable cause to believe that the respondent meets the criteria for inpatient commitment, the clerk or magistrate shall issue an order for transport to or custody at a 24-hour facility described in G.S. 122C-252; provided, however, that if a 24-hour facility is not immediately available or appropriate to the respondent's medical condition, the respondent may be temporarily detained under appropriate supervision in accordance with G.S. 122C-263(d)(2) and released in accordance with G.S. 122C-263(d)(2).
- This section applies exclusively to an individual who is transported to an area facility or other place for an examination by a commitment examiner in accordance with subsection (a) of this section."

SECTION 24. G.S. 122C-263 reads as rewritten:

"§ 122C-263. Duties of law-enforcement law enforcement officer; first examination by physician or eligible psychologist.examination.

Without unnecessary delay after assuming custody, the law enforcement officer or the individual designated by the clerk or magistrate under G.S. 122C 251(g) required to provide transportation pursuant to G.S. 122C-251(g) shall take the respondent to an area a facility or other location identified by the LME/MCO in the community crisis services plan adopted pursuant to G.S. 122C-202.2 that has an available commitment examiner and is capable of performing a first examination in conjunction with a health screening at the same location, unless exigent circumstances require the respondent be transported to an emergency department. for examination by a physician or eligible psychologist; if a physician or eligible psychologist. If a commitment examiner is not available, whether on-site, on-call, or via telemedicine, in the area facility, at any facility or location, or if a plan has not been adopted, the person designated to provide transportation shall take the respondent to an alternative non-hospital provider or facility-based crisis center for a first examination in conjunction with a health screening at the same location. If no non-hospital provider or facility-based crisis center for a first examination in conjunction with a health screening at the same location for health screening and first examination exists, the person designated to provide transportation shall take the respondent to any physician or eligible psychologist locally available, a private hospital or clinic, a general hospital, an acute care hospital, or a State facility for the mentally ill. If a physician or eligible psychologist commitment examiner is not immediately available, the respondent may be temporarily detained in an area facility, if one is available; if an area facility is not available, the respondent may be detained under appropriate supervision in the respondent's home, in a private hospital or a clinic, in a general hospital, or in a State facility for the mentally ill, but not in a jail or other penal facility.

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- (1) For the purposes of this section, "non-hospital provider" means an outpatient provider that provides either behavioral health or medical services.
- (a1) A facility or other location to which a respondent is transported under subsection (a) of this section shall provide a health screening of the respondent. The health screening shall be conducted by a commitment examiner or other individual who is determined by the area facility, contracted facility, or other location to be qualified to perform the health screening. The Department will work with commitment examiner professionals to develop a screening tool for this purpose. The respondent may either be in the physical face-to-face presence of the person conducting the screen or may be examined utilizing telemedicine equipment and procedures. Documentation of the health screening required under this subsection that is completed prior to transporting the patient to any general hospital, acute care hospital, or designated facility shall accompany the patient or otherwise be made available at the time of transportation to the receiving facility.
- (b) The examination set forth in subsection (a) of this section is not required if:under any of the following circumstances:
 - (1) The affiant who obtained the custody order is a physician or eligible psychologistcommitment examiner who recommends inpatient commitment; commitment.
 - (2) The custody order states that the respondent was charged with a violent crime, including a crime involving assault with a deadly weapon, and he—the respondent was found incapable of proceeding; or proceeding.
 - (3) Repealed by Session Laws 1987, c. 596, s. 3.

In any of these cases, the <u>law-enforcement law enforcement</u> officer <u>or person designated under G.S. 122C-251(g)</u> shall take the respondent directly to a 24-hour facility described in G.S. 122C-252.

The physician or eligible psychologist commitment examiner described in subsection (a) of this section shall examine the respondent as soon as possible, and in any event within 24 hours, hours after the respondent is presented for examination. When the examination set forth in subsection (a) of this section is performed by a physician or eligible psychologistcommitment examiner, the respondent may either be in the physical face-to-face presence of the physician or eligible psychologistcommitment examiner or may be examined utilizing telemedicine equipment and procedures. A physician or eligible psychologistcommitment examiner who examines a respondent by means of telemedicine must be satisfied to a reasonable medical certainty that the determinations made in accordance with subsection (d) of this section would not be different if the examination had been done in the physical presence of the physician or eligible psychologist. A physician or eligible psychologist commitment examiner. A commitment examiner who is not so satisfied must note that the examination was not satisfactorily accomplished, and the respondent must be taken for a face-to-face examination in the physical presence of a person authorized to perform examinations under this section. As used in this subsection, "telemedicine" is the use of two-way real-time interactive audio and video between places of lesser and greater medical capability or expertise to provide and support health care when distance separates participants who are in different geographical locations. A recipient is referred by one provider to receive the services of another provider via telemedicine.

The examination shall include but is not limited to an assessment of the respondent's: at least all of the following with respect to the respondent.

- (1) Current and previous mental illness and mental retardation including, if available, previous treatment history; history.
- (2) Dangerousness to self, as defined in G.S. 122C-3(11)a. or others, as defined in G.S. 122C-3(11)b.;G.S. 122C-3(11)b.
- (3) Ability to survive safely without inpatient commitment, including the availability of supervision from family, friends or others; and others.

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- Capacity to make an informed decision concerning treatment. (4)
- (d) After conclusion of the examination the physician or eligible psychologist commitment examiner shall make the following determinations:
 - If the physician or eligible psychologist commitment examiner finds that:all of (1)the following:
 - a. The respondent is mentally ill; ill.
 - The respondent is capable of surviving safely in the community with b. available supervision from family, friends, or others; others.
 - Based on the respondent's psychiatric history, the respondent is in need c. of treatment in order to prevent further disability or deterioration that would predictably result in dangerousness as defined by G.S. 122C-3(11); and G.S. 122C-3(11).
 - d. The respondent's current mental status or the nature of the respondent's illness limits or negates the respondent's ability to make an informed decision to seek voluntarily or comply with recommended treatment.

The physician or eligible psychologistcommitment examiner shall so show on the examination report and shall recommend outpatient commitment. In addition the examining physician or eligible psychologist commitment examiner shall show the name, address, and telephone number of the proposed outpatient treatment physician or eenter.center in accordance with subsection (f) of this section. The person designated in the order to provide transportation shall return the respondent to the respondent's regular residence or, with the respondent's consent, to the home of a consenting individual located in the originating county, and the respondent shall be released from custody.

If the physician or eligible psychologist commitment examiner finds that the (2) respondent is mentally ill and is dangerous to self, as defined in G.S. 122C-3(11)a., or others, as defined in G.S. 122C-3(11)b., the physician or eligible psychologistcommitmenr examiner shall recommend inpatient commitment, and shall so show on the examination report. If, in addition to mental illness and dangerousness, the physician or eligible psychologist commitment examiner also finds that the respondent is known or reasonably believed to be mentally retarded, this finding shall be shown on the report. The Upon notification, the law enforcement officer or other designated person shall take the respondent to a 24-hour facility described in G.S. 122C-252 pending a district court hearing. To the extent feasible, in providing the transportation of the respondent, the law enforcement officer shall act within six hours of notification. The other designated person shall take the respondent to a 24-hour facility described in G.S. 122C-252 pending a district court hearing within six hours of notification. If there is no area 24-hour facility and if the respondent is indigent and unable to pay for care at a private 24-hour facility, the law enforcement officer or other designated person shall take the respondent to a State facility for the mentally ill designated by the Commission in accordance with G.S. 143B-147(a)(1)a. for custody, observation, and treatment and immediately notify the clerk of superior court of this action. If a 24-hour facility is not immediately available or appropriate to the respondent's medical condition, the respondent may be temporarily detained under appropriate supervision at the site of the first examination, examination. Upon the commitment examiner's determination that a 24-hour facility is available and medically appropriate, the law enforcement officer or other designated person shall transport the respondent after receiving a request for transportation by the facility of the commitment

examiner. To the extent feasible, in providing the transportation of the respondent, the law enforcement officer shall act within six hours of notification. The other designated person shall transport the respondent without unnecessary delay and within six hours after receiving a request for transportation by the facility of the commitment examiner. At any time during the respondent's temporary detention under appropriate supervision, if a commitment examiner provided that at anytime that a physician or eligible psychologist determines that the respondent is no longer in need of inpatient commitment, the proceedings shall be terminated and the respondent transported and released in accordance with subdivision (3) of this subsection. However, if the physician or eligible psychologistcommitment examiner determines that the respondent meets the criteria for outpatient commitment, as defined in subdivision (1) of this subsection, the physician or eligible psychologist commitment examiner may recommend outpatient commitment, and the respondent shall be transported and released in accordance with subdivision (1) of this subsection. Any decision to terminate the proceedings or to recommend outpatient commitment after an initial recommendation of inpatient commitment shall be documented and reported to the clerk of superior court in accordance with subsection (e) of this section. If the respondent is temporarily detained and a 24-hour facility is not available or medically appropriate seven days after the issuance of the custody order, a physician or psychologist commitment examiner shall report this fact to the clerk of superior court and the proceedings shall be terminated. Termination of proceedings pursuant to this subdivision shall not prohibit or prevent the initiation of new involuntary commitment proceedings when appropriate. A commitment examiner may initiate a new involuntary commitment proceeding prior to the expiration of this seven-day period, as long as the respondent continues to meet applicable criteria. Affidavits filed in support of proceedings terminated pursuant to this subdivision may not be submitted in support of any subsequent petitions for involuntary commitment. If the affiant initiating new commitment proceedings is a physician or eligible psychologist, commitment examiner, the affiant shall conduct a new examination and may not rely upon examinations conducted as part of proceedings terminated pursuant to this subdivision.

In the event an individual known or reasonably believed to be mentally retarded is transported to a State facility for the mentally ill, in no event shall that individual be admitted to that facility except as follows:

- a. Persons described in G.S. 122C-266(b);
- b. Persons admitted pursuant to G.S. 15A-1321;
- c. Respondents who are so extremely dangerous as to pose a serious threat to the community and to other patients committed to non-State hospital psychiatric inpatient units, as determined by the Director of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services or his designee; and
- d. Respondents who are so gravely disabled by both multiple disorders and medical fragility or multiple disorders and deafness that alternative care is inappropriate, as determined by the Director of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services or his designee.

Individuals transported to a State facility for the mentally ill who are not admitted by the facility may be transported by law enforcement officers or

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designated staff of the State facility in State-owned vehicles to an appropriate 24-hour facility that provides psychiatric inpatient care.

No later than 24 hours after the transfer, the responsible professional at the original facility shall notify the petitioner, the clerk of court, and, if consent is granted by the respondent, the next of kin, that the transfer has been completed.

- (3) If the physician or eligible psychologistcommitment examiner finds that neither condition described in subdivisions (1) or (2) of this subsection exists, the proceedings shall be terminated. The person designated in the order to provide transportation shall return the respondent to the respondent's regular residence or, with the respondent's consent, to the home of a consenting individual located in the originating county and the respondent shall be released from custody.
- The findings of the physician or eligible psychologist commitment examiner and the facts on which they are based shall be in writing in all cases. The physician or eligible psychologist commitment examiner shall send a copy of the findings to the clerk of superior court by the most reliable and expeditious means. If it cannot be reasonably anticipated that the clerk will receive the copy within 48 hours of the time that it was signed, the physician or eligible psychologist shall also communicate his findings to the clerk by telephone.
- When outpatient commitment is recommended, the examining physician or eligible psychologist, commitment examiner, if different from the proposed outpatient treatment physician or center, shall give the respondent a written notice listing the name, address, and telephone number of the proposed outpatient treatment physician or center and directing the respondent to appear at the address at a specified date and time. The examining physician or eligible psychologist before the appointment shall notify by telephone the designated outpatient treatment physician or center and shall send a copy of the notice and his examination report to the physician or center. shall contact the LME/MCO that serves the county where the respondent resides or the LME/MCO that coordinated services for the respondent to inform the LME/MCO that the respondent is being recommended for outpatient commitment. The commitment examiner shall give the respondent a written notice listing the name, address, and telephone number of the proposed outpatient treatment physician or center
- (g) The physician or eligible psychologist, commitment examiner, at the completion of the examination, shall provide the respondent with specific information regarding the next steps that will occur."

SECTION 25. G.S. 122C-263.1 reads as rewritten:

- "§ 122C-263.1. Secretary's authority to waive requirement of first examination by physician or eligible psychologist; certify commitment examiners; training of providers commitment examiners performing examinations. examinations; LME/MCO responsibilities.
- Physicians and eligible psychologists are qualified to perform the commitment examinations required under G.S. 122C-263(c) and G.S. 122C-283(c). The Secretary of Health and Human Services may, upon request of an LME, waive the requirements of G.S. 122C-261 through G.S. 122C-263 and G.S. 122C-281 through G.S. 122C-283 pertaining to initial (first level) examinations by a physician or eligible psychologist of individuals meeting the criteria of G.S. 122C-261(a) or G.S. 122C-281(a), as applicable, as follows: may individually certify to perform the first commitment examinations required by G.S. 122C-261 through G.S. 122C-263 and G.S. 122C-281 through G.S. 122C-283, other health, mental health, and substance abuse professionals whose scope of practice includes diagnosing and documenting psychiatric or substance use disorders and conducting mental status examinations to determine capacity to give informed consent to treatment as follows:

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- The Secretary has received a request from an LME to substitute for a physician or eligible psychologist, a licensed clinical social worker, a master's level psychiatric nurse, or a master's level certified clinical addictions specialist in accordance with subdivision (8) of this subsection to conduct the initial (first-level) examinations of individuals meeting the criteria of G.S. 122C-261(a) or G.S. 122C-281(a). In making this type of request, the LME shall specifically describe all of the following:request:
 - h. How the purpose of the statutory requirement would be better served by waiving the requirement and substituting the proposed change under the waiver. To certify a licensed clinical social woker, a master's level nurse practitioner, a licensed professional counsellor, or a physician's assistant to conduct the first examinations described in G.S. 122C-263(c) and G.S. 122C-283(c).
 - b. How the waiver will enable the LME to improve the delivery or management of mental health, developmental disabilities, and substance abuse services. To certify a master's level licensed clinical addictions specialist to conduct the first examination described in G.S. 122C-283(c).
 - _c. How the health, safety, and welfare of individuals will continue to be at least as well protected under the waiver as under the statutory requirement.
 - (2) The Secretary shall review the request and may approve it upon finding all of the following:
 - a. The request meets the requirements of this section.
 - _b. The request furthers the purposes of State policy under G.S. 122C-2 and mental health, developmental disabilities, and substance abuse services reform.
 - c. The request improves the delivery of mental health, developmental disabilities, and substance abuse services in the counties affected by the waiver and also protects the health, safety, and welfare of individuals receiving these services.
 - d. The Department determines that the applicant possesses the professional licensure, registration, or certification to qualify the applicant as a professional whose scope of practice includes diagnosing and documenting psychiatric or substance use disorders and conducting mental status examinations to determine capacity to give informed consent to treatment.
 - e. The applicant for certification has successfully completed the Department's standardized training program for involuntary commitment and has successfully passed the examination for that program.
 - _(3) The Secretary shall evaluate the effectiveness, quality, and efficiency of mental health, developmental disabilities, and substance abuse services and protection of health, safety, and welfare under the waiver.
- (4) A <u>waiver-certification</u> granted by the Secretary under this section shall be in effect for a period of up to three years and may be rescinded at any time within this period if the Secretary finds the <u>LME-certified individual</u> has failed to meet the requirements of this section. <u>Certification may be renewed every three years upon completion of a refresher training program approved by the Department.</u>

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- (5) In no event shall the substitution-certification of a licensed clinical social worker, master's level psychiatric nurse practitioner, licensed professional counsellor, physician assistant or master's level certified clinical addictions specialist under a waiver granted under this section be construed as authorization to expand the scope of practice of the licensed clinical social worker, the master's level psychiatric nurse, nurse practitioner, licensed professional counsellor, physician assistant or the master's level certified clinical addictions specialist.
- The Department shall require that individuals performing certified to perform initial examinations under the waiverthis section have successfully completed the Department's standardized involuntary commitment training program and examination. The Department shall maintain a list of these individuals on its Internet Web site.
- As part of its waiver request, the LME shall document the availability of a (7)physician to provide backup support.
- No less than annually, the Department shall submit a list of certified first (7a)commitment examiners to the Chief District Court Judge of each judicial district in North Carolina and maintain a current list of certified first commitment examiners on its Internet Web site.
- A master's level eertified licensed clinical addiction specialist shall only be (8)authorized to conduct the initial examination of individuals meeting the criteria of G.S. 122C-281(a).
- The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services Department shall expand its standardized certification training program to include refresher training for all certified providers performing initial examinations pursuant to subsection (a) of this section."

SECTION 26. G.S. 122C-264 reads as rewritten:

"§ 122C-264. Duties of clerk of superior court and the district attorney.

- Upon receipt of a physician's or eligible psychologist's commitment examiner's finding that the respondent meets the criteria of G.S. 122C-263(d)(1) and that outpatient commitment is recommended, the clerk of superior court of the county where the petition was initiated, upon direction of a district court judge, shall calendar the matter for hearing and shall notify the respondent, the proposed outpatient treatment physician or center, and the petitioner of the time and place of the hearing. The petitioner may file a written waiver of his right to notice under this subsection with the clerk of court.
- Upon receipt by the clerk of superior court pursuant to G.S. 122C-266(c) of a physician's or eligible psychologist's commitment examiner's finding that a respondent meets the criteria of G.S. 122C-263(d)(2) and that inpatient commitment is recommended, the clerk of superior court of the county where the 24-hour facility is located shall, after determination required by G.S. 122C-261(c) and upon direction of a district court judge, assign counsel if necessary, calendar the matter for hearing, and notify the respondent, his counsel, and the petitioner of the time and place of the hearing. The petitioner or respondent, directly or through counsel, may file a written waiver of his the right to notice under this subsection with the clerk of court.
- (b1) Upon receipt of a physician's or eligible psychologist's commitment examiner's certificate that a respondent meets the criteria of G.S. 122C-261(a) and that immediate hospitalization is needed pursuant to G.S. 122C-262, the clerk of superior court of the county where the treatment facility is located shall submit the certificate to the Chief District Court Judge. The court shall review the certificate within 24 hours, excluding Saturday, Sunday, and holidays, for a finding of reasonable grounds in accordance with [G.S.] 122C-261(b). The clerk

shall notify the treatment facility of the court's findings by telephone and shall proceed as set forth in subsections (b), (c), and (f) of this section.
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SECTION 27. G.S. 122C-265 reads as rewritten:

"§ 122C-265. Outpatient commitment; examination and treatment pending hearing.

- (a) If a respondent, who has been recommended for outpatient commitment by an examining physician or eligible psychologistcommitment examiner different from the proposed outpatient treatment physician or center, fails to appear for examination by the proposed outpatient treatment physician or center at the designated time, the physician or center shall notify the clerk of superior court who shall issue an order to a law-enforcement law enforcement officer or other person authorized under G.S. 122C-251-to take the respondent into custody and take him immediately to the outpatient treatment physician or center for evaluation. The custody order is valid throughout the State. The law-enforcement officer may wait during the examination and return the respondent to his home after the examination.
- (b) The examining <u>physician commitment examiner</u> or the proposed outpatient treatment physician or center may prescribe to the respondent reasonable and appropriate medication and treatment that are consistent with accepted medical standards pending the district court hearing.
- (c) In no event may a respondent released on a recommendation that he <u>or she</u> meets the outpatient commitment criteria be physically forced to take medication or <u>forceably-forcibly</u> detained for treatment pending a district court hearing.
- (d) If at any time pending the district court hearing the outpatient treatment physician or center determines that the respondent does not meet the criteria of G.S. 122C-263(d)(1), he-the physician shall release the respondent and notify the clerk of court and the proceedings shall be terminated.
- (e) If a respondent becomes dangerous to <u>himself,self</u> as defined in G.S. 122C-3(11)a., or others, as defined in G.S. 122C-3(11)b., pending a district court hearing on outpatient commitment, new proceedings for involuntary inpatient commitment may be initiated.
- (f) If an inpatient commitment proceeding is initiated pending the hearing for outpatient commitment and the respondent is admitted to a 24-hour facility to be held for an inpatient commitment hearing, notice shall be sent by the clerk of court in the county where the respondent is being held to the clerk of court of the county where the outpatient commitment was initiated and the outpatient commitment proceeding shall be terminated."

SECTION 28. G.S. 122C-267 reads as rewritten:

"§ 122C-267. Outpatient commitment; district court hearing.

(c) Certified copies of reports and findings of physicians and psychologists commitment examiners and medical records of previous and current treatment are admissible in evidence.

SECTION 29. G.S. 122C-268 reads as rewritten:

"§ 122C-268. Inpatient commitment; district court hearing.

- (a) A hearing shall be held in district court within 10 days of the day the respondent is taken into law enforcement custody pursuant to G.S. 122C-261(e) or G.S. 122C-262. If a respondent temporarily detained under G.S. 122C-263(d)(2) is subject to a series of successive custody orders issued pursuant to G.S. 122C-263(d)(2), the hearing shall be held within 10 days after the day that the respondent is taken into custody under the most recent custody order. A continuance of not more than five days may be granted upon motion of:of any of the following:
 - (1) The court; court.
 - (2) Respondent's counsel; orcounsel.
 - (3) The State, sufficiently in advance to avoid movement of the respondent.

- (f) Certified copies of reports and findings of physicians and psychologists commitment examiners and previous and current medical records are admissible in evidence, but the respondent's right to confront and cross-examine witnesses may not be denied.
- Hearings may To the extent feasible, hearings shall be held in an appropriate room not used for treatment of clients at the facility in which the respondent is being treated if it in a manner approved by the chief district court judge if the facility is located within the presiding judge's district court district as defined in G.S. 7A 133, by audio and video transmission between a treatment facility and a courtroom in which the judge and the respondent can see and hear each other, or G.S. 7A-133. Hearings may be held in the judge's chambers. A hearing may not be held in a regular courtroom, over objection of the respondent, if in the discretion of a judge a more suitable place is available. A hearing may be held by audio and video transmission between the treatment facility and a courtroom in a manner that allows (i) the judge and the respondent to see and hear each other and (ii) the respondent to communicate fully and confidentially with the respondent's counsel during the proceeding. Prior to any hearing held by audio and video transmission, the chief district court judge shall submit to the Administrative Office of the Courts the procedures and type of equipment for audio and video transmission for approval by the Administrative Office of the Courts. Notwithstanding the provisions of this subsection, if the respondent, through counsel, objects to a hearing held by audio and video transmission, the hearing shall be held in the physical presence of the presiding district court judge. Regardless of the manner and location for hearings, hearings shall be held in a manner that complies with any applicable federal and State laws governing the confidentiality and security of confidential information, including any information transmitted from the treatment facility by audio and video transmission. If the respondent has counsel, the respondent shall be allowed to communicate fully and confidentially with his attorney during the proceeding. Prior to the use of the audio and video transmission, the procedures and type of equipment for audio and video transmission shall be submitted to the Administrative Office of the Courts by the chief district court judge and approved by the Administrative Office of the Courts.

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SECTION 30. G.S. 122C-271 reads as rewritten:

"§ 122C-271. Disposition.

- (a) If an examining physician or eligible psychologista commitment examiner has recommended outpatient commitment and the respondent has been released pending the district court hearing, the court may make one of the following dispositions:
 - (1) If the court finds by clear, cogent, and convincing evidence that the respondent is mentally ill; that he is capable of surviving safely in the community with available supervision from family, friends, or others; that based on respondent's treatment history, the respondent is in need of treatment in order to prevent further disability or deterioration that would predictably result in dangerousness as defined in G.S. 122C-3(11); and that the respondent's current mental status or the nature of his illness limits or negates his ability to make an informed decision to seek voluntarily or comply with recommended treatment, it may order outpatient commitment for a period not in excess of 90 days.
 - (2) If the court does not find that the respondent meets the criteria of commitment set out in subdivision (1) of this subsection, the respondent shall be discharged and the facility at which he was last a clientproposed outpatient physician center so notified.
 - (3) Before ordering any outpatient commitment under this subsection, the court shall make findings of fact as to the availability of outpatient treatment from an outpatient treatment physician or center that has agreed to accept the respondent as a client of outpatient treatment services. The court shall show

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on the order the outpatient treatment physician or center that is to be responsible for the management and supervision of the respondent's outpatient commitment. If the designated outpatient treatment physician or center will be monitoring and supervising the respondent's outpatient commitment pursuant to a contract for services with an LME/MCO, the court shall show on the order the identity of the LME/MCO. The clerk of court shall send a copy of the outpatient commitment order to the designated outpatient treatment physician or center and to the respondent client or the legally responsible person. The clerk of court shall also send a copy of the order to that LME/MCO. Copies of outpatient commitment orders sent by the clerk of court to an outpatient treatment center or physician under this section, including orders sent to an LME/MCO, shall be sent by the most reliable and expeditious means, but in no event less than 48 hours after the hearing.

- (b) If the respondent has been held in a 24-hour facility pending the district court hearing pursuant to G.S. 122C-268, the court may make one of the following dispositions:
 - (4) Before ordering any outpatient commitment, the court shall make findings of fact as to the availability of outpatient treatment.treatment from an outpatient treatment physician or center that has agreed to accept the respondent as a client of outpatient treatment services. The court shall also show on the order the outpatient treatment physician or center who is to be responsible for the management and supervision of the respondent's outpatient commitment. When an outpatient commitment order is issued for a respondent held in a 24-hour facility, the court may order the respondent held at the facility for no more than 72 hours in order for the facility to notify the designated outpatient treatment physician or center of the treatment needs of the respondent. The clerk of court in the county where the facility is located shall send a copy of the outpatient commitment order to the designated outpatient treatment physician or center center and to the respondent or the legally responsible person. If the designated outpatient treatment physician or center shall be monitoring and supervising the respondent's outpatient commitment pursuant to a contract for services with an LME/MCO, the clerk of court shall how on the order the identity of the LME/MCO. The clerk of court shall send a copy of the order to the LME/MCO. Copies of outpatient commitment orders sent by the clerk of court to an outpatient treatment center or physician pursuant to this subdivision, including orders sent to an LME/MCO, shall be sent by the most reliable and expeditious means, but in no event less than 48 hours after the hearing. If the outpatient commitment will be supervised in a county other than the county where the commitment originated, the court shall order venue for further court proceedings to be transferred to the county where the outpatient commitment will be supervised. Upon an order changing venue, the clerk of superior court in the county where the commitment originated shall transfer the file to the clerk of superior court in the county where the outpatient commitment is to be supervised.

SECTION 31. G.S. 122C-276 reads as rewritten:

"§ 122C-276. Inpatient commitment; rehearings for respondents other than insanity acquittees.

(c) Subject to the provisions of G.S. 122C-269(c), rehearings shall be held at the facility in which the respondent is receiving treatment as authorized in G.S. 122C-268(g). The judge is a

judge of the district court of the district court district as defined in G.S. 7A-133 in which the facility is located or a district court judge temporarily assigned to that district.

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SECTION 32. G.S. 122C-281 reads as rewritten:

"Part 8. Involuntary Commitment of Substance Abusers, Facilities for Substance Abusers.

§ 122C-281. Affidavit and petition before clerk or magistrate; custody order.

- (a) Any individual who has knowledge of a substance abuser who is dangerous to himself self or others may appear before a clerk or assistant or deputy clerk of superior court or a magistrate, execute an affidavit to this effect, and petition the clerk or magistrate for issuance of an order to take the respondent into custody for examination by a physician or eligible psychologist.commitment examiner. The affidavit shall include the facts on which the affiant's opinion is based. Jurisdiction under this subsection is in the clerk or magistrate in the county where the respondent resides or is found.
- (b) If the clerk or magistrate finds reasonable grounds to believe that the facts alleged in the affidavit are true and that the respondent is probably a substance abuser and dangerous to <a href="https://hittage.com/hitta
- (c) If the clerk or magistrate issues a custody order, he the clerk or magistrate shall also make inquiry in any reliable way as to whether the respondent is indigent within the meaning of G.S. 7A-450. A magistrate shall report the result of this inquiry to the clerk.
- If the affiant is a physician or eligible psychologist, commitment examiner who has examined the respondent, he or she may execute the affidavit before any official authorized to administer oaths. He The commitment examiner is not required to appear before the clerk or magistrate for this purpose. His The commitment examiner's examination shall comply with the requirements of the initial examination as provided in G.S. 122C-283(c). The affiant shall file the affidavit and examination findings with the clerk of court in the manner described in G.S. 122C-261(d)(1). If the physician or eligible psychologistcommitment examiner recommends commitment and the clerk or magistrate finds probable cause to believe that the respondent meets the criteria for commitment, he the clerk or magistrate shall issue an order to a law enforcement officer to take the respondent into custody for transportation to or custody at a 24-hour facility or release the respondent facility, or, if the respondent is released pending hearing, as described in G.S. 122C-283(d)(1). G.S. 122C-283(d)(1), order that a hearing be held as provided in G.S. 122C 284(a). If a physician or eligible psychologist executes an affidavit for commitment of a respondent, a second qualified professional shall perform the examination required by G.S. 122C-285. Any person or entity who or which has been designated in compliance with G.S. 122C-251(g) shall be permitted to complete all or part of the duties of a law enforcement officer, in accord with the designation.
- (e) Upon receipt of the custody order of the clerk or magistrate, a <u>law-enforcementlaw enforcement</u> officer or other <u>person-designated person identified</u> in the order shall take the respondent into custody within 24 hours after the order is signed. The custody order is valid throughout the State.
- (e1) No commitment examiner, area facility, acute care hospital, general hospital, or other site of first examination, or their officials, staff, employees, or other individuals responsible for the custody, examination, detention, management, supervision, treatment, or release of an individual examined for commitment, who is not grossly negligent, shall be held liable in any civil or criminal action for taking measures to temporarily detain an individual for the period of time necessary to complete a commitment examination, submit an affidavit to the magistrate or clerk of court, and await the issuance of a custody order as authorized by subsection (d) of this section.

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When a petition is filed for an individual who is a resident of a single portal area, the procedures for examination by a physician or eligible psychologist as set forth in G.S. 122C-283(c) shall be carried out in accordance with the area plan. When an individual from a single portal area is presented for commitment at a facility directly, he may be accepted for admission in accordance with G.S. 122C-285. The facility shall notify the area authority within 24 hours of admission and further planning of treatment for the individual is the joint responsibility of the area authority and the facility as prescribed in the area plan."

SECTION 33. G.S. 122C-282 reads as rewritten:

"§ 122C-282. Special emergency procedure for violent individuals.

When an individual subject to commitment under the provisions of this Part is also violent and requires restraint and when delay in taking him-the individual to a physician or eligible psychologist commitment examiner for examination would likely endanger life or property, a law-enforcementlaw enforcement officer may take the person into custody and take him or her immediately before a magistrate or clerk. The law-enforcement law enforcement officer shall execute the affidavit required by G.S. 122C-281 and in addition shall swear that the respondent is violent and requires restraint and that delay in taking the respondent to a physician or eligible psychologistcommitment examiner for an examination would endanger life or property.

If the clerk or magistrate finds by clear, cogent, and convincing evidence that the facts stated in the affidavit are true, that the respondent is in fact violent and requires restraint, and that delay in taking the respondent to a physician or eligible psychologist commitment examiner for an examination would endanger life or property, he the clerk or magistrate shall order the law-enforcementlaw enforcement officer to take the respondent directly to a 24-hour facility described in G.S. 122C-252.

Respondents received at a 24-hour facility under the provisions of this section shall be examined and processed thereafter in the same way as all other respondents under this Part."

SECTION 34. G.S. 122C-283 reads as rewritten:

"§ 122C-283. Duties of law-enforcement officer; first examination by physician or eligible psychologist.commitment examiner.

- Without unnecessary delay after assuming custody, the law-enforcementlaw enforcement officer or the individual designated by the clerk or magistrateor required to provide transportation under G.S. 122C-251(g) to provide transportation shall take the respondent to an areaa facility or other location identified by the LME/MCO in the community crisis services plan adopted pursuant to G.S. 122C 202.2 that has an available commitment examiner and is capable of performing a first examination in conjunction with a health screening in the same location, unless exigent circumstances require the respondent be transported to an emergency department. for examination by a physician or eligible psychologist If a commitment examiner is not available, whether on-site, on-call or via telemedicine, at any facility or location, or if a plan has not been adopted, the person designated to provide transportation shall take the respondent to an alternative non-hospital provider or facility-based crisis center for a first examination in conjunction with a health screening at the same location. If no non-hospital provider or facilitybased crisis center for a first examination in conjunction with a health screening at the same location, the person designated to provide transportations shall take the respondent to a private hospital or clinic, a general hospital, and acute care hospital, or a State facility for the mentally ill. if a physician or eligible psychologist is not available in the area facility, he shall take the respondent to any physician or eligible psychologist locally available. If a physician or eligible psychologistcommitment examiner is not immediately available, the respondent may be temporarily detained in an area facility if one is available; if an area facility is not available, he may be detained under appropriate supervision, in his home, in a private hospital or a clinic, or in a general hospital, but not in a jail or other penal facility.
 - For the purposes of this section, "non-hospital provider" means an outpatient (1) provider that provides either behavioral health or medical services.

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- A facility, or other location to which a respondent is transported under subsection (a) of this section shall provide a health screening of the respondent. The health screening shall be conducted by a physician or other individual who is determined by the area facility, contracted facility, or other location to be qualified to perform the health screening. The respondent may either be in the physical face-to-face presence of the health screening examiner or may be examined utilizing telemedicine equipment and procedures. Documentation of the health screening required under this subsection that is completed prior to transporting the patient to any general or acute care hospital shall accompany the patient or otherwise be made available at the time of transportation to the receiving facility.
- The examination set forth in subsection (a) of this section is not required if:under either of the following circumstances:
 - The affiant who obtained the custody order is a physician or eligible (1) psychologist; or commitment examiner.
 - The respondent is in custody under the special emergency procedure described (2) in G.S. 122C-282.

In these cases when it is recommended that the respondent be detained in a 24-hour facility, the law enforcement law enforcement officer shall take the respondent directly to a 24-hour facility described in G.S. 122C-252.

- The physician or eligible psychologistcommitment examiner described in subsection (a) of this section shall examine the respondent as soon as possible, and in any event within 24 hours, after the respondent is presented for examination. The examination shall include but is not limited to an assessment of the respondent's:
 - Current and previous substance abuse including, if available, previous (1) treatment history; and
 - Dangerousness to himself or others as defined in G.S. 122C-3(11).
- After the conclusion of the examination examination, the physician or eligible (d) psychologist commitment examiner shall make the following determinations:
 - If the physician or eligible psychologist commitment examiner finds that the (1) respondent is a substance abuser and is dangerous to himself self or others, he the commitment examiner shall recommend commitment and whether the respondent should be released or be held at a 24-hour facility pending hearing and shall so show on [the] histhe examination report. Based on the physician's or eligible psychologist's recommendation commitment examiner's recommendation, the law-enforcementlaw enforcement officer or other designated individual shall take the respondent to a 24-hour facility described in G.S. 122C-252 or release the respondent. If a 24-hour facility is not immediately available or medically appropriate, the respondent may be temporarily detained under appropriate supervision and the procedures described in G.S. 122C-263(d)(2) shall apply.
 - If the physician or eligible psychologist commitment examiner finds that the (2) condition described in subdivision (1) of this subsection does not exist, the respondent shall be released and the proceedings terminated.
- The findings of the physician or eligible psychologist commitment examiner and the facts on which they are based shall be in writing in all cases. A copy of the findings shall be sent to the clerk of superior court by the most reliable and expeditious means. If it cannot be reasonably anticipated that the clerk will receive the copy within 48 hours of after the time that it was signed, the physician or eligible psychologist commitment examiner shall also communicate his the findings to the clerk by telephone."

SECTION 35. G.S. 122C-284 reads as rewritten:

"§ 122C-284. Duties of clerk of superior court.

- (a) Upon receipt by the clerk of superior court of a physician's or eligible psychologist's finding made by a commitment examiner or other qualified professional pursuant to G.S. 122C-285(c) that a respondent is a substance abuser and dangerous to himself self or others and that commitment is recommended, the clerk of superior court of the county where the facility is located, if the respondent is held in a 24-hour facility, or the clerk of superior court where the petition was initiated shall upon direction of a district court judge assign counsel, calendar the matter for hearing, and notify the respondent, his respondent's counsel, and the petitioner of the time and place of the hearing. The petitioner or respondent, directly, or through counsel, may file a written waiver of his the right to notice under this subsection with the clerk of court.
- (b) Notice to the respondent required by subsection (a) of this section shall be given as provided in G.S. 1A-1, Rule 4(j) at least 72 hours before the hearing. Notice to other individuals shall be given by mailing at least 72 hours before the hearing a copy by first-class mail postage prepaid to the individual at his <u>or her</u> last known address. G.S. 1A-1, Rule 6 shall not apply.

SECTION 36. G.S. 122C-285 reads as rewritten:

"§ 122C-285. Commitment; second examination and treatment pending hearing.

- (a) Within 24 hours of arrival at a 24-hour facility described in G.S. 122C-252, the respondent shall be examined by a qualified professional. This professional shall be a physician if the initial commitment evaluation was conducted by an eligible psychologist.commitment examiner who is not a physician. The examination shall include the assessment specified in G.S. 122C-283(c). If the physician or qualified professional finds that the respondent is a substance abuser and is dangerous to himself—self or others, he—the physician or qualified professional shall hold and treat the respondent at the facility or designate other treatment pending the district court hearing. If the physician or qualified professional finds that the respondent does not meet the criteria for commitment under G.S. 122C-283(d)(1), he—the physician or qualified professional shall release the respondent and the proceeding shall be terminated. In this case the reasons for the release shall be reported in writing to the clerk of superior court of the county in which the custody order originated. If the respondent is released, the law enforcement law enforcement officer or other person designated or required under G.S. 122C-251(g) to provide transportation shall return the respondent to the originating county.
- (b) If the 24-hour facility described in G.S. 122C-252 is the facility in which the first examination by a physician or eligible psychologistcommitment examiner occurred and is the same facility in which the respondent is held, the second examination must occur not later than the following regular working day.
- (c) The findings of the physician or qualified professional along with a summary of the facts on which they are based shall be made in writing in all cases. A copy of the written findings shall be sent to the clerk of superior court by reliable and expeditious means."

SECTION 37. G.S. 122C-286 reads as rewritten:

"§ 122C-286. Commitment; district court hearing.

- (a) A hearing shall be held in district court within 10 days of the day the respondent is taken into custody. If a respondent temporarily detained under G.S. 122C-263(d)(2) is subject to a series of successive custody orders issued pursuant to G.S. 122C-263(d)(2), the hearing shall be held within 10 days after the day the respondent is taken into custody under the most recent custody order. Upon its own motion or upon motion of the responsible professional, the respondent, or the State, the court may grant a continuance of not more than five days.
- (b) The respondent shall be present at the hearing unless the respondent, through counsel, submits a written waiver of personal appearance. A subpoena may be issued to compel the respondent's presence at a hearing. The petitioner and the responsible professional of the area authority facility or the proposed treating physician or his a designee of the proposed treating physician may be present and may provide testimony.

- (c) Certified copies of reports and findings of physicians and psychologistsphysicians, psychologists, and other commitment examiners and medical records of previous and current treatment are admissible in evidence, but the respondent's right to confront and cross-examine witnesses shall not be denied.
- (d) The respondent may be represented by counsel of his-choice. If the respondent is indigent within the meaning of G.S. 7A-450, counsel shall be appointed to represent the respondent in accordance with rules adopted by the Office of Indigent Defense Services.
- (e) Hearings may be held at a facility if it is located within the judge's district court district as defined in G.S. 7A-133 or in the judge's chambers. A hearing may not be held in a regular courtroom, over objection of the respondent, if in the discretion of a judge a more suitable place is available.
- (f) The hearing shall be closed to the public unless the respondent requests otherwise. The hearing for a respondent being held at a 24-four facility shall be held in a location and in the manner provided in G.S. 122C-268(g).
- (g) A copy of all documents admitted into evidence and a transcript of the proceedings shall be furnished to the respondent on request by the clerk upon the direction of a district court judge. If the respondent is indigent, the copies shall be provided at State expense.
- (h) To support a commitment order, the court shall find by clear, cogent, and convincing evidence that the respondent meets the criteria specified in G.S. 122C-283(d)(1). The court shall record the facts that support its findings and shall show on the order the area authority facility or physician who is responsible for the management and supervision of the respondent's treatment."

SECTION 38. G.S. 122C-287 reads as rewritten:

"§ 122C-287. Disposition.

The court may make one of the following dispositions:

- (1) If the court finds by clear, cogent, and convincing evidence that the respondent is a substance abuser and is dangerous to himself-self or others, it shall order for a period not in excess of 180 days commitment to and treatment by an area authority-facility or physician who is responsible for the management and supervision of the respondent's commitment and treatment. Before ordering commitment to and treatment by an area facility or a physician who is not a physician at an inpatient facility, the court shall follow the procedures specified in G.S. 122C-271(a)(3) and G.S. 122C-271(b)(4), as applicable.
- (2) If the court finds that the respondent does not meet the commitment criteria set out in subdivision (1) of this subsection, the respondent shall be discharged and the facility in which he was last treated so notified."

SECTION 39. G.S. 122C-290 reads as rewritten:

"§ 122C-290. Duties for follow-up on commitment order.

- (a) The area <u>authority</u>-<u>facility</u> or physician responsible for management and supervision of the respondent's commitment and treatment may prescribe or administer to the respondent reasonable and appropriate treatment either on an outpatient basis or in a 24-hour facility.
- (b) If the respondent whose treatment is provided on an outpatient basis fails to comply with all or part of the prescribed treatment after reasonable effort to solicit the respondent's compliance or whose treatment is provided on an inpatient basis is discharged in accordance with G.S. 122C-205.1(b), the area authority facility or physician may request the clerk or magistrate to order the respondent taken into custody for the purpose of examination. Upon receipt of this request, the clerk or magistrate shall issue an order to a law enforcement officer to take the respondent into custody and to take him immediately to the designated area authority facility or physician for examination. The custody order is valid throughout the State. The law enforcement officer shall turn the respondent over to the custody of the physician or area authority facility who shall conduct the examination and release the respondent or have the respondent taken to a 24-hour facility upon a determination that treatment in the facility will benefit the respondent.

Transportation to the 24-hour facility shall be provided as specified in G.S. 122C-251, upon notice to the clerk or magistrate that transportation is necessary, or as provided in G.S. 122C-408(b). If placement in a 24-hour facility is to exceed 45 consecutive days, the area authority—facility or physician shall notify the clerk of court by the 30th day and request a supplemental hearing as specified in G.S. 122C-291.

- (c) If the respondent intends to move or moves to another county within the State, the area <u>authority</u> or physician shall notify the clerk of court in the county where the commitment is being supervised and request that a supplemental hearing be calendared.
- (d) If the respondent moves to another state or to an unknown location, the designated area <u>authority facility</u> or physician shall notify the clerk of superior court of the county where the commitment is supervised and the commitment shall be terminated."

SECTION 40. G.S. 122C-291 reads as rewritten:

"§ 122C-291. Supplemental hearings.

- (a) Upon receipt of a request for a supplemental hearing, the clerk shall calendar a hearing to be held within 14 days and notify, at least 72 hours before the hearing, the petitioner, the respondent, his attorney, if any, and the designated area authority facility or physician. Notice shall be provided in accordance with G.S. 122C-284(b). The procedures for the hearing shall follow G.S. 122C-286.
- (b) At the supplemental hearing for a respondent who has moved or may move to another county, the court shall determine if the respondent meets the criteria for commitment set out in G.S. 122C-283(d)(1). If the court determines that the respondent no longer meets the criteria for commitment, it shall discharge the respondent from the order and dismiss the case. If the court determines that the respondent continues to meet the criteria for commitment, it shall continue the commitment but shall designate an area authority facility or physician at the respondent's new residence to be responsible for the management or supervision of the respondent's commitment. The court shall order the respondent to appear for treatment at the address of the newly designated area authority facility or physician and shall order venue for further court proceedings under the commitment to be transferred to the new county of supervision. Upon an order changing venue, the clerk of court in the county where the commitment has been supervised shall transfer the records regarding the commitment to the clerk of court in the county where the commitment will be supervised. Also, the clerk of court in the county where the commitment has been supervised shall send a copy of the court's order directing the continuation of treatment under new supervision to the newly designated area authority facility or physician.

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SECTION 41. G.S. 122C-292 reads as rewritten:

"§ 122C-292. Rehearings.

- (a) Fifteen days before the end of the initial or subsequent periods of commitment if the area authority facility or physician determines that the respondent continues to meet the criteria specified in G.S. 122C-283(d)(1), the clerk of superior court of the county where commitment is supervised shall be notified. The clerk, at least 10 days before the end of the commitment period, on order of the district court, shall calendar the rehearing. If the respondent no longer meets the criteria, the area authority-facility or physician shall so notify the clerk who shall dismiss the case.
- (b) Rehearings are governed by the same notice and procedures as initial hearings, and the respondent has the same rights he-hadthat were available to the respondent at the initial hearing including the right to appeal.
- (c) If the court finds that the respondent no longer meets the criteria of G.S. 122C-283(d)(1), it shall unconditionally discharge him. A copy of the discharge order shall be furnished by the clerk to the designated area authority facility or physician. If the respondent continues to meet the criteria of G.S. 122C-283(d)(1), the court may order commitment for additional periods not in excess of 365 days each."

SECTION 42. G.S. 122C-293 reads as rewritten:

"§ 122C-293. Release by area authority facility or physician.

The area authority facility or physician as designated in the order shall discharge a committed respondent unconditionally at any time he the physician determines that the respondent no longer meets the criteria of G.S. 122C-283(d)(1). Notice of discharge and the reasons for the release shall be reported in writing to the clerk of superior court of the county in which the commitment was ordered."

SECTION 43. G.S. 122C-294 reads as rewritten:

"§ 122C-294. Local plan.plan and data submission.

Each area authority shall develop a local plan with local law enforcement agencies, local courts, local hospitals, and local medical societies necessary to facilitate implementation of this Part(a) The local plan in accordance with G.S. 122C-202.2 and G.S. 122C-251(g) shall be submitted to the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services on or before October 1, 2019. If the area authority modifies the plan, the modified plan shall be submitted to the Division of Mental Health, Developmental Disabilities, and Substance at least 10 days prior to the effective date of the new plan.

(b) The Department shall provide the data collected by the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services concerning the number of respondents receiving treatment under involuntary commitment in designated facilities to the Fiscal Research Division and the Joint Legislative Oversight Committee for Health and Human Services on October 1 of each year beginning in 2019 and any other time upon request."

SECTION 44. Each LME/MCO shall submit to the Department of Health and Human Services a copy of its current community crisis services plan adopted pursuant to G.S. 122C-202.2, as enacted by this act, by the earlier of (i) 12 months after the date the Department receives notification that the federal Centers for Medicaid and Medicare has approved all necessary waivers and State Plan amendments for Medicaid and NC Health Choice transformation as provided for in S.L. 2015-245, as amended, or (ii) six months prior to the date the Department actually initiates capitated contracts with Prepaid Health Plans, as defined in Section 4 of S.L. 2015 245, as amended, for the delivery of Medicaid and NC Health Choice services. The Department shall notify each LME/MCO when the earlier of these conditions occurs.

SECTION 45.(a) G.S. 35A-1105 reads as rewritten:

"§ 35A-1105. Petition before clerk.

A verified petition for the adjudication of incompetence of an adult, or of a minor who is within six months of reaching majority, may be filed with the clerk by any person, including any State or local human services agency or healthcare provider through its authorized representative representative without the need for legal counsel."

SECTION 45.(b) G.S. 35A-1112 reads as rewritten:

"§ 35A-1112. Hearing on petition; adjudication order.

(b) The petitioner and the respondent are entitled to present testimony and documentary evidence, to subpoena witnesses and the production of documents, and to examine and cross-examine witnesses. If the petitioner is a State or local human service agency or a healthcare provider, evidence may be presented without the need for legal counsel.

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SECTION 46. Section 44 of this act is effective when it becomes law. The remainder of this act is effective October 1, 2019, and applies to proceedings initiated on or after that date.

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GENERAL ASSEMBLY OF NORTH CAROLINA SESSION 2017

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SENATE BILL 630*

(Public) Short Title: Revise IVC Laws to Improve Behavioral Health. Sponsors: Senators Hise, Krawiec, Randleman (Primary Sponsors); Cook, Tucker, and Woodard. Referred to: Rules and Operations of the Senate April 5, 2017 A BILL TO BE ENTITLED AN ACT REVISING THE LAWS PERTAINING TO INVOLUNTARY COMMITMENT IN ORDER TO IMPROVE THE DELIVERY OF BEHAVIORAL HEALTH SERVICES IN NORTH CAROLINA. The General Assembly of North Carolina enacts: **SECTION 1.** G.S. 122C-3 reads as rewritten: "§ 122C-3. Definitions. The following definitions apply in this Chapter: "Commitment examiner" means a physician, an eligible psychologist, or any (8a) health professional or mental health professional who is certified under G.S. 122C-263.1 to perform the first examination for involuntary commitment described in G.S. 122C-263(c) or G.S. 122C-283(c) as required by Parts 7 and 8 of this Article. "Incapable" with respect to an individual means in the opinion of a physician (16a)or eligible psychologist, the individual currently lacks sufficient understanding or capacity to make and communicate mental health treatment decisions. An adult individual who is incapable is not the same as an incompetent adult unless the adult individual has been adjudicated incompetent under Chapter 35A of the General Statutes. "Incompetent adult" means an adult individual who has been adjudicated (17)incompetent incompetent under Chapter 35A of the General Statutes. (20)"Legally responsible person" means: (i) when applied to an adult, who has been adjudicated incompetent, a guardian; (ii) when applied to a minor, a parent, guardian, a person standing in loco parentis, or a legal custodian other than a parent who has been granted specific authority by law or in a custody order to consent for medical care, including psychiatric treatment; or (iii) when applied to an adult who is incapable as defined in G.S. 122C-72(c) and who has not been adjudicated incompetent, a health care agent named pursuant to a valid health care power of attorney; provided, however, that if an incapable adult does not have a health care agent or guardian, "legally responsible person" means one of the persons specified in



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subdivisions (3) through (7) of subsection (c) of G.S. 90-21.13, to be selected based on the priority indicated in said subdivisions (3) through (7).

 (20b) "Local management entity" or "LME" means an area authority, county program, or consolidated human services agency. It is a collective term that refers to functional responsibilities rather than governance structure. area authority.

"Outpatient treatment physician or center" as used in Part 7 of Article 5 of (27a)this Chapter means a physician or center that provides treatment services directly to the outpatient commitment respondent. An LME/MCO that contracts with an outpatient treatment physician or center to provide outpatient treatment services to a respondent is not an outpatient treatment physician or center. Every LME/MCO is responsible for contracting with qualified providers of services in accordance with G.S. 122C-141, 122C-142(a), 122C-115.2(b)(1)b., and 122C-115.4(b)(2) to ensure the availability of qualified providers of outpatient commitment services to clients of LME/MCOs who are respondents to outpatient commitment proceedings and meet the criteria for outpatient commitment. An LME/MCO provider shall not be designated as an outpatient treatment physician or center on an outpatient commitment order unless the respondent is a client of an LME/MCO or is eligible for services through an LME/MCO, or the respondent otherwise qualifies for the provision of services offered by the provider.

(29a) "Program director" means the director of a county program established pursuant to G.S. 122C-115.1.

SECTION 2. G.S. 122C-4 reads as rewritten:

"§ 122C-4. Use of phrase "client or his-the legally responsible person."

(a) Except as otherwise provided by law, whenever in this Chapter the phrase "client or his the legally responsible person" is used, and the client is a minor or an incompetent adult, the duty or right involved shall be exercised not by the client, but by the legally responsible person.

(b) Except as otherwise provided by law, whenever in this Chapter the phrase "client or the legally responsible person" is used, and the client is an incapable adult who has not been adjudicated incompetent under Chapter 35A of the General Statutes, the duty or right involved shall be exercised not by the client but by a health care agent named pursuant to a valid health care power of attorney, if one exists, or by the client as expressed in a valid advance instruction for mental health treatment, if one exists. If no health care power of attorney or advance instruction for mental health treatment exists, the legally responsible person for an incapable adult who has not been adjudicated incompetent under Chapter 35A of the General Statutes shall be one of the persons listed in subdivisions (3) through (7) of subsection (c) of G.S. 90-21.13, to be selected based on the priority order indicated in said subdivisions (3) through (7)."

SECTION 3. G.S. 122C-53 reads as rewritten:

"§ 122C-53. Exceptions; client.

(a) A facility may disclose confidential information if the client or <u>his-the</u> legally responsible person consents in writing to the release of the information to a specified person. This release is valid for a specified length of time and is subject to revocation by the consenting individual.

- (b) A facility may disclose (i) the fact of admission or discharge of a client and (ii) the time and location of the admission or discharge to the client's next of kin whenever the responsible professional determines that the disclosure is in the best interest of the client.
- (c) Upon request a client shall have access to confidential information in his client the client's record except information that would be injurious to the client's physical or mental well-being as determined by the attending physician or, if there is none, by the facility director or his the facility director's designee. If the attending physician or, if there is none, the facility director or his the facility director's designee has refused to provide confidential information to a client, the client may request that the information be sent to a physician or psychologist of the client's choice, and in this event the information shall be so provided.
- (d) Except as provided by G.S. 90-21.4(b), upon request the legally responsible person of a client shall have access to confidential information in the client's record; except information that would be injurious to the client's physical or mental well-being as determined by the attending physician or, if there is none, by the facility director or his-the facility director's designee. If the attending physician or, if there is none, the facility director or his-the facility director's designee has refused to provide confidential information to the legally responsible person, the legally responsible person may request that the information be sent to a physician or psychologist of the legally responsible person's choice, and in this event the information shall be so provided.
- (e) A client advocate's access to confidential information and his the client's responsibility for safeguarding this information are as provided by subsection (g) of this section.
- (f) As used in subsection (g) of this section, the following terms have the meanings specified:
 - (1) "Internal client advocate" means a client advocate who is employed by the facility or has a written contractual agreement with the Department or with the facility to provide monitoring and advocacy services to clients in the facility in which the client is receiving services; and services.
 - (2) "External client advocate" means a client advocate acting on behalf of a particular client with the written consent and authorization; authorization under either of the following circumstances:
 - a. In the case of a client who is an adult and who has not been adjudicated incompetent under Chapter 35A or former Chapters 33 or 35 of the General Statutes, of the elient; or client.
 - b. In the case of any other client, of the client and his the legally responsible person.
- (g) An internal client advocate shall be granted, without the consent of the client or https://doi.org/10.10/ access to routine reports and other confidential information necessary to fulfill his-monitoring and advocacy functions. In this role, the internal client advocate may disclose confidential information received to the client involved, to his or her legally responsible person, to the director of the facility or his-the director's designee, to other individuals within the facility who are involved in the treatment or habilitation of the client, or to the Secretary in accordance with the rules of the Commission. Any further disclosure shall require the written consent of the client and his-the legally responsible person. An external client advocate shall have access to confidential information only upon the written consent of the client and his-the legally responsible person. In this role, the external client advocate may use the information only as authorized by the client and his-the legally responsible person.
- (h) In accordance with G.S. 122C-205, the facility shall notify the appropriate individuals upon the escape from and subsequent return of clients to a 24-hour facility.
- (i) Upon the request of (i) a client who is an adult and who has not been adjudicated incompetent under Chapter 35A or former Chapters 33 or 35 of the General Statutes, or (ii) the

legally responsible person for any other client, a facility shall disclose to an attorney confidential information relating to that client."

SECTION 4. G.S. 122C-54 reads as rewritten:

"§ 122C-54. Exceptions; abuse reports and court proceedings.

(a1) Upon a determination by the facility director or his-the facility director's designee that disclosure is in the best interests of the client, a facility may disclose confidential information for purposes of filing a petition for involuntary commitment of a client pursuant to Article 5 of this Chapter or for purposes of filing a petition for the adjudication of incompetency of the client and the appointment of a guardian or an interim guardian under Chapter 35A of the General Statutes.

- (c) Certified copies of written results of examinations by physicians and other medical and court records in the cases of clients voluntarily admitted or involuntarily committed and facing district court hearings and rehearings pursuant to Article 5 of this Chapter shall be furnished by the facility to the client's counsel, the attorney representing the State's interest, and the court. Notwithstanding the confidentiality of these records, the client's counsel shall have access to any medical and court records the client's counsel deems relevant to the court proceeding and shall not be required to obtain the client's consent in order to access these records. The confidentiality of client information shall be preserved in all matters except those pertaining to the necessity for admission or continued stay in the facility or commitment under review. The relevance of confidential information for which disclosure is sought in a particular case shall be determined by the court with jurisdiction over the matter.
- (d) Any individual seeking confidential information contained in the court files or the court records of a proceeding made pursuant to Article 5 of this Chapter-Chapter, except for the respondent, may file a written motion in the cause setting out why the information is needed. A district court judge may issue an order to disclose the confidential information sought if he-the judge finds (i) the order is appropriate under the circumstances and if he finds that(ii) it is in the best interest of the individual admitted or committed or of the public to have the information disclosed. An individual who is or has been a respondent in a proceeding pursuant to Article 5 of this Chapter shall be provided the court records of the proceeding upon submitting a written request to the clerk of superior court in the county in which the proceeding is pending. The clerk of court shall take reasonable and appropriate measures to verify the identity of the individual making the request. The respondent's legally responsible person shall exercise the respondent's right to access the court records if the respondent is a minor or an incompetent adult at the time of the request.

(e) Upon the request of the legally responsible person or the minor admitted or committed, and after that minor has both been released and reached adulthood, the court records of that minor made in proceedings pursuant to Article 5 of this Chapter may be expunged from the files of the court. The minor and his-the minor's legally responsible person shall be informed in writing by the court of the right provided by this subsection at the time that the application for admission is filed with the court.

(g) A facility may disclose confidential information to an attorney who represents either the facility or an employee of the facility, if such information is relevant to litigation, to the operations of the facility, or to the provision of services by the facility. An employee may discuss confidential information with his-the-employee's attorney or with an attorney representing the facility in which he-the-employee is employed.

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SECTION 5. G.S. 122C-55 reads as rewritten:

"§ 122C-55. Exceptions; care and treatment.

- (a) Any facility may share confidential information regarding any client of that facility with any other facility when necessary to coordinate appropriate and effective care, treatment or habilitation of the client. For the purposes of this section, coordinate—the following definitions apply:
 - (1) "Coordinate" means the provision, coordination, or management of mental health, developmental disabilities, and substance abuse services and other health or related services by one or more facilities and includes the referral of a client from one facility to another.
 - (2) "Facility" and "area facility" include an area authority.
 - "Secretary" includes the Community Care of North Carolina Program, or other primary care case management programs that contract with the Department to provide a primary care case management program for recipients of publicly funded health and related services.
- (a1) Any facility may share confidential information regarding any client of that facility with the Secretary, and the Secretary may share confidential information regarding any client with a facility when necessary to conduct quality assessment and improvement activities or to coordinate appropriate and effective care, treatment or habilitation of the client. For purposes of this subsection, subsection (a6), and subsection (a7) of this section, the purposes or activities for which confidential information may be disclosed include, but are not limited to, case management and care coordination, disease management, outcomes evaluation, the development of clinical guidelines and protocols, the development of care management plans and systems, population-based activities relating to improving or reducing health care costs, and the provision, coordination, or management of mental health, developmental disabilities, and substance abuse services and other health or related services. As used in this section, "facility" includes an LME and "Secretary" includes the Community Care of North Carolina Program, or other primary care case management programs that contract with the Department to provide a primary care case management program for recipients of publicly funded health and related services.

SECTION 6. G.S. 122C-115.4(b) is amended by adding a new subdivision to read: "(7a) Community crisis services planning in accordance with G.S. 122C-202.2." **SECTION 7.** G.S. 122C-117(a)(14) reads as rewritten:

"(14) Maintain a 24-hour a day, seven day a week crisis response service.service and adopt a community crisis services plan in accordance with G.S. 122C-202.2. Crisis response shall include telephone and face-to-face capabilities. Crisis phone response shall include triage and referral to appropriate face-to-face crisis providers and shall be initiated within one hour of notification. Crisis services do not require prior authorization but shall be delivered in compliance with appropriate policies and procedures. Crisis services shall be designed for prevention, intervention, and resolution, not merely triage and transfer, and shall be provided in the least restrictive setting possible, consistent with individual and family need and community safety."

SECTION 8. Part 1 of Article 5 of Chapter 122C of the General Statutes is amended by adding a new section to read:

"§ 122C-202.2. LME/MCO community crisis services plan; commitment examiners; transporting agencies; training; collaboration.

(a) Every LME/MCO shall adopt a community crisis services plan developed in accordance with this section to facilitate the implementation of Parts 7 and 8 of this Article within its catchment area. The community crisis services plan for the LME/MCO's catchment

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area shall be comprised of separate plans, known as "local area crisis services plans" or "local plans," for each of the local areas or regions within the catchment area that the LME/MCO identifies as an appropriate local planning area, taking into consideration the available resources and interested stakeholders within a particular geographic area or region of the catchment area. Each LME/MCO may determine the number and geographic boundaries of the local planning areas within its catchment area. Each local area crisis services plan shall, for the local area covered by the local plan, do at least all of the following:

- (1)Identify one or more area facilities where a respondent subject to a transportation and custody order must be taken for a first examination by a commitment examiner as required by G.S. 122C-263(a) and G.S. 122C-283(a). If an area facility is identified in the plan as an appropriate facility for conducting the first examination for commitment, law enforcement officers, and any persons designated to provide transportation and custody under G.S. 122C-251(g), shall transport the commitment respondent to the area facility in accordance with, and under circumstances addressed in, the local area crisis services plan. If no area facility is available in the local planning area to conduct the first examination for commitment, the local plan shall identify an acute care hospital or hospitals or other location for first examination. This subdivision applies when a magistrate or clerk of court orders a respondent to be taken into custody for examination by a commitment examiner. This subdivision does not apply when the respondent is already present on the premises of a location and the first examiner at that location is the affiant who is petitioning to initiate the commitment process.
- Identify any persons that the LME/MCO has designated under G.S. 122C-251(g) to be responsible for all or part of the transportation and custody of respondents in involuntary commitment proceedings under this Article, to the extent that the LME/MCO has exercised its authority under G.S. 122C-251(g). Any plan adopted by an LME/MCO under G.S. 122C-251(g) shall be included as a part of the local area crisis services plan for the area to which it pertains. Counties and cities shall retain the responsibilities for custody and transportation set forth in this Article except as otherwise set forth in a plan developed and adopted pursuant G.S. 122C-251(g).
- Identify appropriate and available training for law enforcement personnel. (3) and any persons designated under G.S. 122C-251(g), who provide transportation and custody of involuntary commitment respondents. To the extent feasible, law enforcement officers shall participate in the training program identified by the LME/MCO. Persons who are designated under G.S. 122C-251(g) to provide all or part of the transportation and custody required for involuntary commitment proceedings under this Article and who are not law enforcement officers shall participate in the training. To the extent feasible, the identified training shall address the use of de-escalation strategies and techniques, the safe use of force and restraint, respondent rights relevant to custody and transportation, the location of any area facilities identified by the LME/MCO pursuant to subdivision (1) of this subsection, and the completion and return of the custody order to the clerk of superior court. The training identified by the LME/MCO may be comprised of one or more programs, and may include a crisis intervention team program or other mental health training program or a combination of these programs. To the extent feasible, the LME/MCO shall identify training that

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includes a component for dialogue with consumers of mental health, developmental disabilities, and substance abuse services.

- Law enforcement agencies, acute care hospitals, magistrates or clerks of court, area facilities with identified commitment examiners, the LME/MCO, and other relevant community partners or stakeholders shall participate in the development of the local area crisis services plans described in this section.
- (c) The plans adopted under this section may address any matters necessary to facilitate the custody, transportation, examination, and treatment of respondents to commitment proceedings under Parts 7 and 8 of this Article."

SECTION 9. G.S. 122C-206 reads as rewritten:

"§ 122C-206. Transfers of clients between 24-hour facilities, facilities; transfer of clients from 24-hour facilities to acute care hospitals.

- Before transferring a voluntary adult client from one 24-hour facility to another, the (a) responsible professional at the original facility shall: (i) get authorization from the receiving facility that the facility will admit the client; (ii) get consent from the client; and (iii) if consent to share information is granted by the elient, client or if disclosure of the information is permitted under G.S. 122C-53(b), notify the next of kin of the time and location of the transfer. The preceding requirements of this paragraph may be waived if the client has been admitted under emergency procedures to a State facility not serving the client's region of the State. Following an emergency admission, the client may be transferred to the appropriate State facility without consent according to the rules of the Commission.
- Before transferring a respondent held for a district court hearing or a committed respondent from one 24-hour facility to another, the responsible professional at the original facility shall:
 - Obtain authorization from the receiving facility that the facility will admit (1) the respondent; and
 - Provide reasonable notice to the respondent, or respondent or the legally (2) responsible person, and to the respondent's counsel, of the reason for the transfer and document the notice in the client's record.

No later that than 24 hours after the transfer, the responsible professional at the original facility shall notify the petitioner, the clerk of court, the respondent's counsel, and, if consent is granted by the respondent, respondent or disclosure of the information is permitted under G.S. 122C-53(b), the next of kin, that the transfer is completed complete. If the transfer is completed before the judicial commitment hearing, these proceedings shall be initiated by the receiving facility. If the respondent is a minor, an incompetent adult, or an individual with a health care power of attorney who is deemed incapable, then the responsible professional at the original facility shall, not later than 24 hours after the transfer, notify the client's legally responsible person of the location of the transfer and that the transfer is complete.

- Minors and incompetent adults, admitted pursuant to Parts 3 and 4 of this Article, may be transferred from one 24-hour facility to another following the same procedures specified in subsection (b) of this section. In addition, the legally responsible person shall be consulted before the proposed transfer and notified, within 24 hours after the transfer is complete, of the location of the transfer and that the transfer is complete. If the transfer is completed before the judicial determination required in G.S. 122C-223 or G.S. 122C-232, these proceedings shall be initiated by the receiving facility.
- If a client described in subsections (b) or (c) of this section is to be transferred from one 24-hour facility to another another, or to an acute care hospital pursuant to subsection (e) of this section, and transportation is needed, the responsible professional at the original facility shall notify the clerk of court or magistrate, and the clerk of court or magistrate shall issue a custody order for transportation of the client as provided by G.S. 122C-251.

- (d) Minors and incompetent adults, admitted pursuant to Part 5 of this <u>Article and incapable adults admitted pursuant to Part 2A of this Article</u>, may be transferred from one 24-hour facility to another provided that prior to transfer the responsible professional at the original facility shall:
 - (1) Obtain authorization from the receiving facility that the facility will admit the client; and
 - (2) Provide reasonable notice to the client regarding the reason for transfer and document the notice in the client's record; and
 - (3) Provide reasonable notice to and consult with the legally responsible person regarding the reason for the transfer and document the notice and consultation in the client's record.

No later than 24 hours after the transfer, the responsible professional at the original facility shall notify the legally responsible person that the transfer is completed.

- (e) The responsible professional may transfer a client from one <u>24-hour</u> facility to another <u>or to an acute care hospital</u> for emergency medical treatment, emergency medical evaluation, or emergency surgery without notice to or consent from the client. Within a reasonable period of time the responsible professional shall notify the next of kin or the legally responsible person of the client of the <u>time and location of the transfer</u>.
- (f) When a client is transferred <u>from one 24-hour facility</u> to another facility solely for medical reasons, the client shall be returned to the original facility when the medical care is completed unless the responsible professionals at both facilities concur that discharge of the client who is not subject to G.S. 122C-266(b) is appropriate.
- (f1) When a client is transferred from a 24-hour facility to an acute care hospital solely for medical reasons, the hospital shall return the client to the original facility as soon as the next client space becomes available at the original facility after completion of the client's medical care, and the original facility must accept the return of the client; provided, however, that if the responsible professionals at both facilities concur that discharge of a client who is not subject to G.S. 122C-266(b) is appropriate, the client shall be released. If, at the time of the transfer, a client is being held under a custody order pending a second commitment examination or a district court hearing under involuntary commitment proceedings, the custody order shall remain valid throughout the period of time necessary to complete the client's medical care and transport the client between the 24-hour facility and the acute care hospital; provided, however, that the requirement for a timely hearing under G.S. 122C-268(a) applies. Any decision to terminate the proceedings because the respondent no longer meets the criteria for commitment or because a hearing cannot be held within the time required by G.S. 122C-268(a) shall be documented and reported to the clerk of superior court in accordance with G.S. 122C-266(c).
 - (g) The Commission may adopt rules to implement this section."

SECTION 10. G.S. 122C-210.1 reads as rewritten:

"§ 122C-210.1. Immunity from liability.

No facility facility, including an area facility, a facility licensed under this Chapter, an acute care hospital, a general hospital, or an area authority, LME, or LME/MCO, or any of its officials, staff, or employees, or any physician or other individual who is responsible for the custody, transportation, examination, management, supervision, treatment, or release of a client and who follows accepted professional judgment, practice, and standards takes reasonable measures in good faith under the authority of this Article and is not grossly negligent is civilly or criminally liable, personally or otherwise, for actions arising from these responsibilities or for actions of the client. This immunity is in addition to any other legal immunity from liability to which these facilities facilities, agencies, or individuals may be entitled and applies to actions performed in connection with, or arising out of, the admission custody, transportation, examination, admission, or commitment of any individual pursuant to this Article."

SECTION 11. G.S. 122C-210.3 reads as rewritten:

A custody order entered by the clerk or magistrate pursuant to this Chapter may be delivered to the law enforcement officer or other person designated under G.S. 122C-251(g) by electronic or facsimile transmission."

SECTION 12. G.S. 122C-211 reads as rewritten: "§ 122C-211. Admissions.

- Except as provided in subsections (b) through (f1) of this section, any individual, including a parent in a family unit, in need of treatment for mental illness or substance abuse may seek voluntary admission at any facility by presenting himself or herself for evaluation to the facility. No physician's statement is necessary, but a written application for evaluation or admission, signed by the individual seeking admission, admission or the individual's legally responsible person, is required. The application form shall be available at all times at all facilities. However, no one shall be denied admission because application forms are not available. An evaluation shall determine whether the individual is in need of care, treatment, habilitation or rehabilitation for mental illness or substance abuse or further evaluation by the facility. Information provided by family members regarding the individual's need for treatment shall be reviewed in the evaluation. If applicable, information provided in an advance instruction for mental health treatment by the client or the client's legally responsible person shall be reviewed in the evaluation. An individual may not be accepted as a client if the facility determines that the individual does not need or cannot benefit from the care, treatment, habilitation, or rehabilitation available and that the individual is not in need of further evaluation by the facility. The facility shall give to an individual who is denied admission a referral to another facility or facilities that may be able to provide the treatment needed by the client.
- (b) In 24-hour facilities the application shall acknowledge that the applicant may be held by the facility for a period of 72 hours after any written request for release that the applicant may make, and shall acknowledge that the 24-hour facility may have the legal right to petition for involuntary commitment of the applicant during that period. At the time of application, the facility shall tell the applicant about procedures for discharge.
- (c) Any individual who voluntarily seeks admission to a 24-hour facility in which medical care is an integral component of the treatment shall be examined and evaluated by a physician of the facility within 24 hours of admission. The evaluation shall determine whether the individual is in need of treatment for mental illness or substance abuse or further evaluation by the facility. If the evaluating physician determines that the individual will not benefit from the treatment available, the individual shall not be accepted as a client.
- (d) Any individual who voluntarily seeks admission to any 24-hour facility, other than one in which medical care is an integral component of the treatment, shall have a medical examination within 30 days before or after admission if it is reasonably expected that the individual will receive treatment for more than 30 days or shall produce a current, valid physical examination report, signed by a physician, completed within 12 months prior to the current admission. When applicable, this examination may be included in an examination conducted to meet the requirements of G.S. 122C-223 or G.S. 122C-232.
- (e) When an individual from a single portal area seeks admission to an area or State 24 hour facility, the admission shall follow the procedures as prescribed in the area plan. When an individual from a single portal area presents himself for admission to the facility directly and is in need of an emergency admission, the individual may be accepted for admission. The facility shall notify the area authority within 24 hours of the admission. Further planning of treatment for the client is the joint responsibility of the area authority and the facility as prescribed in the area plan.
- (f) A family unit may voluntarily seek admission to a 24-hour substance abuse facility that is able to provide, directly or by contract, treatment, habilitation, or rehabilitation services

that will specifically address the family unit's needs. These services shall include gender-specific substance abuse treatment, habilitation, or rehabilitation for the parent as well as assessment, well-child care, and, as needed, early intervention services for the child. A family unit that voluntarily seeks admission to a 24-hour substance abuse facility shall be evaluated by the facility to determine whether the family unit would benefit from the services of the facility. A facility shall not accept a family unit as a client if the facility determines that the family unit does not need or cannot benefit from the care, habilitation, or rehabilitation available at the facility. The facility shall give to a family unit that is denied admission a referral to another facility or facilities that may be able to provide treatment needed by the family unit. Except as otherwise provided, this section applies to a parent in a family unit seeking admission under this section.

- (fl) An individual in need of treatment for mental illness may be admitted to a facility pursuant to an advance instruction for mental health treatment or pursuant to the authority of a health care agent named in a valid health care power of attorney, provided that the individual is incapable, as defined in G.S. 122C 72(4) at the time of the need for admission. An individual admitted to a facility pursuant to an advance instruction for mental health treatment may not be retained for more than 10 days, except as provided for in subsection (b) of this section. When a health care power of attorney authorizes a health care agent to seek the admission of an incapable individual, the health care agent shall act for the individual in applying for admission to a facility and in consenting to medical treatment at the facility when consent is required, provided that the individual is incapable.
- (g) As used in this Part, the term "family unit" means a parent and the parent's dependent children under the age of three years."

SECTION 13. G.S. 122C-212 reads as rewritten:

"§ 122C-212. Discharges.

- (a) Except as provided in <u>subsections subsection</u> (b) and (c) of this section, an individual who has been voluntarily admitted to a facility shall be discharged upon his <u>or her</u> own request. A request for discharge from a 24-hour facility shall be in writing.
- (b) An individual who has been voluntarily admitted to a 24-hour facility may be held for 72 hours after his <u>or her</u> written application for discharge is submitted.
- (e) When an individual from a single portal area who has been voluntarily admitted to an area or State 24 hour facility is discharged, the discharge shall follow the procedures as prescribed in the area plan."

SECTION 14. Article 5 of Chapter 122C of the General Statutes is amended by adding a new Part to read:

"Part 2A. Voluntary Admissions and Discharges; Incapable Adults; Facilities for Individuals
With Mental Illness and Substance Use Disorder.

"§ 122C-213. Voluntary admission of individuals determined to be incapable.

- (a) An individual in need of treatment for mental illness and who is incapable, as defined in G.S. 122C-3 and G.S. 122C-72, may be admitted to and treated in a facility pursuant to an advance instruction for mental health treatment executed in accordance with Part 2 of Article 3 of this Chapter or pursuant to the authority of a health care agent named in a valid health care power of attorney executed in accordance with Article 3 of Chapter 32A of the General Statutes.
- (b) Except as otherwise provided in this Part, G.S. 122C-211 applies to admissions of incapable adults under this Part.
- (c) An individual making an advance instruction for mental health treatment may grant or withhold consent for mental health treatment, including the use of psychotropic medication, electroconvulsive treatment, and admission to and retention in a 24-hour facility for mental illness. An attending physician or other mental health treatment provider shall act in accordance with an advance instruction for mental health treatment upon a determination that the

individual making the advance instruction is incapable, in which case, the provisions of Part 2 of Article 3 of this Chapter apply.

- (d) When a health care power of attorney authorizes a health care agent pursuant to G.S. 32A-19 to make mental health treatment decisions for an incapable individual, the health care agent shall act for the individual in applying for admission and consenting to treatment at a facility, consistent with the extent and limitations of authority granted in the health care power of attorney for as long as the individual remains incapable.
- (e) A 24-hour facility may not hold an individual who is determined to be incapable at the time of admission and who is admitted pursuant to an advance instruction for mental health treatment for more than 15 days, except as provided in G.S. 122C-211(b); provided, however, that an individual who regains sufficient understanding and capacity to make and communicate mental health treatment decisions may elect to continue his or her admission and treatment pursuant to the individual's informed consent in accordance with G.S. 122C-211.

"§ 122C-214. Discharge of individuals determined to be incapable.

- (a) The responsible professional shall unconditionally discharge an individual admitted to a facility pursuant to this Part at any time it is determined that the individual is no longer mentally ill or in need of treatment at the facility.
- (b) An individual who has been voluntarily admitted to a facility pursuant to this Part and who is no longer deemed incapable shall be discharged upon his or her own request. An individual's request for discharge from a 24-hour facility shall be in writing. A facility may hold an individual who has been voluntarily admitted to a 24-hour facility pursuant to this Part for up to 72 hours after the individual submits a written request for discharge, but the facility shall release the individual upon the expiration of 72 hours following submission of the written request for discharge unless the responsible professional obtains an order under Part 7 or 8 of this Article to hold the client.
- (c) A health care agent named in a valid health care power of attorney may submit on behalf of an individual admitted to a facility under this Part a written request to have the individual discharged from the facility, provided (i) the individual remains incapable at the time of the request and (ii) the request is consistent with the authority expressed in the health care power of attorney. A facility may hold an individual for up to 72 hours after a health care agent submits a written request for the individual's discharge but shall release the individual upon the expiration of 72 hours following submission of the written request for discharge unless the responsible professional obtains an order under Part 7 or 8 of this Article to hold the client.
- (d) If, in the opinion of a physician or eligible psychologist, an individual admitted to a facility under this Part regains sufficient understanding and capacity to make and communicate mental health treatment decisions while in treatment, and the individual refuses to sign an authorization for continued treatment within 72 hours after regaining decisional capacity, the facility shall discharge the individual unless the responsible professional obtains an order under Part 7 or 8 of this Article to hold the client.
- (e) In any case in which an order is issued authorizing the involuntary commitment of an individual admitted to a facility under this Part, the facility's further treatment and holding of the individual shall be in accordance with Part 7 or 8 of this Article, whichever is applicable.

"§§ 122C-215 through 122C-220: Reserved for future codification purposes."

SECTION 15. G.S. 122C-221(a) reads as rewritten:

"(a) Except as otherwise provided in this Part, a minor may be admitted to a facility if the minor is mentally ill or a substance abuser and in need of treatment. Except as otherwise provided in this Part, the provisions of G.S. 122C-211 shall apply to admissions of minors under this Part. Except as provided in G.S. 90-21.5, in applying for admission to a facility, in consenting to medical treatment when consent is required, and in any other legal procedure under this Article, the legally responsible person shall act for the minor. The application for admission of the minor shall be in writing and signed by the legally responsible person. If a

minor reaches the age of 18 while in treatment under this Part, further treatment is authorized only on the written authorization of the client or under the provisions of Part 7 or Part 8 of Article 5 of this Chapter."

SECTION 16. G.S. 122C-224(c) reads as rewritten:

"(c) Within 24 hours after admission, the facility shall notify the clerk of court in the county where the facility is located that the minor has been admitted and that a hearing for concurrence in the admission must be scheduled. At the time notice is given to schedule a hearing, the facility shall (i) notify the clerk of the names and addresses of the legally responsible person and the responsible professional and (ii) provide the clerk with a copy of the legally responsible person's written application for admission of the minor and the facility's written evaluation of the minor, both of which are required under G.S. 122C-211(a)."

SECTION 17. Part 4 of Article 5 of Chapter 122C of the General Statutes is amended by adding a new section to read:

"§ 122C-230. Applicability of Part 4.

This Part applies to adults who are adjudicated incompetent by a court of competent jurisdiction. This Part does not apply to the admission of adults who are deemed incapable but who have not been adjudicated incompetent."

SECTION 18. G.S. 122C-232 reads as rewritten:

"§ 122C-232. Judicial determination.

- (a) When an incompetent adult is admitted to a 24-hour facility where the incompetent adult will be subjected to the same restrictions on his-freedom of movement present in the State facilities for the mentally ill, or to similar restrictions, a hearing shall be held in the district court in the county in which the 24-hour facility is located within 10 days of after the day that the incompetent adult is admitted to the facility. A continuance of not more than five days may be granted upon motion of:any of the following:
 - (1) The court; court.
 - (2) Respondent's counsel; or counsel.
 - (3) The responsible professional.

The Commission shall adopt rules governing procedures for admission to other 24-hour facilities not falling within the category of facilities where freedom of movement is restricted; these rules shall be designed to ensure that no incompetent adult is improperly admitted to or remains in a facility.

- (a1) Prior to admission, the facility shall provide the incompetent adult and the legally responsible person with written information describing the procedures for court review of the admission and the procedures for discharge.
- (a2) Within 24 hours after admission, the facility shall notify the clerk of court of the county in which the facility is located that the incompetent adult has been admitted and that a hearing for concurrence in the admission must be scheduled. At the time the facility provides notice to the court to schedule a hearing for concurrence, the facility shall notify the clerk of the names and addresses of the legally responsible person and the responsible professional and provide a copy of the legally responsible person's written application for evaluation or admission of the incompetent adult and the facility's evaluation of the incompetent adult.
- (b) In any case requiring the hearing described in subsection (a) of this section, no petition is necessary; the written application for voluntary admission shall serve as the initiating document for the hearing. The court shall determine whether the incompetent adult is mentally ill or a substance abuser and is in need of further treatment at the facility. Further treatment at the facility should be undertaken only when lesser measures will be insufficient. If the court finds by clear, cogent, and convincing evidence that these requirements have been met, the court shall concur with the voluntary admission of the incompetent adult and set the length of the authorized admission for a period not to exceed 90 days. If the court finds that these requirements have not been met, it shall order that the incompetent adult be released. A finding

of dangerousness to self or others is not necessary to support the determination that further treatment should be undertaken.

- (c) Unless otherwise provided in this Part, the hearing specified in subsection (a) of this section, including the provisions for representation of indigent incompetent adults, all subsequent proceedings, and conditional release are governed by the involuntary commitment procedures of Part 7 of this Article.
- (d) In addition to the notice of hearings and rehearings to the incompetent adult and his or her counsel required under Part 7 of this Article, notice shall be given by the clerk to the legally responsible person, person or his successor to the legally responsible person. The legally responsible person or his-a successor to the legally responsible person may also file with the clerk of court a written waiver of his the right to receive notice."

SECTION 19. G.S. 122C-251 reads as rewritten:

"§ 122C-251. Transportation. Custody and transportation.

- (a) Except as provided in subsections (f) and (g), transportation of a respondent within a county under the involuntary commitment proceedings of this Article, including admission and discharge, shall be provided by the city or county. The city has the duty to provide transportation of a respondent who is a resident of the city or who is can be taken into custody in the city limits. The county has the duty to provide transportation for a respondent who resides in the county outside city limits or who is can be taken into custody outside of city limits. However, cities and counties may contract with each other to provide transportation.
- (b) Except as provided in subsections (f) and (g) or in G.S. 122C-408(b), transportation between counties under the involuntary commitment proceedings of this Article for admission to a 24-hour facility shall be provided by the county where the respondent is taken into custody. Transportation between counties under the involuntary commitment proceedings of this Article for respondents held in 24-hour facilities who have requested a change of venue for the district court hearing shall be provided by the county where the petition for involuntary commitment was initiated. Transportation between counties under the involuntary commitment proceedings of this Article for discharge of a respondent from a 24-hour facility shall be provided by the county of residence of the respondent. However, a respondent being discharged from a facility may use his own transportation at his own expense. Transportation between counties under the involuntary commitment proceedings of this Article for a first examination at a location described in G.S. 122C-263(a) and G.S. 122C-238(a) shall be provided by the county where the respondent is taken into custody.
- (c) Transportation of a respondent may be (i) by city- or county-owned vehicles or vehicles, (ii) by private vehicle by contract with the city or county or (iii) as provided in a plan adopted under subsection (g) of this section. To the extent feasible, law enforcement officers transporting respondents shall dress in plain clothes and shall travel in unmarked vehicles. Further, law enforcement officers, to the extent possible feasible, shall advise respondents when taking them into custody that they are not under arrest and have not committed a crime, but are being taken into custody and transported to receive treatment and for their own safety and that of others.
- (d) To the extent feasible, in providing transportation of a respondent, a city or county shall provide a driver or attendant who is the same sex as the respondent, unless the law enforcement officer allows a family member of the respondent to accompany the respondent in lieu of an attendant of the same sex as the respondent.
- (e) In taking custody and providing transportation as required by this section, the law enforcement officer may not use reasonable force to restrain the respondent if unless it appears necessary to protect himself, the law enforcement officer, the respondent, or others. The law enforcement officer shall use the least restrictive and most reasonable restraint under the circumstances and afford the respondent as much dignity as the circumstances permit, taking into consideration the age, medical condition, special needs, and

- behavior of the respondent. To the extent feasible, the law enforcement officer's application of force or restraint shall avoid aggravating or worsening the respondent's preexisting injuries or medical conditions. To the extent feasible, the law enforcement officer shall consult a parent, caretaker, or other legally responsible person prior to restraining a minor. The law enforcement officer shall record on the return of service portion of the custody order the type of mechanical restraint used on a respondent, if any, when taking the respondent into custody or transporting the respondent. No law enforcement aw enforcement officer may be held criminally or civilly liable for assault, false imprisonment, or other torts or crimes on account of reasonable measures taken under the authority of this Article. The limitations and conditions in this subsection on the use of force and restraint do not apply to acute care hospitals or general hospitals and their employees or contractors when the use of force and restraint by these entities and persons is governed by rules for accreditation adopted by accrediting bodies that review these entities and persons for compliance with the accreditation rules.
- (f) Notwithstanding the provisions of subsections (a), (b), and (c) of this section, a clerk, a magistrate, or a district court judge, where applicable, may authorize the family or immediate friends of the respondent, if they so request, to transport the respondent in accordance with the procedures of this Article. This authorization shall only be granted in cases where the danger to the public, the family or friends of the respondent, or the respondent himself or herself is not substantial. The family or immediate friends of the respondent shall bear the costs of providing this transportation.
- The governing body of a city or county city, county, or LME/MCO may adopt a plan for the custody and transportation of respondents in involuntary commitment proceedings in-under this Article. Law enforcement personnel, The plan may designate law enforcement officers, volunteers, or other public or private agency personnel may be designated to provide all or parts of the custody and transportation required by involuntary commitment proceedings, proceedings, including taking a respondent into custody as ordered by a clerk of superior court or magistrate. Persons so designated shall be trained in accordance with G.S. 122C-202.2(a)(3) and the plan shall assure adequate safety and protections for both the public and the respondent. Law enforcement, Affected law enforcement agencies, acute care hospitals, magistrates, clerks of superior court, area facilities, other affected agencies, and the area authority shall participate in the planning. If any person other than a law enforcement agency is designated by a city or county, the person so designated Any person or agency designated by a city, county, or LME/MCO to provide all or parts of the custody and transportation required by involuntary commitment proceedings shall provide the custody and transportation and follow the procedures in this Article. References in this Article to a law-enforcement law enforcement officer apply to this person designated person or agency. A person shall not be designated without the consent of (i) the person or (ii) the agency that employs the person or contracts for the person's services. Counties and cities shall retain the responsibilities set forth in this Article, except as otherwise described in a plan developed and adopted pursuant this subsection.
- (h) The cost and expenses for custody and transportation of transporting a respondent to or from a 24-hour facility as required by the involuntary commitment procedures of this Article is the responsibility of the county of residence of the respondent unless otherwise provided in a plan adopted under subsection (g) of this section. The State (when providing transportation under G.S. 122C-408(b)), a city, or a county is entitled to recover the reasonable cost of transportation from the county of residence of the respondent. The county of residence of the respondent shall reimburse the State, another county, or a city the reasonable transportation costs incurred as authorized by this subsection. The county of residence of the respondent is entitled to recover the reasonable cost of transportation it has paid to the State, a city, or a county. Provided that the county of residence provides the respondent or other

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individual liable for the respondent's support a reasonable notice and opportunity to object to the reimbursement, the county of residence of the respondent may recover that cost from:

- (1) The respondent, if the respondent is not indigent;
- (2) Any person or entity that is legally liable for the resident's support and maintenance provided there is sufficient property to pay the cost;
- (3) Any person or entity that is contractually responsible for the cost; or
- (4) Any person or entity that otherwise is liable under federal, State, or local law for the cost."

SECTION 20. G.S. 122C-253 reads as rewritten:

"§ 122C-253. Fees under commitment order.

Nothing contained in Parts 6, 7, or 8 of this Article requires a private physician, private psychologist, commitment examiner, or private facility to accept a respondent as a client either before or after commitment. Treatment at a private facility or by a private physician orphysician, private psychologist psychologist, or commitment examiner is at the expense of the respondent to the extent that the charges are not disposed of by contract between the area authority and the private facility. An area authority and its contract agencies shall set and recover fees for inpatient or outpatient treatment services provided under a commitment order in accordance with G.S. 122C-146."

SECTION 21. G.S. 122C-255 reads as rewritten:

"§ 122C-255. Report required.

Beginning January 1, 2012, each Each 24-hour residential facility that (i) falls under the category of nonhospital medical detoxification, facility-based crisis service, or inpatient hospital treatment, (ii) is not a State facility under the jurisdiction of the Secretary of Health and Human Services, and (iii) is designated by the Secretary of Health and Human Services as a facility for the custody and treatment of individuals under a petition of involuntary commitment pursuant to G.S. 122C-252 and 10A NCAC 26C .0101 shall submit a written report on involuntary commitments each January 1 and each July 1 to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services. The report shall include all of the following:

- (1) The number and primary presenting conditions of individuals receiving treatment from the facility under a petition of involuntary commitment.
- (2) The number of individuals for whom an involuntary commitment proceeding was initiated at the facility, who were referred to a different facility or program.
- (3) The reason for referring the individuals described in subdivision (2) of this section to a different facility or program, including the need for more intensive medical supervision."

SECTION 22. G.S. 122C-261 reads as rewritten:

"§ 122C-261. Affidavit and petition before clerk or magistrate when immediate hospitalization is not necessary; custody order.

(a) Anyone who has knowledge of an individual who is mentally ill and either (i) dangerous to self, as defined in G.S. 122C-3(11)a., or dangerous to others, as defined in G.S. 122C-3(11)b., or (ii) in need of treatment in order to prevent further disability or deterioration that would predictably result in dangerousness, may appear before a clerk or assistant or deputy clerk of superior court or a magistrate and execute an affidavit to this effect, and petition the clerk or magistrate for issuance of an order to take the respondent into custody for examination by a physician or eligible psychologist.commitment examiner. The affidavit shall include the facts on which the affiant's opinion is based. If the affiant has knowledge or reasonably believes that the respondent, in addition to being mentally ill, is also mentally retarded, this fact shall be stated in the affidavit. Jurisdiction under this subsection is in the clerk or magistrate in the county where the respondent resides or is found.

- (b) If the clerk or magistrate finds reasonable grounds to believe that the facts alleged in the affidavit are true and that the respondent is probably mentally ill and either (i) dangerous to self, as defined in G.S. 122C-3(11)a., or dangerous to others, as defined in G.S. 122C-3(11)b., or (ii) in need of treatment in order to prevent further disability or deterioration that would predictably result in dangerousness, the clerk or magistrate shall issue an order to a law enforcement officer or any other person authorized under G.S. 122C-251 to take the respondent into custody for examination by a physician or eligible psychologist.commitment examiner. If the clerk or magistrate finds that, in addition to probably being mentally ill, the respondent is also probably mentally retarded, the clerk or magistrate shall contact the area authority before issuing a custody order and the area authority shall designate the facility to which the respondent is to be taken for examination by a physician or eligible psychologist.commitment examiner. The clerk or magistrate shall provide the petitioner and the respondent, if present, with specific information regarding the next steps that will occur for the respondent.

 (c) If the clerk or magistrate issues a custody order, the clerk or magistrate shall also
- (c) If the clerk or magistrate issues a custody order, the clerk or magistrate shall also make inquiry in any reliable way as to whether the respondent is indigent within the meaning of G.S. 7A-450. A magistrate shall report the result of this inquiry to the clerk.
- (d) If the affiant is a physician or eligible psychologist, commitment examiner, all of the following apply:
 - (1) The If the affiant has examined the respondent, the affiant may execute the affidavit before any official authorized to administer oaths. This affiant is not required to appear before the clerk or magistrate for this purpose. This affiant shall file the affidavit with the clerk or magistrate by delivering to the clerk or magistrate the original affidavit or affidavit, by transmitting a copy in paper form that is printed through the facsimile transmission of the affidavit affidavit, or by delivering the affidavit through electronic transmission. If the affidavit is filed through electronic or facsimile transmission, the affiant shall mail the original affidavit no later than five days after the facsimile transmission of the affidavit to the clerk or magistrate to be filed by the clerk or magistrate with the facsimile copy of the affidavit.
 - (2) This affiant's examination shall comply with the requirements of the initial examination as provided in G.S. 122C-263(c). The affiant shall document in writing and file the examination findings with the affidavit delivered to the clerk or magistrate in accordance with subdivision (d)(1) of this section.
 - If the physician or eligible psychologistcommitment examiner recommends (3) outpatient commitment according to the criteria for outpatient commitment set forth in G.S. 122C-263(d)(1) and the clerk or magistrate finds probable cause to believe that the respondent meets the criteria for outpatient commitment, the clerk or magistrate shall issue an order that a hearing before a district court judge be held to determine whether the respondent will be involuntarily committed. The physician or eligible psychologist shall provide the respondent with written notice of any scheduled appointment and the name, address, and telephone number of the proposed outpatient treatment physician or center. The physician or eligible psychologist The commitment examiner shall contact the local management entityLME/MCO that serves the county where the respondent resides or the local management entityLME/MCO that coordinated services for the respondent to inform the local management entityLME/MCO that the respondent is being recommended for outpatient commitment. The LME/MCO shall determine whether the respondent is a client of the LME/MCO or eligible for services through the LME/MCO and, if so, shall identify and schedule an

appointment with a proposed outpatient treatment physician or center and provide the commitment examiner with the name, address, and telephone number of the proposed outpatient treatment physician or center and the date and time that the respondent has been scheduled for an appointment with and the outpatient treatment physician or center. The commitment examiner shall provide the respondent with written notice of any scheduled appointment and the name, address, and telephone number of the proposed outpatient treatment physician or center.

- (4) If the physician or eligible psychologistcommitment examiner recommends inpatient commitment based on the criteria for inpatient commitment set forth in G.S. 122C-263(d)(2) and the clerk or magistrate finds probable cause to believe that the respondent meets the criteria for inpatient commitment, the clerk or magistrate shall issue an order to a law enforcement officer or any other person authorized under G.S. 122C-251(g) to take the respondent into custody for transportation to or custody at a 24-hour facility described in G.S. 122C-252; provided, however, that if a 24-hour facility is not immediately available or appropriate to the respondent's medical condition, the respondent may be temporarily detained under appropriate supervision and, upon further examination, released in accordance with G.S. 122C-263(d)(2).
- If the affiant is a physician or eligible psychologist at a 24-hour facility (5) described in G.S. 122C-252 who recommends inpatient commitment; the respondent is physically present on the premises of the same 24-hour facility; and the clerk or magistrate finds probable cause to believe that the respondent meets the criteria for inpatient commitment, then the clerk or magistrate may issue an order by facsimile transmission or may issue an electronically scanned order by electronic transmission to the physician or eligible psychologist at the 24-hour facility, or a designee, to take the respondent into custody at the 24-hour facility and proceed according to G.S. 122C-266. Upon receipt of the custody order, the physician or eligible psychologist at the 24-hour facility, or a designee, shall immediately (i) notify the respondent that the respondent is not under arrest and has not committed a crime but is being taken into custody to receive treatment and for the respondent's own safety and the safety of others, (ii) take the respondent into custody, and (iii) complete and sign the appropriate portion of the custody order and return the order to the clerk or magistrate either by facsimile transmission or by scanning it and sending it by electronic transmission. The physician or eligible psychologist, or a designee, shall mail the original custody order no later than five days after returning it by means of facsimile or electronic transmission to the clerk or magistrate. The clerk or magistrate shall file the original custody order with the copy of the custody order that was electronically returned.

Notwithstanding the provisions of this subdivision, a clerk or magistrate shall not issue a custody order to a physician or eligible psychologist at a 24-hour facility, or a designee, if the physician or eligible psychologist, or a designee, has not completed training in proper service and return of service. As used in this subdivision, the term "designee" includes the 24-hour facility's on-site police security personnel.

The Department of Health and Human Services shall cooperate and collaborate with the Administrative Office of the Courts and the UNC School of Government to develop protocols to implement this section,

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- including a procedure for notifying clerks and magistrates of the names of the physicians, psychologists, and designees who have completed the training. The Secretary of the Department shall oversee implementation of these protocols.
- If the clerk or magistrate finds probable cause to believe that the respondent, (6)in addition to being mentally ill, is also mentally retarded, the clerk or magistrate shall contact the area authority before issuing the order and the area authority shall designate the facility to which the respondent is to be transported.
- If a physician or eligible psychologist commitment examiner executes an (7)affidavit for inpatient commitment of a respondent, a second-physician who is not the commitment examiner who performed the examination under this section shall be required to perform the examination required by G.S. 122C-266.
- No commitment examiner, area facility, acute care hospital, general hospital, (8) or other site of first examination, or its officials, staff, employees, or other individuals responsible for the custody, examination, detention, management, supervision, treatment, or release of an individual examined for commitment and who follows accepted professional judgment, standards, and practice, shall be held liable in any civil or criminal action for taking reasonable measures to temporarily detain an individual for the period of time necessary to complete a commitment examination, submit an affidavit to the magistrate or clerk of court, and await the issuance of a custody order as authorized by subsection (d) of this section, as long as the commitment examiner has a reasonable and good-faith belief that detention pending the examination and issuance of a custody order is necessary to protect the individual or others from bodily harm or life endangerment. If the individual is temporarily detained under the circumstances described in this subdivision, the examiner shall certify in the affidavit delivered to the clerk or magistrate in accordance with subdivision (d)(1) of this section the reason the individual requires temporary detention pending the issuance of a custody order.
- Except as provided in subdivision (5) of subsection (d) of this section, upon receipt of the custody order of the clerk or magistrate or a custody order issued by the court pursuant to G.S. 15A-1003, a law enforcement officer or other person designated in the order shall take the respondent into custody within 24 hours after the order is signed, and proceed according to G.S. 122C-263. The custody order is valid throughout the State.
- When a petition is filed for an individual who is a resident of a single portal area, the procedures for examination by a physician or eligible psychologist as set forth in G.S. 122C-263 shall be carried out in accordance with the area plan. Prior to issuance of a custody order for a respondent who resides in an area authority with a single portal plan, the clerk or magistrate shall communicate with the area authority to determine the appropriate 24 hour facility to which the respondent should be admitted according to the area plan or to determine if there are more appropriate resources available through the area authority to assist the petitioner or the respondent. When an individual from a single portal area is presented for commitment at a 24 hour area or State facility directly, the individual may not be accepted for admission until the facility notifies the area authority and the area authority agrees to the admission. If the area authority does not agree to the admission, it shall determine the appropriate 24 hour facility to which the individual should be admitted according to the area plan or determine if there are more appropriate resources available through the area authority to assist the individual. If the area authority agrees to the admission, further planning of treatment

for the client is the joint responsibility of the area authority and the facility as prescribed in the area plan.

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Notwithstanding the provisions of this section, in no event shall an individual known or reasonably believed to be mentally retarded be admitted to a State psychiatric hospital, except as follows:

- (1) Persons described in G.S. 122C-266(b);
- (2) Persons admitted pursuant to G.S. 15A-1321;
- (3) Respondents who are so extremely dangerous as to pose a serious threat to the community and to other patients committed to non-State hospital psychiatric inpatient units, as determined by the Director of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services or his designee; and
- (4) Respondents who are so gravely disabled by both multiple disorders and medical fragility or multiple disorders and deafness that alternative care is inappropriate, as determined by the Director of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services or his designee.

Individuals transported to a State facility for the mentally ill who are not admitted by the facility may be transported by law enforcement officers or designated staff of the State facility in State-owned vehicles to an appropriate 24-hour facility that provides psychiatric inpatient care.

No later than 24 hours after the transfer, the responsible professional at the original facility shall notify the petitioner, the clerk of court, and, if consent is granted by the respondent, the next of kin, that the transfer has been completed."

SECTION 23. G.S. 122C-262 reads as rewritten:

"§ 122C-262. Special emergency procedure for individuals needing immediate hospitalization.

- (a) Anyone, including a law enforcement officer, who has knowledge of an individual who is subject to inpatient commitment according to the criteria of G.S. 122C-261(a)G.S. 122C-263(d)(2) and who requires immediate hospitalization to prevent harm to self or others, may transport the individual directly to an area facility or other place, including a State facility for the mentally ill, for examination by a physician or eligible psychologistcommitment examiner in accordance with G.S. 122C-263(c).
- (b) Upon examination by the physician or eligible psychologist, commitment examiner, if the individual meets the <u>inpatient commitment</u> criteria <u>required specified</u> in G.S. 122C-261(a), the physician or eligible psychologist G.S. 122C-263(d)(2) and requires immediate hospitalization to prevent harm to self or others, the commitment examiner shall so certify in writing before any official authorized to administer oaths. The certificate shall also state the reason that the individual requires immediate hospitalization. If the physician or eligible psychologistcommitment examiner knows or has reason to believe that the individual is mentally retarded, the certificate shall so state.
- (c) If the physician or eligible psychologistcommitment examiner executes the oath, appearance before a magistrate shall be waived. The physician or eligible psychologistcommitment examiner shall send a copy of the certificate to the clerk of superior court by the most reliable and expeditious means. If it cannot be reasonably anticipated that the clerk will receive the copy within 24 hours, excluding Saturday, Sunday, and holidays, of the time that it was signed, the physician or eligible psychologistcommitment examiner shall also communicate the findings to the clerk by telephone.
- (d) Anyone, including a law enforcement officer if necessary, may transport the individual to a 24-hour facility described in G.S. 122C-252 for examination and treatment pending a district court hearing. If there is no area 24-hour facility and if the respondent is

indigent and unable to pay for care at a private 24-hour facility, the law enforcement officer or other designated person providing transportation shall take the respondent to a State facility for the mentally ill designated by the Commission in accordance with G.S. 143B-147(a)(1)a and immediately notify the clerk of superior court of this action. The physician's or eligible psychologist'scommitment examiner's certificate shall serve as the custody order and the law enforcement officer or other designated person shall provide transportation in accordance with the provisions of G.S. 122C-251. If a 24-hour facility is not immediately available or appropriate to the respondent's medical condition, the respondent may be temporarily detained under appropriate supervision in accordance with G.S. 122C-263(d)(2) and released in accordance with G.S. 122C-263(d)(2).

In the event an individual known or reasonably believed to be mentally retarded is transported to a State facility for the mentally ill, in no event shall that individual be admitted to that facility except as follows:

- (1) Persons described in G.S. 122C-266(b);
- (2) Persons admitted pursuant to G.S. 15A-1321;
- (3) Respondents who are so extremely dangerous as to pose a serious threat to the community and to other patients committed to non-State hospital psychiatric inpatient units, as determined by the Director of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services or his designee; and
- (4) Respondents who are so gravely disabled by both multiple disorders and medical fragility or multiple disorders and deafness that alternative care is inappropriate, as determined by the Director of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services or his designee.

Individuals transported to a State facility for the mentally ill who are not admitted by the facility may be transported by law enforcement officers or designated staff of the State facility in State-owned vehicles to an appropriate 24-hour facility that provides psychiatric inpatient care.

No later than 24 hours after the transfer, the responsible professional at the original facility shall notify the petitioner, the clerk of court, and, if consent is granted by the respondent, the next of kin, that the transfer has been completed.

- (e) Respondents received at a 24-hour facility under the provisions of this section shall be examined by a second physician in accordance with G.S. 122C-266. After receipt of notification that the district court has determined reasonable grounds for the commitment, further proceedings shall be carried out in the same way as for all other respondents under this Part.
- (f) If, upon examination of a respondent presented in accordance with subsection (a) of this section, the commitment examiner finds that the individual meets the criteria for inpatient commitment specified in G.S. 122C-263(d)(2) but does not require immediate hospitalization to prevent harm to self or others, the commitment examiner may petition the clerk or magistrate in accordance with G.S. 122C-261(d) for an order to take the individual into custody for transport to a 24-hour facility described in G.S. 122C-252. If the commitment examiner recommends inpatient commitment and the clerk or magistrate finds probable cause to believe that the respondent meets the criteria for inpatient commitment, the clerk or magistrate shall issue an order for transport to or custody at a 24-hour facility described in G.S. 122C-252; provided, however, that if a 24-hour facility is not immediately available or appropriate to the respondent's medical condition, the respondent may be temporarily detained under appropriate supervision in accordance with G.S. 122C-263(d)(2) and released in accordance with

G.S. 122C-263(d)(2).

(g) This section applies exclusively to an individual who is transported to an examination by a commitment examiner in accordance with subsection (a) of this section."

SECTION 24. G.S. 122C-263 reads as rewritten:

"§ 122C-263. Duties of law-enforcement law enforcement officer; first examination by physician or eligible psychologist.examination.

- Without unnecessary delay after assuming custody, the law enforcement officer or the individual designated by the clerk or magistrate under G.S. 122C-251(g) to provide transportation shall take the respondent to an area facility identified by the LME/MCO in the community crisis services plan adopted pursuant to G.S. 122C-202.2 for examination by a physician or eligible psychologist; if a physician or eligible psychologist commitment examiner. If an area facility identified in the plan or one of its commitment examiners is not available in the area facility, available, or if there is no area facility identified in the plan, the person designated to provide transportation shall take the respondent to any physician or eligible psychologist locally available. If a physician or eligible psychologist acute care hospital identified by the LME/MCO in the community crisis services plan adopted pursuant to G.S. 122C-202.2. If a commitment examiner is not immediately available, available in such area facility or acute care hospital, the respondent may be temporarily detained in an area facility, if one is available; if an area facility is not available, the respondent may be detained under appropriate supervision in the respondent's home, in a private hospital or a clinic, in a general hospital, or in a State facility for the mentally ill, under appropriate supervision in such area facility or acute care hospital but not in a jail or other penal facility. If no identified facility or acute care hospital is available, the law enforcement officer or other designated individual shall transport the respondent to any commitment examiner available in a private hospital or clinic, a general hospital, or a State facility for the mentally ill.
- (a1) An area facility that is identified by the LME/MCO in accordance with G.S. 122C 202.2 as a site for conducting first examinations under subsection (a) of this section shall be capable of performing a medical screening examination of the respondent that consists of a history and physical appropriate to the respondent's complaint or condition, with ancillary testing as necessary. The medical screening examination shall be conducted by a physician or other individual who is determined by the area facility to be qualified to perform the medical screening and is practicing within the scope of his or her licensure. The respondent may either be in the physical face to face presence of the medical screening examiner or may be examined utilizing telemedicine equipment and procedures. If the area facility in subsection (a) of this section determines that an individual qualified to perform a medical screening examination appropriate to the respondent's complaint or condition is not available on-site or via telemedicine, the area facility shall identify and contact another area facility that is capable of performing the medical screening, or an acute care hospital, and the law enforcement officer or other designated person shall transport the respondent to the identified facility or hospital.
- (a2) The responsible professional at an area facility or other site of first examination may transfer a respondent to an acute care hospital for emergency medical treatment, emergency medical evaluation, emergency surgery, or other medical treatment that the site of first examination is unable to provide by directing the law enforcement officer or other person designated under G.S. 122C 251(g) to transport the respondent to an identified acute care hospital. When the respondent is transferred solely for medical reasons, the original facility shall accept the return of the respondent and the respondent shall be returned to the original facility after the medical care is completed unless the responsible professionals at both facilities concur that the respondent no longer meets the criteria for commitment and recommend that the commitment proceedings be terminated. Any decision to terminate the proceedings shall be documented and reported to the clerk of superior court in accordance with subsection (e) of this section.

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- The examination set forth in subsection (a) of this section is not required if:under (b) any of the following circumstances:
- The affiant who obtained the custody order is a physician or eligible (1) psychologist commitment examiner who recommends commitment; commitment.
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- (2) The custody order states that the respondent was charged with a violent crime, including a crime involving assault with a deadly weapon, and he the respondent was found incapable of proceeding; or proceeding.
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Repealed by Session Laws 1987, c. 596, s. 3. (3)

10 11 In any of these cases, the law enforcement law enforcement officer shall take the respondent directly to a 24-hour facility described in G.S. 122C-252.

The physician or eligible psychologist commitment examiner described in subsection (a) of this section shall examine the respondent as soon as possible, and in any event within 24 hours, hours after the respondent is presented for examination. When the examination set forth in subsection (a) of this section is performed by a physician or eligible psychologist commitment examiner, the respondent may either be in the physical face-to-face presence of the physician or eligible psychologist commitment examiner or may be examined telemedicine equipment and procedures. A physician or eligible psychologist commitment examiner who examines a respondent by means of telemedicine must be satisfied to a reasonable medical certainty that the determinations made in accordance with subsection (d) of this section would not be different if the examination had been done in the physical presence of the physician or eligible psychologist. A physician or eligible psychologist commitment examiner. A commitment examiner who is not so satisfied must note that the examination was not satisfactorily accomplished, and the respondent must be taken for a face-to-face examination in the physical presence of a person authorized to perform examinations under this section. As used in this subsection, section, "telemedicine" is the use of two-way real-time interactive audio and video between places of lesser and greater medical capability or expertise to provide and support health care when distance separates participants who are in different geographical locations. A recipient is referred by one provider to receive the services of another provider via telemedicine.

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> The examination shall include but is not limited to an assessment of the respondent's:at least all of the following with respect to the respondent:

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Current and previous mental illness and mental retardation including, if (1) available, previous treatment history; history. Dangerousness to self, as defined in G.S. 122C-3(11)a. or others, as defined (2)

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in G.S. 122C-3(11)b.; G.S. 122C-3(11)b. Ability to survive safely without inpatient commitment, including the (3) availability of supervision from family, friends or others; and others.

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Capacity to make an informed decision concerning treatment. (4)

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After of the examination physician or eligible conclusion the (d) psychologistcommitment examiner shall make the following determinations:

42 43 (1) If the physician or eligible psychologistcommitment examiner finds that:all of the following:

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The respondent is mentally ill; ill. a.

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The respondent is capable of surviving safely in the community with b. available supervision from family, friends, or others; others.

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Based on the respondent's psychiatric history, the respondent is in c. need of treatment in order to prevent further disability or deterioration that would predictably result in dangerousness as defined by G.S. 122C-3(11); and G.S. 122C-3(11).

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d. The respondent's current mental status or the nature of the respondent's illness limits or negates the respondent's ability to make an informed decision to seek voluntarily or comply with recommended treatment.

The physician or eligible psychologistcommitment examiner shall so show on the examination report and shall recommend outpatient commitment. In addition the examining physician or eligible psychologistcommitment examiner shall show the name, address, and telephone number of the proposed outpatient treatment physician or eenter.center in accordance with subsection (f) of this section. The person designated in the order to provide transportation shall return the respondent to the respondent's regular residence or, with the respondent's consent, to the home of a consenting individual located in the originating county, and the respondent shall be released from custody.

If the physician or eligible psychologist commitment examiner finds that the respondent is mentally ill and is dangerous to self, as defined in G.S. 122C-3(11)a., or others, as defined in G.S. 122C-3(11)b., the physician or eligible psychologist commitment examiner shall recommend inpatient commitment, and shall so show on the examination report. If, in addition to and dangerousness, the physician or eligible psychologist commitment examiner also finds that the respondent is known or reasonably believed to be mentally retarded, this finding shall be shown on the report. The Without unnecessary delay, and in any event within six hours after the comment examiner's finding and recommendation, the law enforcement officer or other designated person shall take the respondent to a 24-hour facility described in G.S. 122C-252 pending a district court hearing. If there is no area 24-hour facility and if the respondent is indigent and unable to pay for care at a private 24-hour facility, the law enforcement officer or other designated person shall take the respondent to a State facility for the mentally ill designated by the Commission in accordance with G.S. 143B-147(a)(1)a. for custody, observation, and treatment and immediately notify the clerk of superior court of this action. If a 24-hour facility is not immediately available or appropriate to the respondent's medical condition, the respondent may be temporarily detained under appropriate supervision at the site of the first examination, provided that at anytime that a physician or eligible psychologistexamination. Upon the commitment examiner's determination that a 24-hour facility is available and medically appropriate, the law enforcement officer or other designated person shall commence transporting the respondent without unnecessary delay and, in any event, within six hours after receiving a request for transportation by the commitment examiner. At any time during the respondent's temporary detention under appropriate supervision, if a commitment examiner determines that the respondent is no longer in need of inpatient commitment, the proceedings shall be terminated and the respondent transported and released in accordance with subdivision (3) of this subsection. However, if the physician or eligible psychologist commitment examiner determines that the respondent meets the criteria for outpatient commitment, as defined in subdivision (1) of this subsection, the physician or eligible psychologist commitment examiner may recommend outpatient commitment, and the respondent shall be transported and released in accordance with subdivision (1) of this subsection. Any

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commitment after an initial recommendation of inpatient commitment shall be documented and reported to the clerk of superior court in accordance with subsection (e) of this section. If the respondent is temporarily detained and a 24-hour facility is not available or medically appropriate seven days after the issuance of the custody order, a physician or psychologist commitment examiner shall report this fact to the clerk of superior court and the proceedings shall be terminated. Termination of proceedings pursuant to this subdivision shall not prohibit or prevent the initiation of new involuntary commitment proceedings when appropriate. A commitment examiner may initiate a new involuntary commitment proceeding prior to the expiration of this seven-day period, as long as the respondent continues to meet applicable criteria. Affidavits filed in support of proceedings terminated pursuant to this subdivision may not be submitted in support of any subsequent petitions for involuntary commitment. If the affiant initiating new commitment proceedings is a physician or eligible psychologist commitment examiner, the affiant shall conduct a new examination and may not rely upon examinations conducted as part of proceedings terminated pursuant to this subdivision. In the event an individual known or reasonably believed to be mentally

decision to terminate the proceedings or to recommend outpatient

In the event an individual known or reasonably believed to be mentally retarded is transported to a State facility for the mentally ill, in no event shall that individual be admitted to that facility except as follows:

- a. Persons described in G.S. 122C-266(b);
- b. Persons admitted pursuant to G.S. 15A-1321;
- c. Respondents who are so extremely dangerous as to pose a serious threat to the community and to other patients committed to non-State hospital psychiatric inpatient units, as determined by the Director of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services or his designee; and
- d. Respondents who are so gravely disabled by both multiple disorders and medical fragility or multiple disorders and deafness that alternative care is inappropriate, as determined by the Director of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services or his designee.

Individuals transported to a State facility for the mentally ill who are not admitted by the facility may be transported by law enforcement officers or designated staff of the State facility in State-owned vehicles to an appropriate 24-hour facility that provides psychiatric inpatient care.

No later than 24 hours after the transfer, the responsible professional at the original facility shall notify the petitioner, the clerk of court, and, if consent is granted by the respondent, the next of kin, that the transfer has been completed.

- (3) If the physician or eligible psychologistcommitment examiner finds that neither condition described in subdivisions (1) or (2) of this subsection exists, the proceedings shall be terminated. The person designated in the order to provide transportation shall return the respondent to the respondent's regular residence or, with the respondent's consent, to the home of a consenting individual located in the originating county and the respondent shall be released from custody.
- (e) The findings of the physician or eligible psychologistcommitment examiner and the facts on which they are based shall be in writing in all cases. The physician or eligible

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psychologistcommitment examiner shall send a copy of the findings to the clerk of superior court by the most reliable and expeditious means. If it cannot be reasonably anticipated that the clerk will receive the copy within 48 hours of the time that it was signed, the physician or eligible psychologistcommitment examiner shall also communicate his findings to the clerk by telephone.

- When outpatient commitment is recommended, the examining physician or eligible psychologist, commitment examiner, if different from the proposed outpatient treatment physician or center, shall give the respondent a written notice listing the name, address, and telephone number of the proposed outpatient treatment physician or center and directing the respondent to appear at the address at a specified date and time. The examining physician or eligible psychologist before the appointment shall notify by telephone the designated outpatient treatment physician or center and shall send a copy of the notice and his examination report to the physician or center shall contact the LME/MCO that serves the county where the respondent resides or the LME/MCO that coordinated services for the respondent to inform the LME/MCO that the respondent is being recommended for outpatient commitment. The LME/MCO shall determine whether the respondent is a client of the LME/MCO or eligible for services through the LME/MCO and, if so, shall identify and schedule an appointment with a proposed outpatient treatment physician or center and provide the commitment examiner with the name, address, and telephone number of the proposed outpatient treatment physician or center and the date and time the respondent has been scheduled for an appointment with the outpatient treatment physician or center. The commitment examiner shall give the respondent a written notice listing the name, address, and telephone number of the proposed outpatient treatment physician or center and directing the respondent to appear at the address at a specified date and time. Prior to the appointment, the commitment examiner shall notify by telephone the designated outpatient treatment physician or center and shall send a copy of the notice and the commitment examiner's examination report to the physician or center.
- (g) The physician or eligible psychologist, commitment examiner, at the completion of the examination, shall provide the respondent with specific information regarding the next steps that will occur."

SECTION 25. G.S. 122C-263.1 reads as rewritten:

- "§ 122C-263.1. Secretary's authority to waive requirement of first examination by physician or eligible psychologist; certify commitment examiners; training of certified providers commitment examiners performing first examinations. examinations; LME/MCO responsibilities.
- (a) Physicians and eligible psychologists are qualified to perform the commitment examinations required under G.S. 122C-263(c) and G.S. 122C-283(c). The Secretary of Health and Human Services may, upon request of an LME, waive the requirements of G.S. 122C-261 through G.S. 122C-263 and G.S. 122C-281 through G.S. 122C-283 pertaining to initial (first level) examinations by a physician or eligible psychologist of individuals meeting the eriteria of G.S. 122C-261(a) or G.S. 122C-281(a), as applicable, as follows:may individually certify to perform the first commitment examinations required by G.S. 122C-261 through G.S. 122C-263 and G.S. 122C-281 through G.S. 122C-283, other health, mental health, and substance abuse professionals whose scope of practice includes diagnosing and documenting psychiatric or substance use disorders and conducting mental status examinations to determine capacity to give informed consent to treatment as follows:
 - (1) The Secretary has received a request from an LME to substitute for a physician or eligible psychologist, request:
 - <u>a.</u> <u>To certify</u> a licensed clinical social worker, a master's level <u>psychiatric nurse</u>, <u>or nurse practitioner</u>, a licensed professional <u>counselor</u>, or a physician's assistant to conduct the first examinations <u>described in G.S. 122C-263(c) and G.S. 122C-283(c)</u>.

1		<u>b.</u> <u>To certify</u> a master's level <u>certified</u> <u>licensed</u> clinical addictions
2		specialist in accordance with subdivision (8) of this subsection to
3		conduct the initial (first-level) examinations of individuals meeting
4		the criteria of G.S. 122C-261(a) or G.S. 122C-281(a). In making this
5		type of request, the LME shall specifically describe all of the
6		following:to conduct the first examination described in
7		G.S. 122C-283(c).
8		a. How the purpose of the statutory requirement would be better served
9		by waiving the requirement and substituting the proposed change
10		under the waiver.
11		b. How the waiver will enable the LME to improve the delivery or
12		management of mental health, developmental disabilities, and
13		substance abuse services.
14		e. How the health, safety, and welfare of individuals will continue to be
15		at least as well protected under the waiver as under the statutory
16		requirement.
17	(2)	The Secretary shall review the request and may approve it upon finding all
18	(2)	of the following:
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20		b. The request furthers the purposes of State policy under G.S. 122C-2
21		and mental health, developmental disabilities, and substance abuse
22		services reform.
23		c. The request improves the delivery of mental health, developmental
24		disabilities, and substance abuse services in the counties affected by
25		the waiver and also protects the health, safety, and welfare of
26		individuals receiving these services.
27		d. The Department determines that the applicant possesses the
28		professional licensure, registration, or certification to qualify the
29		applicant as a professional whose scope of practice includes
30		diagnosing and documenting psychiatric or substance use disorders
31		and conducting mental status examinations to determine capacity to
32		give informed consent to treatment.
33		e. The applicant for certification has successfully completed the
34		Department's standardized training program for involuntary
35		commitment and has successfully passed the examination for that
36		program.
37	(3)	The Secretary shall evaluate the effectiveness, quality, and efficiency of
38	. ,	mental health, developmental disabilities, and substance abuse services and
39		protection of health, safety, and welfare under the waiver.
40	(4)	A waiver certification granted by the Secretary under this section shall be in
41	()	effect for a period of up to three years and may be rescinded at any time
42		within this period if the Secretary finds the LME certified individual has
43		failed to meet the requirements of this section. Certification may be renewed
44		every three years upon completion of a refresher training program approved
45		by the Department.
46	(5)	In no event shall the substitution certification of a licensed clinical social
47		worker, master's level psychiatric nurse, nurse practitioner, licensed
48		professional counselor, physician assistant, or master's level certified clinical
49		addictions specialist under a waiver granted under this section be construed
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as authorization to expand the scope of practice of the licensed clinical social

worker, the master's level psychiatric nurse, nurse practitioner, licensed

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- professional counselor, physician assistant, or the master's level certified clinical addictions specialist.
- The Department shall require that individuals performing certified to perform initial examinations under the waiver havethis section have successfully completed the Department's standardized involuntary commitment training program and examination. The Department shall maintain a list of these individuals on its Internet Web site.
- (7) As part of its waiver request, the LME shall document the availability of a physician to provide backup support.
- (7a) No less than annually, the Department shall submit a list of certified first commitment examiners to the Chief District Court Judge of each judicial district in North Carolina and maintain a current list of certified first commitment examiners on its Internet Web site.
- (8) A master's level <u>certified-licensed</u> clinical addiction specialist shall only be authorized to conduct the initial examination of individuals meeting the criteria of G.S. 122C-281(a).
- (b) The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services—Department shall expand its standardized certification training program to include refresher training for all certified providers performing initial examinations pursuant to subsection (a) of this section."

SECTION 26. G.S. 122C-264 reads as rewritten:

"§ 122C-264. Duties of clerk of superior court and the district attorney.

- (a) Upon receipt of a physician's or eligible psychologist's commitment examiner's finding that the respondent meets the criteria of G.S. 122C-263(d)(1) and that outpatient commitment is recommended, the clerk of superior court of the county where the petition was initiated, upon direction of a district court judge, shall calendar the matter for hearing and shall notify the respondent, the proposed outpatient treatment physician or center, and the petitioner of the time and place of the hearing. The petitioner may file a written waiver of his right to notice under this subsection with the clerk of court.
- (b) Upon receipt by the clerk of superior court pursuant to G.S. 122C-266(c) of a physician's or eligible psychologist's finding that a respondent meets the criteria of G.S. 122C-263(d)(2) and that inpatient commitment is recommended, the clerk of superior court of the county where the 24-hour facility is located shall, after determination required by G.S. 122C-261(c) and upon direction of a district court judge, assign counsel if necessary, calendar the matter for hearing, and notify the respondent, his counsel, and the petitioner of the time and place of the hearing. The petitioner may file a written waiver of his right to notice under this subsection with the clerk of court.
- (b1) Upon receipt of a physician's or eligible psychologist's commitment examiner's certificate that a respondent meets the criteria of G.S. 122C-261(a) and that immediate hospitalization is needed pursuant to G.S. 122C-262, the clerk of superior court of the county where the treatment facility is located shall submit the certificate to the Chief District Court Judge. The court shall review the certificate within 24 hours, excluding Saturday, Sunday, and holidays, for a finding of reasonable grounds in accordance with 122C-261(b). The clerk shall notify the treatment facility of the court's findings by telephone and shall proceed as set forth in subsections (b), (c), and (f) of this section.

SECTION 27. G.S. 122C-265 reads as rewritten:

"§ 122C-265. Outpatient commitment; examination and treatment pending hearing.

(a) If a respondent, who has been recommended for outpatient commitment by an examining physician or eligible psychologist a commitment examiner different from the proposed outpatient treatment physician or center, fails to appear for examination by the

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proposed outpatient treatment physician or center at the designated time, the physician or center shall notify the clerk of superior court who shall issue an order to a law-enforcement officer or other person authorized under G.S. 122C-251 to take the respondent into custody and take him immediately to the outpatient treatment physician or center for evaluation. The custody order is valid throughout the State. The law-enforcement officer may wait during the examination and return the respondent to his home after the examination.

- (b) The examining physician commitment examiner or the proposed outpatient treatment physician or center may prescribe to the respondent reasonable and appropriate medication and treatment that are consistent with accepted medical standards pending the district court hearing.
- (c) In no event may a respondent released on a recommendation that he <u>or she</u> meets the outpatient commitment criteria be physically forced to take medication or forceably detained for treatment pending a district court hearing.
- (d) If at any time pending the district court hearing the outpatient treatment physician or center determines that the respondent does not meet the criteria of G.S. 122C-263(d)(1), he-the physician shall release the respondent and notify the clerk of court and the proceedings shall be terminated.
- (e) If a respondent becomes dangerous to himself, self, as defined in G.S. 122C-3(11)a., or others, as defined in G.S. 122C-3(11)b., pending a district court hearing on outpatient commitment, new proceedings for involuntary inpatient commitment may be initiated.
- (f) If an inpatient commitment proceeding is initiated pending the hearing for outpatient commitment and the respondent is admitted to a 24-hour facility to be held for an inpatient commitment hearing, notice shall be sent by the clerk of court in the county where the respondent is being held to the clerk of court of the county where the outpatient commitment was initiated and the outpatient commitment proceeding shall be terminated."

SECTION 28. G.S. 122C-266(a)(2) reads as rewritten:

If the physician finds that the respondent meets the criteria for outpatient commitment under G.S. 122C-263(d)(1), the physician shall show these findings on the physician's examination report, release the respondent pending the district court hearing, and notify the clerk of superior court of the county where the petition was initiated of these findings. In addition, the examining physician shall show on the examination report the name, address, and telephone number of the proposed outpatient treatment physician or center. The physician shall contact the LME/MCO that serves the county in which the respondent resides or that coordinated services for the respondent to inform the LME/MCO that the respondent is being recommended for outpatient commitment. The LME/MCO shall determine whether the respondent is a client of the LME/MCO or eligible for services through the LME/MCO and, if so, shall identify and schedule an appointment with a proposed outpatient treatment physician or center and provide the commitment examiner with the name, address, and telephone number of the proposed outpatient treatment physician or center and the date and time that the respondent has been scheduled for an appointment with the outpatient treatment physician or center. The physician shall give the respondent a written notice listing the name, address, and telephone number of the proposed outpatient treatment physician or center and directing the respondent to appear at that address at a specified date and time. The examining physician before the appointment shall notify by telephone and shall send a copy of the notice and the examination report to the proposed outpatient treatment physician or center."

SECTION 29. G.S. 122C-267(c) reads as rewritten:

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"(c) Certified copies of reports and findings of physicians and psychologists commitment examiners and medical records of previous and current treatment are admissible in evidence."

SECTION 30. G.S. 122C-268 reads as rewritten:

"§ 122C-268. Inpatient commitment; district court hearing.

- A hearing shall be held in district court within 10 days of the day the respondent is taken into law enforcement custody pursuant to G.S. 122C-261(e) or G.S. 122C-262. If a respondent temporarily detained under G.S. 122C-263(d)(2) is subject to a series of successive custody orders issued pursuant to G.S. 122C-263(d)(2), the hearing shall be held within 10 days after the day that the respondent is taken into custody under the most recent custody order. A continuance of not more than five days may be granted upon motion of: of any of the following:
 - (1) The court; court.
 - (2) Respondent's counsel; or counsel.
 - (3) The State, sufficiently in advance to avoid movement of the respondent.

Certified copies of reports and findings of physicians and psychologists commitment examiners and previous and current medical records are admissible in evidence, but the respondent's right to confront and cross-examine witnesses may not be denied.

Hearings may To the extent feasible, hearings shall be held in an appropriate room not used for treatment of clients at the facility in which the respondent is being treated if it in a manner approved by the chief district court judge if the facility is located within the presiding judge's district court district as defined in G.S. 7A-133, by interactive videoconferencing between a treatment facility and a courtroom, or G.S. 7A-133. Hearings may be held in the judge's chambers. A hearing may not be held in a regular courtroom, over objection of the respondent, if in the discretion of a judge a more suitable place is available. A hearing may be held by audio and video transmission between the treatment facility and a courtroom in a manner that allows (i) the judge and the respondent to see and hear each other and (ii) the respondent to communicate fully and confidentially with the respondent's counsel during the proceeding. Prior to any hearing held by audio and video transmission, the chief district court judge shall submit to the Administrative Office of the Courts the procedures and type of equipment for audio and video transmission for approval by the Administrative Office of the Courts. Notwithstanding the provisions of this subsection, if the respondent, through counsel, objects to a hearing held by audio and video transmission, the hearing shall be held in the physical presence of the presiding district court judge. Regardless of the manner and location for hearings, hearings shall be held in a manner that complies with any applicable federal and State laws governing the confidentiality and security of confidential information, including any information transmitted from the treatment facility by audio and video transmission. 11

SECTION 31. G.S. 122C-271 reads as rewritten: "§ 122C-271. Disposition.

If an examining physician or eligible psychologista commitment examiner has recommended outpatient commitment and the respondent has been released pending the district court hearing, the court may make one of the following dispositions:

> If the court finds by clear, cogent, and convincing evidence that the (1) respondent is mentally ill; that he is capable of surviving safely in the community with available supervision from family, friends, or others; that based on respondent's treatment history, the respondent is in need of treatment in order to prevent further disability or deterioration that would predictably result in dangerousness as defined in G.S. 122C-3(11); and that the respondent's current mental status or the nature of his illness limits or negates his ability to make an informed decision to seek voluntarily or

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- comply with recommended treatment, it may order outpatient commitment for a period not in excess of 90 days.
- (2) If the court does not find that the respondent meets the criteria of commitment set out in subdivision (1) of this subsection, the respondent shall be discharged and the facility at which he was last a clientproposed outpatient physician or center so notified.
- (3) Before ordering any outpatient commitment under this subsection, the court shall make findings of fact as to the availability of outpatient treatment from an outpatient treatment physician or center that has agreed to accept the respondent as a client of outpatient treatment services. The court shall show on the order the outpatient treatment physician or center that is to be responsible for the management and supervision of the respondent's outpatient commitment. If the designated outpatient treatment physician or center will be monitoring and supervising the respondent's outpatient commitment pursuant to a contract for services with an LME/MCO, the court shall show on the order the identity of the LME/MCO. The clerk of court shall send a copy of the outpatient commitment order to the designated outpatient treatment physician or center and to the respondent client or the legally responsible person. If the designated outpatient treatment physician or center will be monitoring and supervising the respondent's outpatient commitment pursuant to a contract for services with an LME/MCO, the clerk of court shall also send a copy of the order to that LME/MCO. Copies of outpatient commitment orders sent by the clerk of court to an outpatient treatment center or physician under this section, including orders sent to an LME/MCO, shall be sent by the most reliable and expeditious means, but in no event less than 48 hours after the hearing.
- (b) If the respondent has been held in a 24-hour facility pending the district court hearing pursuant to G.S. 122C-268, the court may make one of the following dispositions:
 - (1) If the court finds by clear, cogent, and convincing evidence that the respondent is mentally ill; that the respondent is capable of surviving safely in the community with available supervision from family, friends, or others; that based on respondent's psychiatric history, the respondent is in need of treatment in order to prevent further disability or deterioration that would predictably result in dangerousness as defined by G.S. 122C-3(11); and that the respondent's current mental status or the nature of the respondent's illness limits or negates the respondent's ability to make an informed decision voluntarily to seek or comply with recommended treatment, it may order outpatient commitment for a period not in excess of 90 days. If the commitment proceedings were initiated as the result of the respondent's being charged with a violent crime, including a crime involving an assault with a deadly weapon, and the respondent was found incapable of proceeding, the commitment order shall so show.
 - (2) If the court finds by clear, cogent, and convincing evidence that the respondent is mentally ill and is dangerous to self, as defined in G.S. 122C-3(11)a., or others, as defined in G.S. 122C-3(11)b., it may order inpatient commitment at a 24-hour facility described in G.S. 122C-252 for a period not in excess of 90 days. However, no respondent found to be both mentally retarded and mentally ill may be committed to a State, area or private facility for the mentally retarded. An individual who is mentally ill and dangerous to self, as defined in G.S. 122C-3(11)a., or others, as defined in G.S. 122C-3(11)b., may also be committed to a combination of inpatient

 and outpatient commitment at both a 24-hour facility and an outpatient treatment physician or center for a period not in excess of 90 days. If the commitment proceedings were initiated as the result of the respondent's being charged with a violent crime, including a crime involving an assault with a deadly weapon, and the respondent was found incapable of proceeding, the commitment order shall so show. If the court orders inpatient commitment for a respondent who is under an outpatient commitment order, the outpatient commitment is terminated; and the clerk of the superior court of the county where the district court hearing is held shall send a notice of the inpatient commitment to the clerk of superior court where the outpatient commitment was being supervised.

- (3) If the court does not find that the respondent meets either of the commitment criteria set out in subdivisions (1) and (2) of this subsection, the respondent shall be discharged, and the facility in which the respondent was last a client so notified.
- (4) Before ordering any outpatient commitment, the court shall make findings of fact as to the availability of outpatient treatment. The court shall also show on the order the outpatient treatment physician or center who is to be responsible for the management and supervision of the respondent's outpatient commitment. When an outpatient commitment order is issued for a respondent held in a 24-hour facility, the court may order the respondent held at the facility for no more than 72 hours in order for the facility to notify the designated outpatient treatment physician or center of the treatment needs of the respondent including any combination of inpatient and outpatient commitment, the 24-hour facility shall identify for the court an outpatient treatment physician or center that meets all of the following criteria:
 - <u>a.</u> Has participated in discharge planning for the respondent.
 - b. Has agreed to accept the respondent as a client of outpatient treatment services.
 - c. Has scheduled the respondent for an outpatient appointment to take place no later than seven days after the respondent's discharge from the 24-hour facility.

The court shall make findings of fact as to the availability of an outpatient treatment physician or center that has met the conditions of this subsection. If the respondent is a client of an LME/MCO or eligible for services through an LME/MCO, and before the court orders any outpatient commitment, the LME/MCO shall participate in the respondent's discharge planning and assist the 24-hour facility in identifying an outpatient treatment physician or center that is able to comply with the provisions of this subsection. The court shall show on the order the outpatient treatment physician or center who is responsible for the management and supervision of the respondent's outpatient commitment. If the treatment center or physician shall be providing outpatient treatment services to the respondent pursuant to a contract for services with an LME/MCO, the order shall also show the LME/MCO. The clerk of court in the county where the facility is located shall send a copy of the outpatient commitment order to the designated outpatient treatment physician or center and to the respondent or the legally responsible person. If the designated outpatient treatment physician or center shall be monitoring and supervising the respondent's outpatient commitment pursuant to a contract for services with an LME/MCO, the

clerk of court shall also send a copy of the order to the LME/MCO. Copies of outpatient commitment orders sent by the clerk of court to an outpatient treatment center or physician pursuant to this subdivision, including orders sent to an LME/MCO, shall be sent by the most reliable and expeditious means, but in no event less than 48 hours after the hearing. If the outpatient commitment will be supervised in a county other than the county where the commitment originated, the court shall order venue for further court proceedings to be transferred to the county where the outpatient commitment will be supervised. Upon an order changing venue, the clerk of superior court in the county where the commitment originated shall transfer the file to the clerk of superior court in the county where the outpatient commitment is to be supervised.

- (c) If the respondent was found not guilty by reason of insanity and has been held in a 24-hour facility pending the court hearing held pursuant to G.S. 122C-268.1, the court may make one of the following dispositions:
 - (1) If the court finds that the respondent has not proved by a preponderance of the evidence that he no longer has a mental illness or that he is no longer dangerous to others, it shall order inpatient treatment at a 24-hour facility for a period not to exceed 90 days.
 - (2) If the court finds that the respondent has proven by a preponderance of the evidence that he no longer has a mental illness or that he is no longer dangerous to others, the court shall order the respondent discharged and released."

SECTION 32. G.S. 122C-276(c) reads as rewritten:

"(c) Subject to the provisions of G.S. 122C-269(c), rehearings shall be held at the facility in which the respondent is receiving treatment. as authorized in G.S. 122C-268(g). The judge is a judge of the district court of the district court district as defined in G.S. 7A-133 in which the facility is located or a district court judge temporarily assigned to that district."

SECTION 33. G.S. 122C-281 reads as rewritten:

"§ 122C-281. Affidavit and petition before clerk or magistrate; custody order.

- (a) Any individual who has knowledge of a substance abuser who is dangerous to himself self or others may appear before a clerk or assistant or deputy clerk of superior court or a magistrate, execute an affidavit to this effect, and petition the clerk or magistrate for issuance of an order to take the respondent into custody for examination by a physician or eligible psychologist-commitment examiner. The affidavit shall include the facts on which the affiant's opinion is based. Jurisdiction under this subsection is in the clerk or magistrate in the county where the respondent resides or is found.
- (b) If the clerk or magistrate finds reasonable grounds to believe that the facts alleged in the affidavit are true and that the respondent is probably a substance abuser and dangerous to <a href="https://hittage.com/hitta
- (c) If the clerk or magistrate issues a custody order, he the clerk or magistrate shall also make inquiry in any reliable way as to whether the respondent is indigent within the meaning of G.S. 7A-450. A magistrate shall report the result of this inquiry to the clerk.
- (d) If the affiant is a physician or eligible psychologist, commitment examiner who has examined the respondent, he or she may execute the affidavit before any official authorized to administer oaths. He—The commitment examiner is not required to appear before the clerk or magistrate for this purpose. His—The commitment examiner's examination shall comply with the requirements of the initial examination as provided in G.S. 122C-283(c). Such affiant shall file the affidavit and examination findings with the clerk of court in the manner described in

- G.S. 122C-261(d)(1). If the physician or eligible psychologistcommitment examiner recommends commitment and the clerk or magistrate finds probable cause to believe that the respondent meets the criteria for commitment, he the clerk or magistrate shall issue an order to a law enforcement officer or other person designated under G.S. 122C-251(g) to take the respondent into custody for transportation to or custody at a 24-hour facility or release the respondent, facility; or if the respondent is released pending hearing, as described in G.S. 122C-283(d)(1). G.S. 122C-283(d)(1), order that a hearing be held as provided in G.S. 122C-284(a). If a physician or eligible psychologist executes an affidavit for commitment of a respondent, a second qualified professional shall perform the examination required by G.S. 122C-285.
- (e) Upon receipt of the custody order of the clerk or magistrate, a <u>law enforcement law enforcement</u> officer or other person designated in the order shall take the respondent into custody within 24 hours after the order is signed. The custody order is valid throughout the State.
- No commitment examiner, area facility, acute care hospital, general hospital, or (e1)other site of first examination, or their officials, staff, employees, or other individuals responsible for the custody, examination, detention, management, supervision, treatment, or release of an individual examined for commitment and who follows accepted professional judgment, standards, and practice, shall be held liable in any civil or criminal action for taking reasonable measures to temporarily detain an individual for the period of time necessary to complete a commitment examination, submit an affidavit to the magistrate or clerk of court, and await the issuance of a custody order as authorized by subsection (d) of this section, as long as the commitment examiner has a reasonable and good-faith belief that detention pending the examination and issuance of a custody order is necessary to protect the individual or others from bodily harm or life endangerment. If the individual is temporarily detained under the circumstances described in this subsection, the commitment examiner shall certify in the affidavit delivered to the clerk or magistrate in accordance with subdivision (d)(1) of this section the reason the individual requires temporary detention pending the issuance of a custody order.
- (f) When a petition is filed for an individual who is a resident of a single portal area, the procedures for examination by a physician or eligible psychologist as set forth in G.S. 122C 283(c) shall be carried out in accordance with the area plan. When an individual from a single portal area is presented for commitment at a facility directly, he may be accepted for admission in accordance with G.S. 122C 285. The facility shall notify the area authority within 24 hours of admission and further planning of treatment for the individual is the joint responsibility of the area authority and the facility as prescribed in the area plan."

SECTION 34. G.S. 122C-282 reads as rewritten:

"§ 122C-282. Special emergency procedure for violent individuals.

When an individual subject to commitment under the provisions of this Part is also violent and requires restraint and when delay in taking him the individual to a physician or eligible psychologistcommitment examiner for examination would likely endanger life or property, a law enforcement officer may take the person into custody and take him or her immediately before a magistrate or clerk. The law enforcement law enforcement officer shall execute the affidavit required by G.S. 122C-281 and in addition shall swear that the respondent is violent and requires restraint and that delay in taking the respondent to a physician or eligible psychologistcommitment examiner for an examination would endanger life or property.

If the clerk or magistrate finds by clear, cogent, and convincing evidence that the facts stated in the affidavit are true, that the respondent is in fact violent and requires restraint, and that delay in taking the respondent to a physician or eligible psychologist commitment examiner for an examination would endanger life or property, he-the clerk or magistrate shall order the

law-enforcementlaw enforcement officer to take the respondent directly to a 24-hour facility described in G.S. 122C-252.

Respondents received at a 24-hour facility under the provisions of this section shall be examined and processed thereafter in the same way as all other respondents under this Part."

SECTION 35. G.S. 122C-283 reads as rewritten:

"§ 122C-283. Duties of law-enforcement officer; first examination by physician or eligible psychologist.commitment examiner.

- Without unnecessary delay after assuming custody, the law-enforcement officer or the individual designated by the clerk or magistrate under G.S. 122C-251(g) to provide transportation shall take the respondent to an area facility identified by the LME/MCO in the crisis services plan adopted pursuant to G.S. 122C-202.2 for examination by a physician or eligible psychologist; if a physician or eligible psychologistcommitment examiner. If the area facility identified in the plan or one of the facility's commitment examiners is not available in the area facility, he available, the person designated to provide transportation shall take the respondent to any physician or eligible psychologist locally available. If a physician or eligible psychologist is not immediately available, the respondent may be temporarily detained in an area facility if one is available; if an area facility is not available, he may be detained under appropriate supervision, in his home, other area facility or an acute care hospital as identified and provided in the LME/MCO's community crisis services plan adopted pursuant to G.S. 122C-202.2. If no identified facility or hospital is available, the respondent shall be transported to any commitment examiner available in a private hospital or a clinic, or in a general hospital, hospital. If a commitment examiner is not available in an area facility or acute care hospital, the respondent may be temporarily detained under appropriate supervision in the area facility or hospital but not in a jail or other penal facility.
- (a1) An area facility that is identified by the LME/MCO in accordance with G.S. 122C-202.2 as a site for conducting first examinations under subsection (a) of this section shall be capable of performing a medical screening examination of the respondent that consists of a history and physical appropriate to the respondent's complaint or condition, with ancillary testing as necessary. The medical screening examination shall be conducted by a physician or other individual who is determined by the area facility to be qualified to perform the medical screening and is practicing within the scope of his or her licensure. The respondent may either be in the physical face-to-face presence of the medical screening examiner or may be examined utilizing telemedicine equipment and procedures. If the area facility in subsection (a) of this section determines that an individual qualified to perform a medical screening examination appropriate to the respondent's complaint or condition is not available on-site or via telemedicine, the area facility shall identify and contact another area facility that is capable of performing the medical screening, or an acute care hospital, and the law enforcement officer or other designated person shall transport the respondent to the identified facility or hospital.
- transfer a respondent to an acute care hospital for emergency medical treatment, emergency medical evaluation, emergency surgery, or other medical treatment that the site of first examination is unable to provide by directing the law enforcement officer or other person designated under G.S. 122C-251(g) to transport the respondent to an identified acute care hospital. When the respondent is transferred solely for medical reasons, the original facility shall accept the return of the respondent and the respondent shall be returned to the original facility after the medical care is completed unless the responsible professionals at both facilities concur that the respondent no longer meets the criteria for commitment and recommend that the commitment proceedings be terminated. Any decision to terminate the proceedings shall be documented and reported to the clerk of superior court in accordance with subsection (e) of this

- (b) The examination set forth in subsection (a) of this section is not required if: under either of the following circumstances:
 - (1) The affiant who obtained the custody order is a physician or eligible psychologist; or commitment examiner.
 - (2) The respondent is in custody under the special emergency procedure described in G.S. 122C-282.

In these cases when it is recommended that the respondent be detained in a 24-hour facility, the law-enforcement officer shall take the respondent directly to a 24-hour facility described in G.S. 122C-252.

- (c) The <u>physician or eligible psychologistcommitment examiner</u> described in subsection (a) of this section shall examine the respondent as soon as possible, and in any event within 24 hours, after the respondent is presented for examination. The examination shall include but is not limited to an assessment of the respondent's:
 - (1) Current and previous substance abuse including, if available, previous treatment history; and
 - (2) Dangerousness to himself or others as defined in G.S. 122C-3(11).
- (d) After the conclusion of the examination examination, the physician or eligible psychologist commitment examiner shall make the following determinations:
 - (1) If the physician or eligible psychologistcommitment examiner finds that the respondent is a substance abuser and is dangerous to himself-self or others, he-the commitment examiner shall recommend commitment and whether the respondent should be released or be held at a 24-hour facility pending hearing and shall so show on [the] his examination report. Based on the physician's or eligible psychologist'scommitment examiner's recommendation recommendation, the law-enforcement law enforcement officer or other designated individual shall take the respondent to a 24-hour facility described in G.S. 122C-252 or release the respondent. If a 24-hour facility is not immediately available or medically appropriate, the respondent may be temporarily detained under appropriate supervision and the procedures described in G.S. 122C-263(d)(2) shall apply.
 - (2) If the <u>physician or eligible psychologistcommitment examiner</u> finds that the condition described in subdivision (1) of this subsection does not exist, the respondent shall be released and the proceedings terminated.
- (e) The findings of the physician or eligible psychologistcommitment examiner and the facts on which they are based shall be in writing in all cases. A copy of the findings shall be sent to the clerk of superior court by the most reliable and expeditious means. If it cannot be reasonably anticipated that the clerk will receive the copy within 48 hours of after the time that it was signed, the physician or eligible psychologistcommitment examiner shall also communicate his the findings to the clerk by telephone."

SECTION 36. G.S. 122C-284 reads as rewritten:

"§ 122C-284. Duties of clerk of superior court.

(a) Upon receipt by the clerk of superior court of a physician's or eligible psychologist's finding made by a commitment examiner or other qualified professional pursuant to G.S. 122C-285(c) that a respondent is a substance abuser and dangerous to himself-self or others and that commitment is recommended, the clerk of superior court of the county where the facility is located, if the respondent is held in a 24-hour facility, or the clerk of superior court where the petition was initiated shall upon direction of a district court judge assign counsel, calendar the matter for hearing, and notify the respondent, his-respondent's counsel, and the petitioner of the time and place of the hearing. The petitioner may file a written waiver of his-the right to notice under this subsection with the clerk of court.

- (b) Notice to the respondent required by subsection (a) of this section shall be given as provided in G.S. 1A-1, Rule 4(j) at least 72 hours before the hearing. Notice to other individuals shall be given by mailing at least 72 hours before the hearing a copy by first-class mail postage prepaid to the individual at his <u>or her</u> last known address. G.S. 1A-1, Rule 6 shall not apply.
- (c) Upon receipt of notice that transportation is necessary to take a committed respondent to a 24-hour facility pursuant to G.S. 122C-290(b), the clerk shall issue a custody order for the respondent.
- (d) The clerk of superior court shall upon the direction of a district court judge calendar all hearings, supplemental hearings, and rehearings and provide all notices required by this Part."

SECTION 37. G.S. 122C-285 reads as rewritten:

"§ 122C-285. Commitment; second examination and treatment pending hearing.

- (a) Within 24 hours of arrival at a 24-hour facility described in G.S. 122C-252, the respondent shall be examined by a qualified professional. This professional shall be a physician if the initial commitment evaluation was conducted by an eligible psychologist commitment examiner who is not a physician. The examination shall include the assessment specified in G.S. 122C-283(c). If the physician or qualified professional finds that the respondent is a substance abuser and is dangerous to himself self or others, he the physician or qualified professional shall hold and treat the respondent at the facility or designate other treatment pending the district court hearing. If the physician or qualified professional finds that the respondent does not meet the criteria for commitment under G.S. 122C-283(d)(1), he the physician or qualified professional shall release the respondent and the proceeding shall be terminated. In this case the reasons for the release shall be reported in writing to the clerk of superior court of the county in which the custody order originated. If the respondent is released, the law enforcement law enforcement officer or other person designated to provide transportation shall return the respondent to the originating county.
- (b) If the 24-hour facility described in G.S. 122C-252 is the facility in which the first examination by a physician or eligible psychologistcommitment examiner occurred and is the same facility in which the respondent is held, the second examination must occur not later than the following regular working day.
- (c) The findings of the physician or qualified professional along with the facts on which they are based shall be made in writing in all cases. A copy of the written findings shall be sent to the clerk of superior court by reliable and expeditious means."

SECTION 38. G.S. 122C-286 reads as rewritten:

"§ 122C-286. Commitment; district court hearing.

- (a) A hearing shall be held in district court within 10 days of the day the respondent is taken into custody. If a respondent temporarily detained under G.S. 122C-263(d)(2) is subject to a series of successive custody orders issued pursuant to G.S. 122C-263(d)(2), the hearing shall be held within 10 days after the day the respondent is taken into custody under the most recent custody order. Upon its own motion or upon motion of the responsible professional, the respondent, or the State, the court may grant a continuance of not more than five days.
- (b) The respondent shall be present at the hearing unless the respondent, through counsel, submits a written waiver of personal appearance. A subpoena may be issued to compel the respondent's presence at a hearing. The petitioner and the responsible professional of the area authority facility or the proposed treating physician or his a designee of the proposed treating physician may be present and may provide testimony.
- (c) Certified copies of reports and findings of physicians and psychologists physicians, psychologists, and other commitment examiners and medical records of previous and current treatment are admissible in evidence, but the respondent's right to confront and cross-examine witnesses shall not be denied.

- (d) The respondent may be represented by counsel of his choice. If the respondent is indigent within the meaning of G.S. 7A-450, counsel shall be appointed to represent the respondent in accordance with rules adopted by the Office of Indigent Defense Services.
- (e) Hearings may be held at a facility if it is located within the judge's district court district as defined in G.S. 7A-133 or in the judge's chambers. A hearing may not be held in a regular courtroom, over objection of the respondent, if in the discretion of a judge a more suitable place is available.
- (f) The hearing shall be closed to the public unless the respondent requests otherwise. The hearing for a respondent being held at a 24-four facility shall be held in a location and in the manner provided in G.S. 122C-268(g).
- (g) A copy of all documents admitted into evidence and a transcript of the proceedings shall be furnished to the respondent on request by the clerk upon the direction of a district court judge. If the respondent is indigent, the copies shall be provided at State expense.
- (h) To support a commitment order, the court shall find by clear, cogent, and convincing evidence that the respondent meets the criteria specified in G.S. 122C-283(d)(1). The court shall record the facts that support its findings and shall show on the order the area authority facility or physician who is responsible for the management and supervision of the respondent's treatment."

SECTION 39. G.S. 122C-287 reads as rewritten: "§ 122C-287. Disposition.

The court may make one of the following dispositions:

- (1) If the court finds by clear, cogent, and convincing evidence that the respondent is a substance abuser and is dangerous to himself-self or others, it shall order for a period not in excess of 180 days commitment to and treatment by an area authority facility or physician who is responsible for the management and supervision of the respondent's commitment and treatment.

 Before ordering commitment to and treatment by an area facility or a physician who is not a physician at an inpatient facility, the court shall follow the procedures specified in G.S. 122C-271(a)(3) and G.S. 122C-271(b)(4), as applicable. The court shall not order commitment to an area facility unless the respondent is eligible for services at the area facility through an LME/MCO or otherwise qualifies for the provision of services offered by the provider.
- (2) If the court finds that the respondent does not meet the commitment criteria set out in subdivision (1) of this subsection, the respondent shall be discharged and the facility in which he was last treated so notified."

SECTION 40. G.S. 122C-290 reads as rewritten:

"§ 122C-290. Duties for follow-up on commitment order.

- (a) The area authority-facility or physician responsible for management and supervision of the respondent's commitment and treatment may prescribe or administer to the respondent reasonable and appropriate treatment either on an outpatient basis or in a 24-hour facility.
- (b) If the respondent whose treatment is provided on an outpatient basis fails to comply with all or part of the prescribed treatment after reasonable effort to solicit the respondent's compliance or whose treatment is provided on an inpatient basis is discharged in accordance with G.S. 122C-205.1(b), the area authority—facility or physician may request the clerk or magistrate to order the respondent taken into custody for the purpose of examination. Upon receipt of this request, the clerk or magistrate shall issue an order to a law enforcement officer to take the respondent into custody and to take him immediately to the designated area authority—facility or physician for examination. The custody order is valid throughout the State. The law enforcement officer shall turn the respondent over to the custody of the physician or area authority—facility who shall conduct the examination and release the respondent or have the

respondent taken to a 24-hour facility upon a determination that treatment in the facility will benefit the respondent. Transportation to the 24-hour facility shall be provided as specified in G.S. 122C-251, upon notice to the clerk or magistrate that transportation is necessary, or as provided in G.S. 122C-408(b). If placement in a 24-hour facility is to exceed 45 consecutive days, the area authority-facility or physician shall notify the clerk of court by the 30th day and request a supplemental hearing as specified in G.S. 122C-291.

- (c) If the respondent intends to move or moves to another county within the State, the area <u>authority-facility</u> or physician shall notify the clerk of court in the county where the commitment is being supervised and request that a supplemental hearing be calendared.
- (d) If the respondent moves to another state or to an unknown location, the designated area authority facility or physician shall notify the clerk of superior court of the county where the commitment is supervised and the commitment shall be terminated."

SECTION 41. G.S. 122C-291 reads as rewritten:

"§ 122C-291. Supplemental hearings.

- (a) Upon receipt of a request for a supplemental hearing, the clerk shall calendar a hearing to be held within 14 days and notify, at least 72 hours before the hearing, the petitioner, the respondent, his attorney, if any, and the designated area authority facility or physician. Notice shall be provided in accordance with G.S. 122C-284(b). The procedures for the hearing shall follow G.S. 122C-286.
- At the supplemental hearing for a respondent who has moved or may move to another county, the court shall determine if the respondent meets the criteria for commitment set out in G.S. 122C-283(d)(1). If the court determines that the respondent no longer meets the criteria for commitment, it shall discharge the respondent from the order and dismiss the case. If the court determines that the respondent continues to meet the criteria for commitment, it shall continue the commitment but shall designate an area authority facility or physician at the respondent's new residence to be responsible for the management or supervision of the respondent's commitment. The court shall order the respondent to appear for treatment at the address of the newly designated area authority facility or physician and shall order venue for further court proceedings under the commitment to be transferred to the new county of supervision. Upon an order changing venue, the clerk of court in the county where the commitment has been supervised shall transfer the records regarding the commitment to the clerk of court in the county where the commitment will be supervised. Also, the clerk of court in the county where the commitment has been supervised shall send a copy of the court's order directing the continuation of treatment under new supervision to the newly designated area authority-facility or physician.
- (c) At a supplemental hearing for a respondent to be held longer than 45 consecutive days in a 24-hour facility, the court shall determine if the respondent meets the criteria for commitment set out in G.S. 122C-283(d)(1). If the court determines that the respondent continues to meet the criteria and that further treatment in the 24-hour facility is necessary, the court may authorize continued care in the facility for not more than 90 days, after which a rehearing for the purpose of determining the need for continued care in the 24-hour facility shall be held, or the court may order the respondent released from the 24-hour facility and continued on the commitment on an outpatient basis. If the court determines that the respondent no longer meets the criteria for commitment the respondent shall be released and his case dismissed.
- (d) At any time during the term of commitment order, a respondent may apply to the court for a supplemental hearing for the purpose of discharge from the order. The application shall be made in writing to the clerk of superior court. At the supplemental hearing the court shall determine whether the respondent continues to meet the criteria for commitment. The court may reissue or change the commitment order or discharge the respondent and dismiss the case."

SECTION 42. G.S. 122C-292 reads as rewritten:

"§ 122C-292. Rehearings.

- (a) Fifteen days before the end of the initial or subsequent periods of commitment if the area authority facility or physician determines that the respondent continues to meet the criteria specified in G.S. 122C-283(d)(1), the clerk of superior court of the county where commitment is supervised shall be notified. The clerk, at least 10 days before the end of the commitment period, on order of the district court, shall calendar the rehearing. If the respondent no longer meets the criteria, the area authority facility or physician shall so notify the clerk who shall dismiss the case.
- (b) Rehearings are governed by the same notice and procedures as initial hearings, and the respondent has the same rights he had that were available to the respondent at the initial hearing including the right to appeal.
- (c) If the court finds that the respondent no longer meets the criteria of G.S. 122C-283(d)(1), it shall unconditionally discharge him. A copy of the discharge order shall be furnished by the clerk to the designated area authority—facility or physician. If the respondent continues to meet the criteria of G.S. 122C-283(d)(1), the court may order commitment for additional periods not in excess of 365 days each."

SECTION 43. G.S. 122C-293 reads as rewritten:

"§ 122C-293. Release by area authority or physician.

The area authority—facility or physician as designated in the order shall discharge a committed respondent unconditionally at any time he—the physician determines that the respondent no longer meets the criteria of G.S. 122C-283(d)(1). Notice of discharge and the reasons for the release shall be reported in writing to the clerk of superior court of the county in which the commitment was ordered."

SECTION 44. G.S. 122C-294 reads as rewritten:

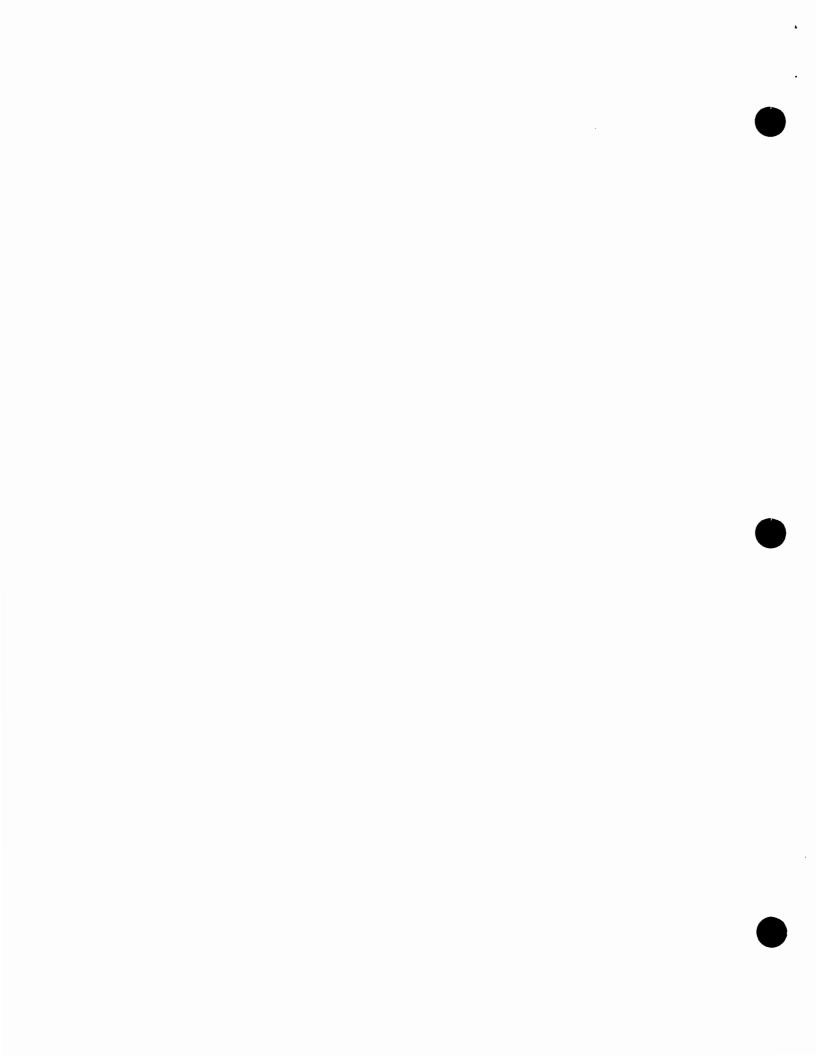
"§ 122C-294. Local plan.

Each area authority shall develop a local plan <u>in accordance with G.S. 122C-202.2</u> with local law-enforcement agencies, local courts, local hospitals, and <u>local medical societiesothers</u> <u>as</u> necessary to facilitate implementation of this Part."

SECTION 45.(a) Each LME/MCO shall submit to the Department of Health and Human Services a copy of its current community crisis services plan adopted pursuant to G.S. 122C-202.2, as enacted by this act, by the earlier of (i) 12 months after the date the Department receives notification that the federal Centers for Medicaid and Medicare has approved all necessary waivers and State Plan amendments for Medicaid and NC Health Choice transformation as provided for in S.L. 2015-245, as amended, or (ii) six months prior to the date the Department actually initiates capitated contracts with Prepaid Health Plans, as defined in Section 4 of S.L. 2015-245, as amended, for the delivery of Medicaid and NC Health Choice services. The Department shall notify each LME/MCO when the earlier of these conditions occurs.

SECTION 45.(b) This section is effective when it becomes law.

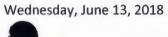
SECTION 46. Except as otherwise provided, this act becomes effective December 1, 2017, and applies to proceedings initiated on or after that date.

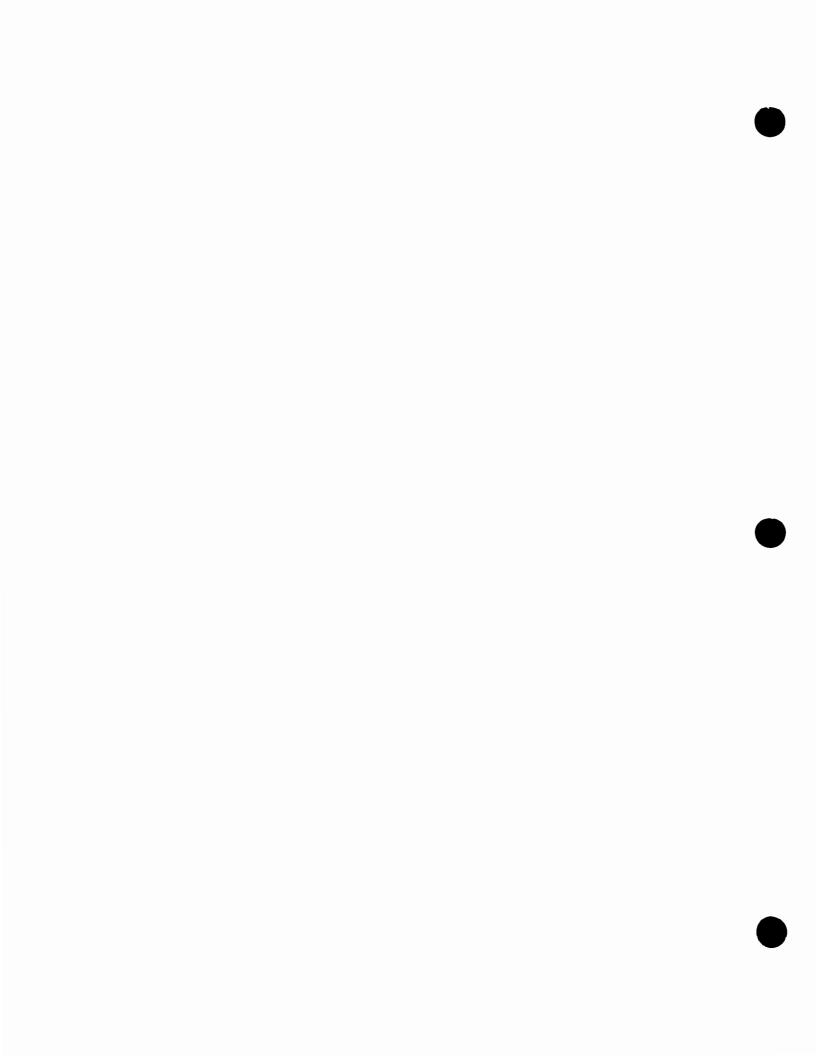


House Pages Assignments Wednesday, June 13, 2018 Session: 2:00 PM

Committee	Room	Time	Staff	Comments	Member
State and Local Government	544	10:00 AM	Anna Joshi		Speaker Tim Moore
			Mason Leonard		Speaker Tim Moore
			John Morgan		Speaker Tim Moore
			Isaac Williams		Speaker Tim Moore
Health	643	11:00 AM	Frederick Hornack		Speaker Tim Moore
			Wesley Manning		Rep. Jean Farmer- Butterfield
			Chloe Renfer		Speaker Tim Moore
			Matthew Wolf		Rep. Verla Insko
Judiciary I	415	1:00 PM	Cade McConnell		Rep. Jason Saine
		~	Natalie Van Dyke		Rep. Darren G. Jackson
			Anna Blake Glatthaar		Rep. Ted Davis, Jr.
			Matthew Wolf		Rep. Verla Insko

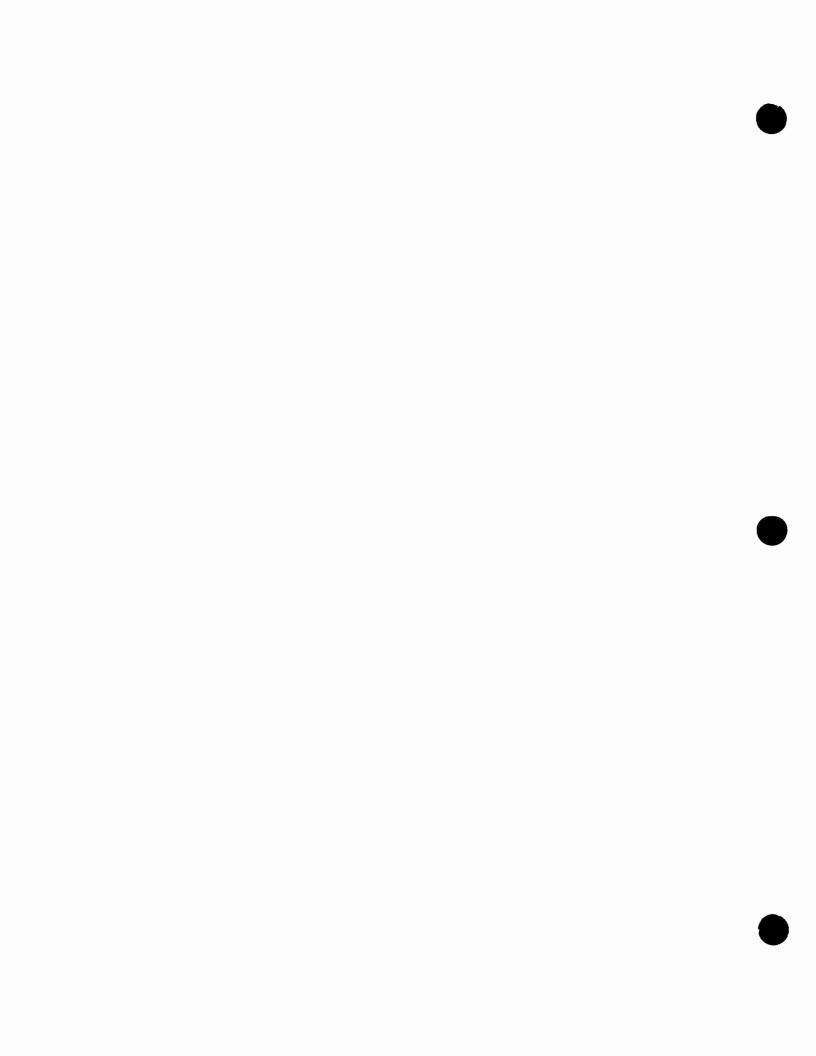
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Committee Sergeants at Arms

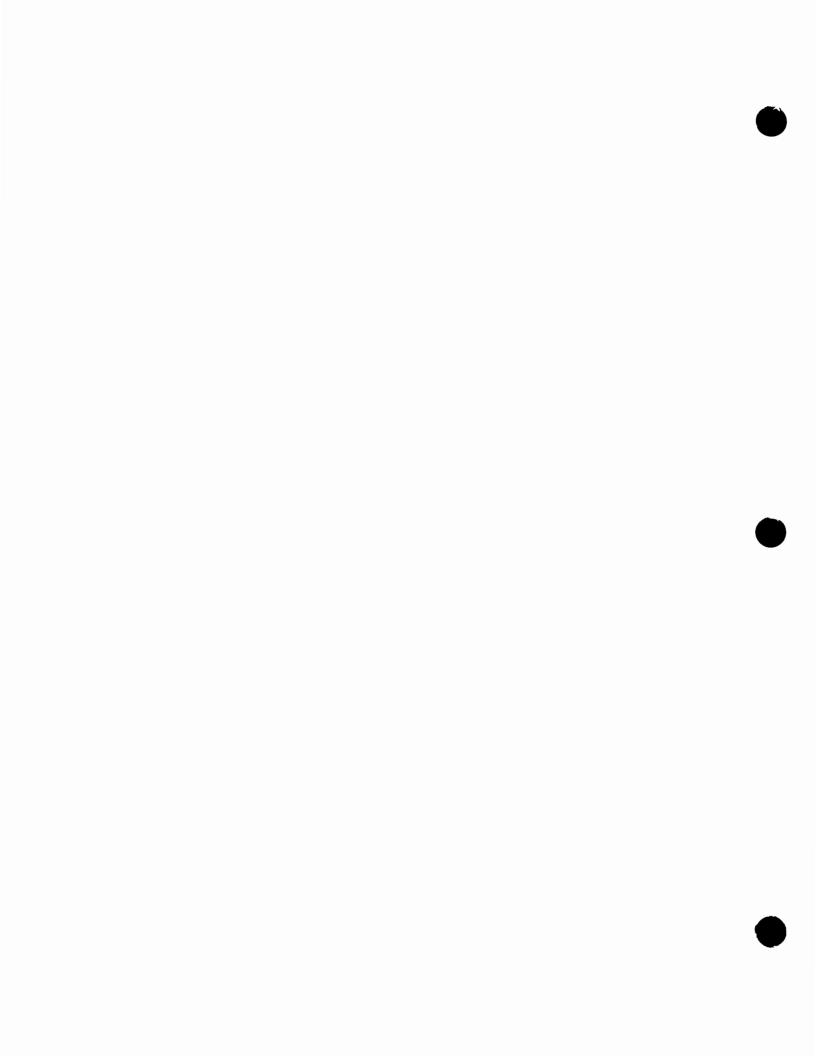
NAME OF COMMITTEE House Committee on Health
DATE: 6/13/2018 Room: 643
House Sgt-At Arms:
1. Name: Warren Hawkins
2. Name: Doug Harris
Name: Dean Marshbourne
4. Name: Malachi McCullough, Jr
5. Name:
Senate Sgt-At Arms:
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SPEAKER REGISTRATION SHEET

Name of Committee House Committee on Health Date 6/13/2018

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Charles Hobgood	NC Dept. of Justice	369	
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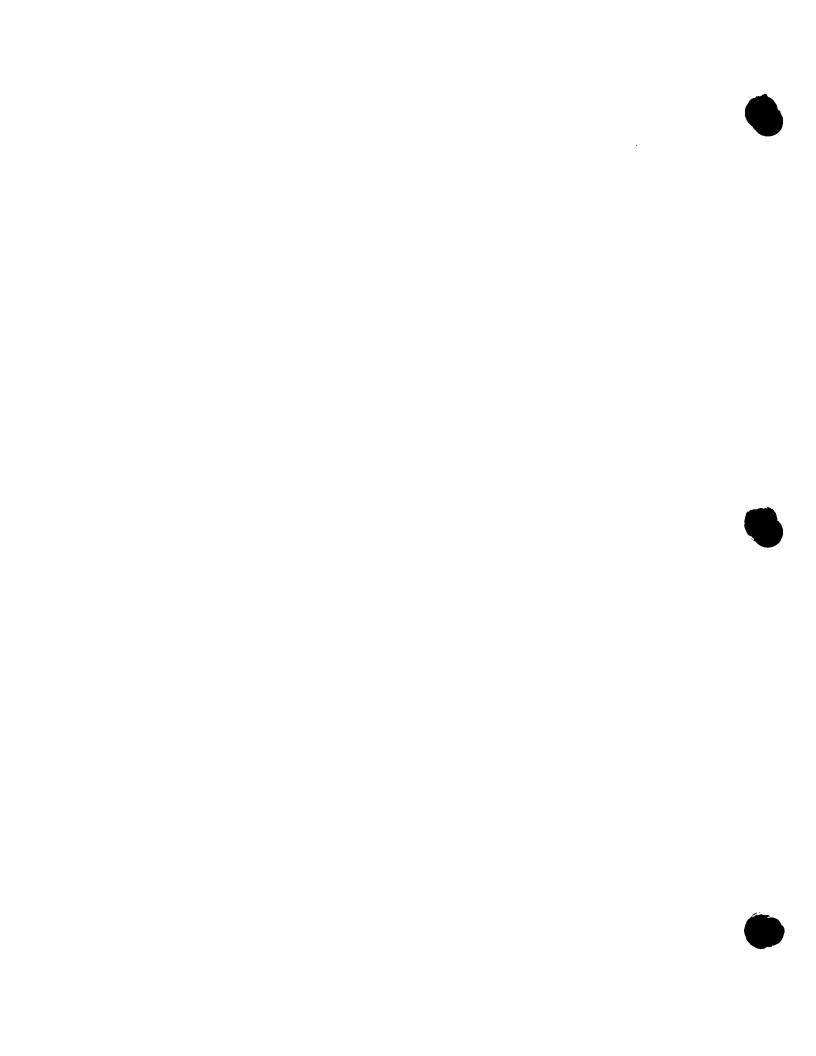


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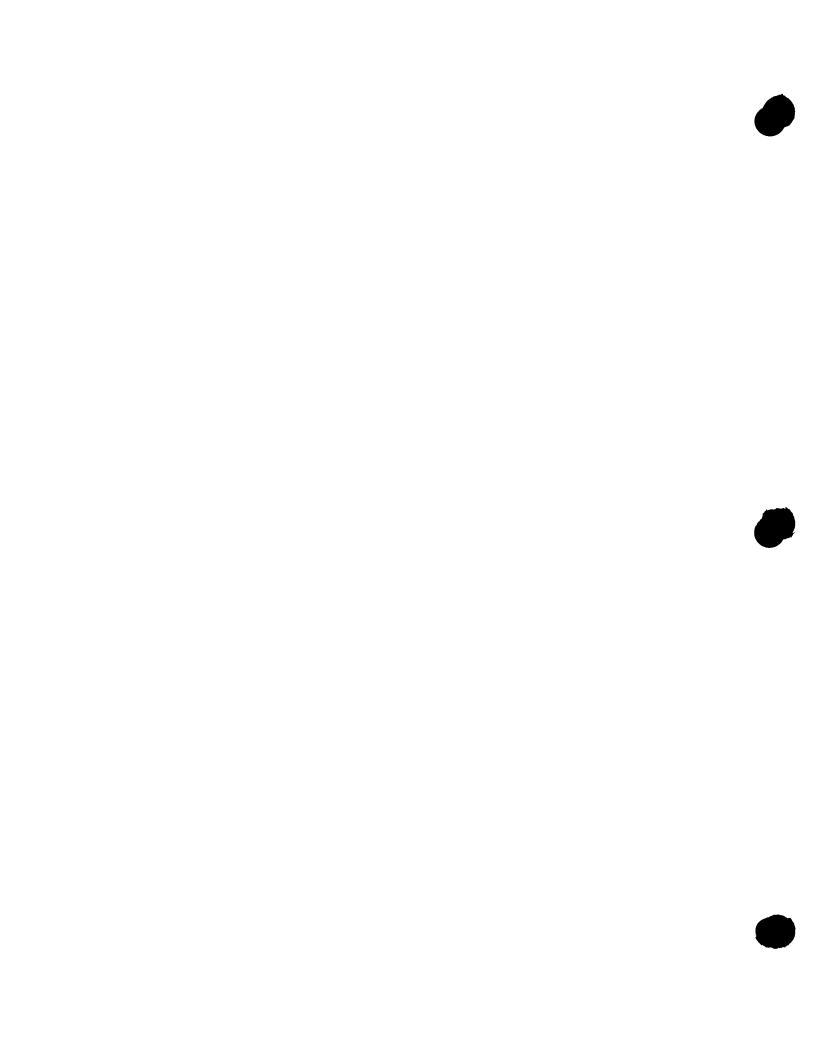
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Laura Hartman	Ecu, Brody School of Medicine, Greenville, NC
Juhi Gor	ECU, Brody School of Medicine; Greenville, NC

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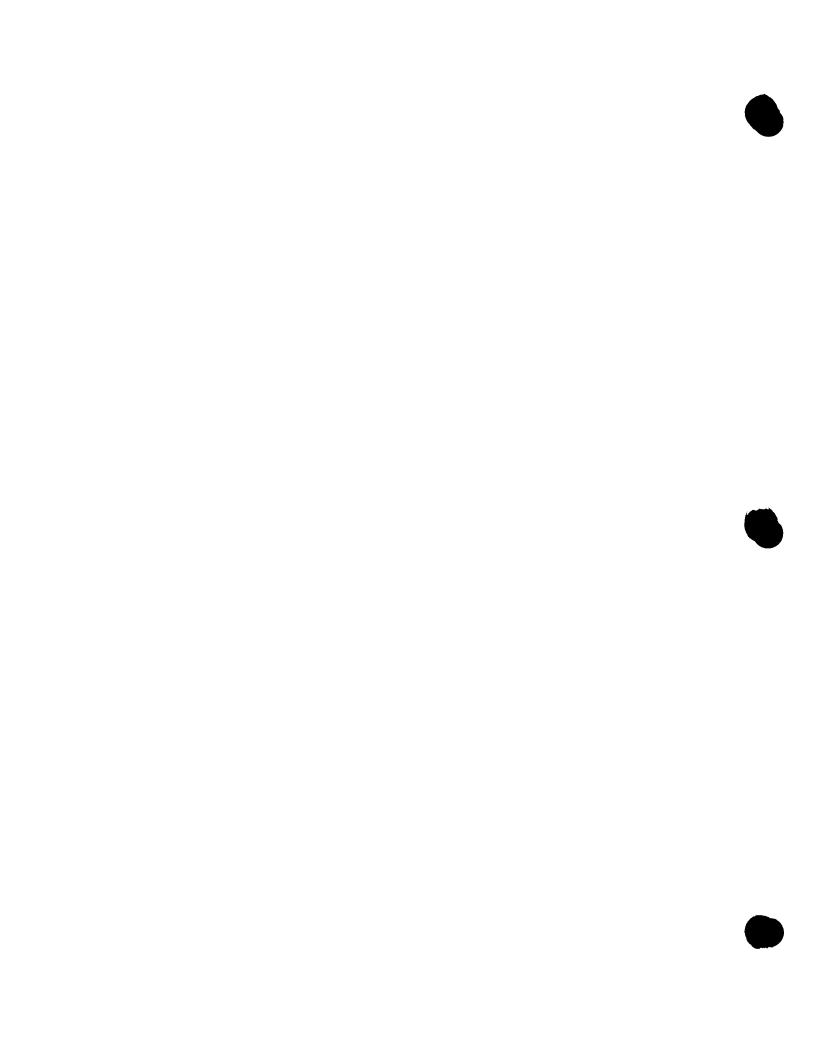


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Dr. Jessica Trackens	Ne Acad Family Physicians
Alexander Young	Brody School of Medicine LINC Scholars
Sanjana Piabhu	11 11
Kyle Luke	
Tyler Powell	Brody School of Medicine LINC Scholars
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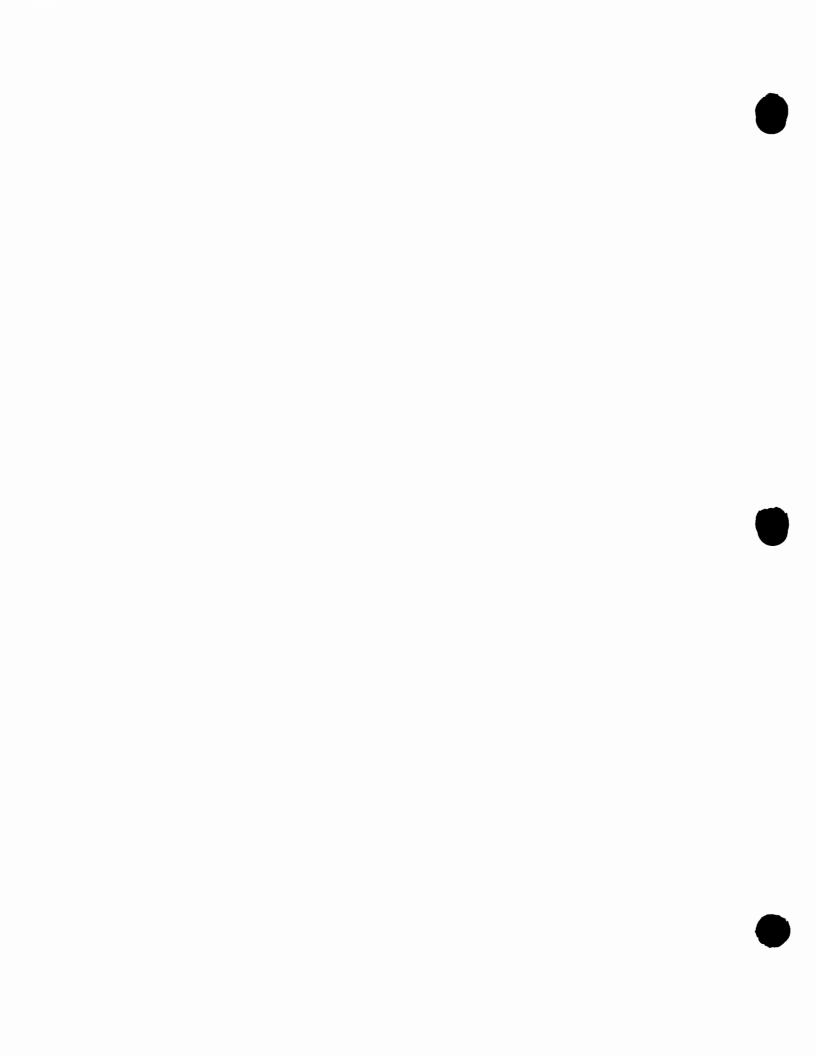


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Davey Burgard	NOMS
Kristen Dorsey, mD	NCMS
Showne Guthire, MD	NCMS/NCAFP
Cynthia SATU TA-C	NCMS
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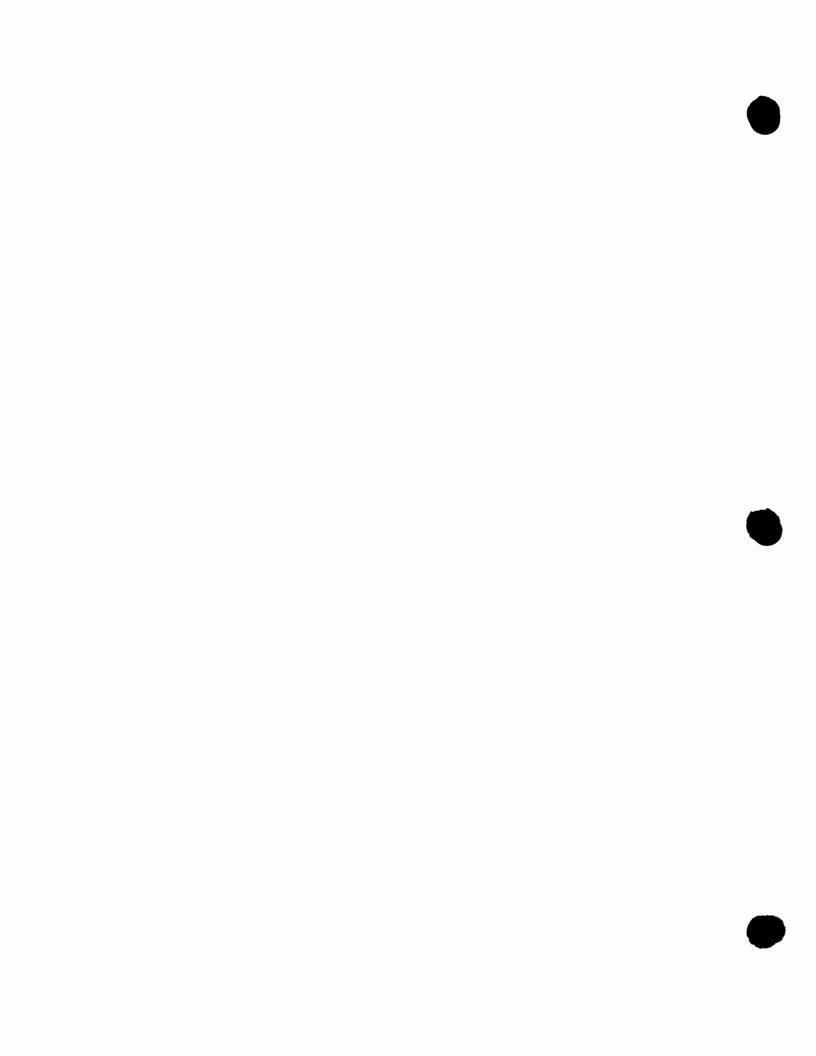


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Megan Campbell	NCAFP/NCMS
Shack Cando	ENTAFRICMS
Charles W. Rhodes mo	NCAFP
Moule Dozier	NCJustice Center
william Learnerwood	NCAFP/UNC SOM
PamelaShipman	Morrach
Bradford Sneedin	NCDOZ
Eddie Kirby	NCDOJ
Steve Mitales	Astollac

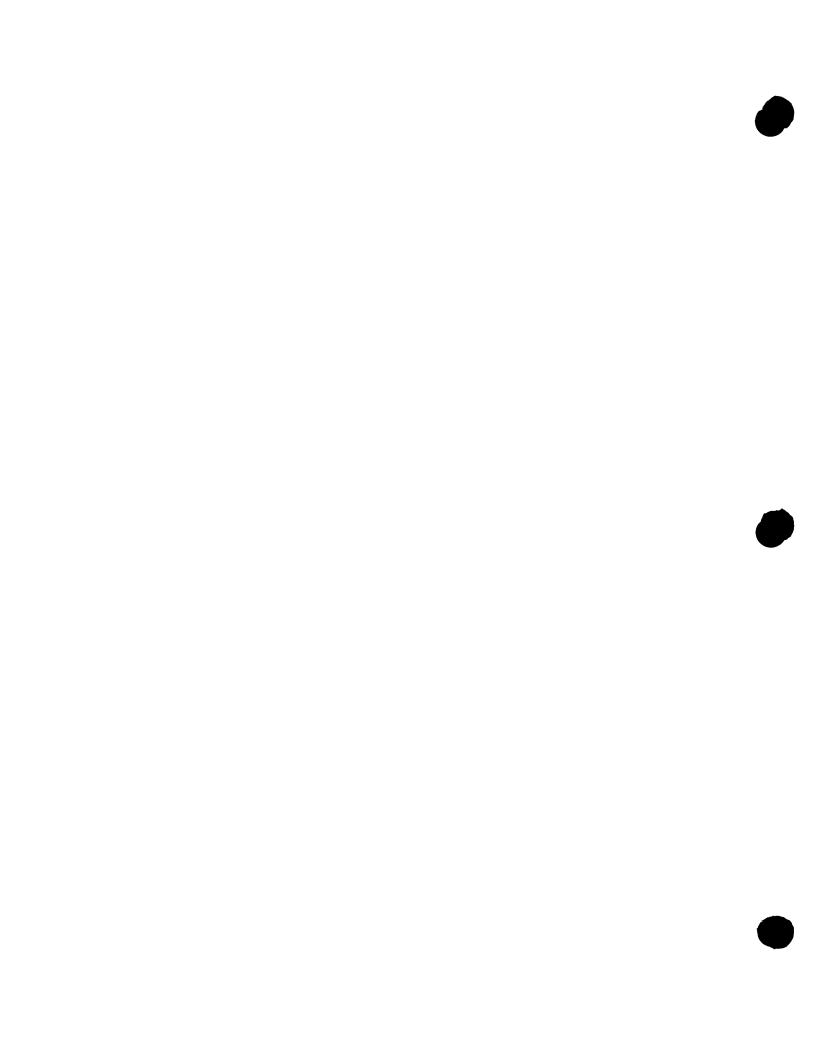


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	M. P. E. James	DCF
	Brin Blank	NE Acadmy of Fam Physicians
	Adam Pridemare	Nenec
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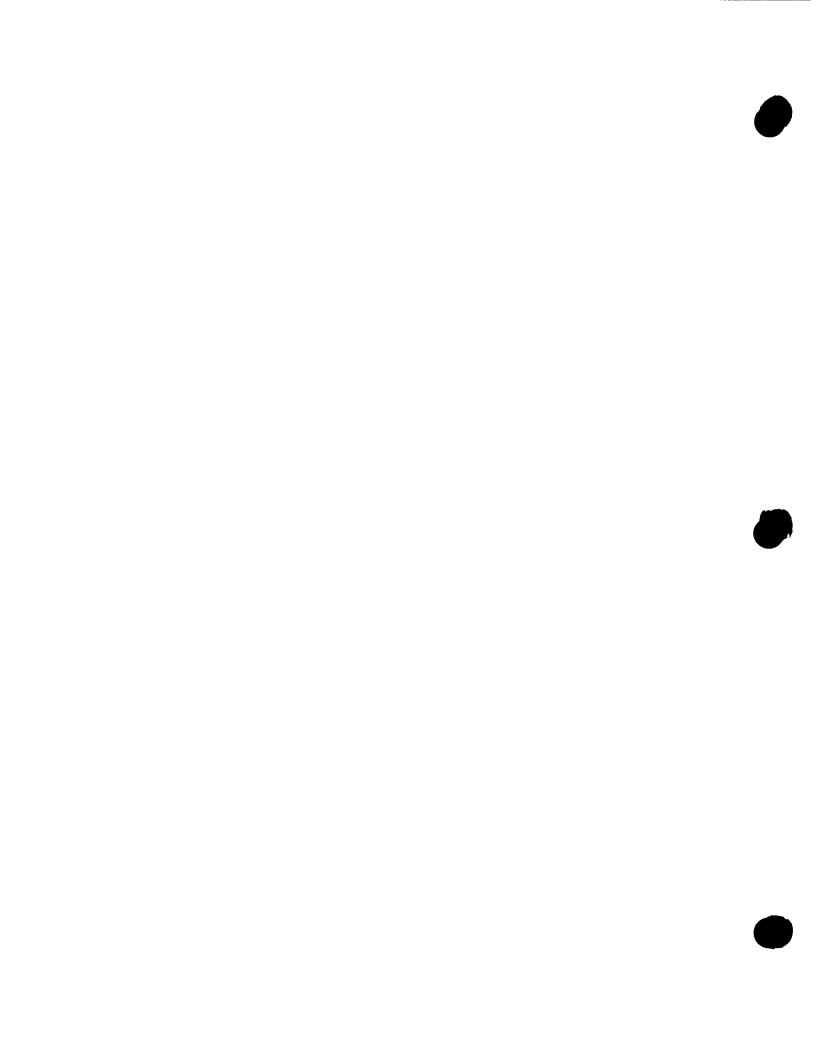
Michelle Brooks	ECU
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KelleHetcher	CFTF
Andrew Sumich	Neme
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Jos Laier	CSH
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Paul Sherma	NCFB
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Tom Baron	EDF

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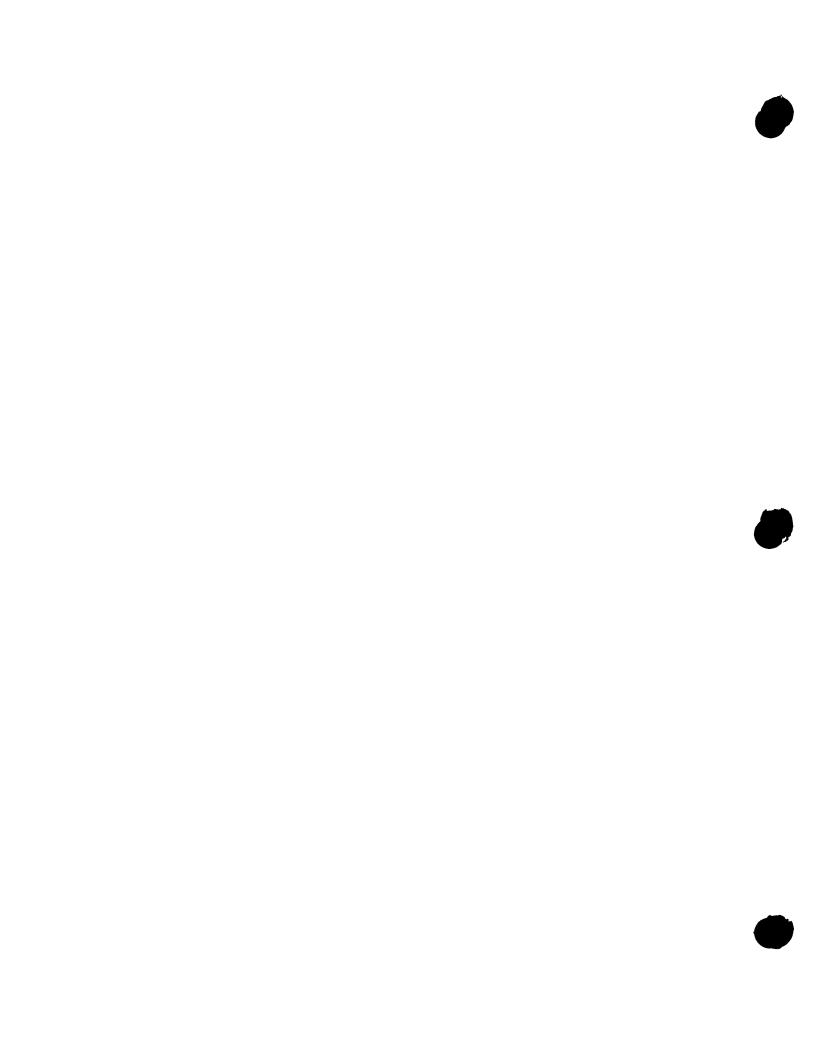


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Kara Wishaar	SA
Dana Simpson	SA
Barbere-Ann Bybel	UNCH
CHANCEMA LAWSON	UNKM
NI CHOULE KARIN	NCHA
Jacob Alley	NCIHA
Julie Henry	NCHA
Miriar Tant	MCHA
Space LAWLER	NCMA
Jaran McQuilla	KEA

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House Committee on Health Wednesday, August 22, 2018 at 10:00 AM Room 643 of the Legislative Office Building

MINUTES

The House Committee on Health met at 10:00 AM on August 22, 2018 in Room 643 of the Legislative Office Building. Representatives Cunningham, Dobson, Dollar, Earle, Farmer-Butterfield, Bert Jones, Ford, Lucas, and Potts attended.

Representative Bert Jones, Chair, presided.

Representative Jones recognized the Sgt-at-Arms; Bill Bass, Jim Moran, Terry McCraw and Will Crocker.

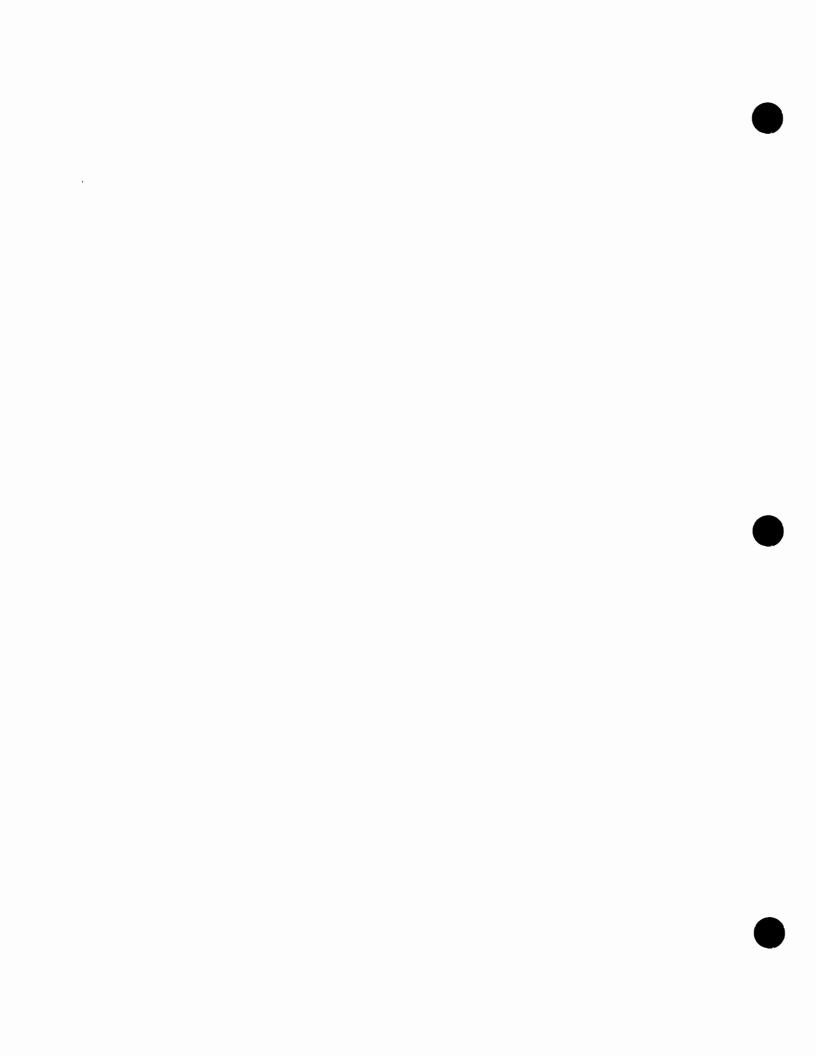
The following presentations were presented.

Community Dental Health Coordinator: A Strategy for Dental Care Case Management in Rural Communities. (Attachment 1)

A Patients Perspective on Lyme Disease by Nia Davenport

Two years ago this would have been impossible for me to be here before you. The amount of energy to focus, the sounds, lights and even the ability to drive here to Raleigh to stand before you was out of my reach. Today is a good day and I'm at a good point, there is hope. About 15 years ago I started having strange symptoms starting with fevers, achiness and not being able to move the joints in my hands. After several weeks of the symptoms of not subsiding I finally went to the Emergency Room and the doctors there told me it must be a virus. It would have to work itself out. I have a Type A personality and not allowed to have sick days. I would always muscle my way through everything. I was a CPA, Life Coach and Financial Planner. Always interacting with others, solving problems and running a household. In 2012 as time went on it was getting more difficult to focus, I could not concentrate. The aches and pains of middle age became more amplified and I was not sleeping. Each of these symptoms were addressed by several doctors who specialized in the areas I was having trouble. The medications were holding the symptoms at bay but were not healing me in the process. When the doctors came to that conclusion I started to die. I came off all medicines and I couldn't could not remember my name, remember my children, the symptoms I had disrupted my life. The doctors got together and got me an appointment with a Brain Specialist in another state. After a battery of tests and several brain scans they asked me how many concussions I have had. I told them none. The doctors told me my brain was shutting down. After several more tests I tested positive for Lyme Disease. Over the next year I went to doctors that specialized in Lyme Disease. The treatment was and is challenging, a lot of baby steps and prayer but I am now able to enjoy my family and life.

The Lyme Dilemma – Starting a Conversation. (Attachment 2)

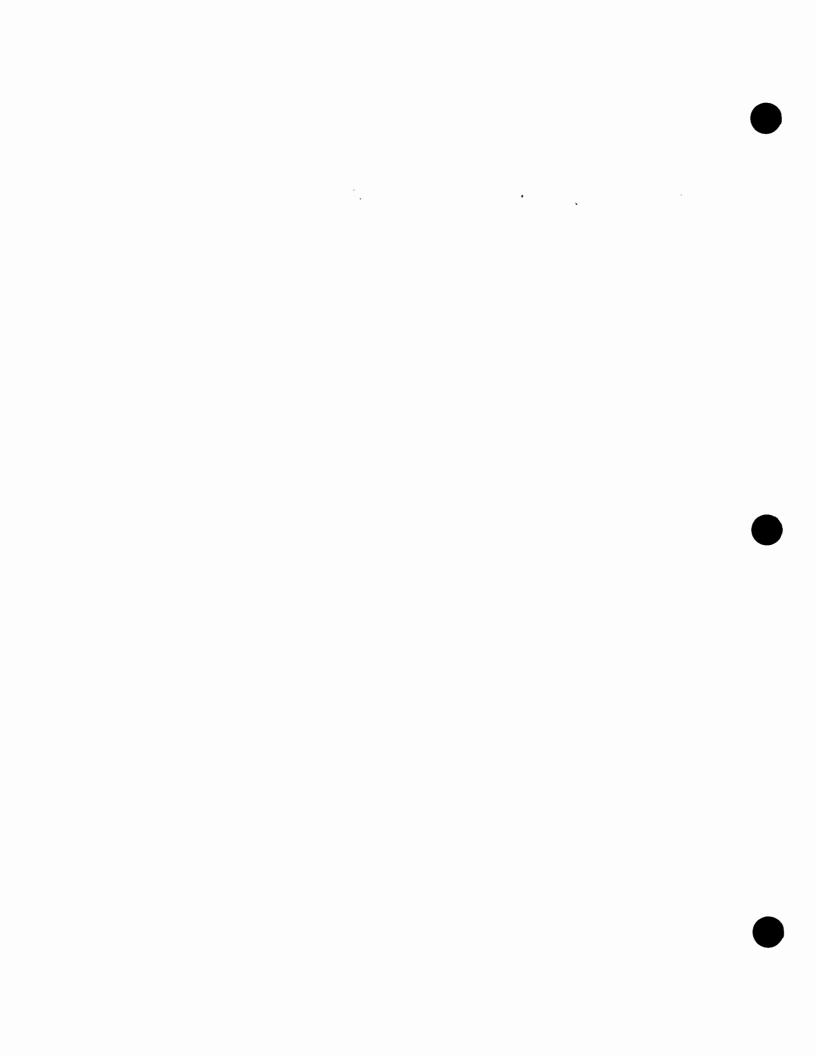


The meeting adjourned at 12:00 PM.

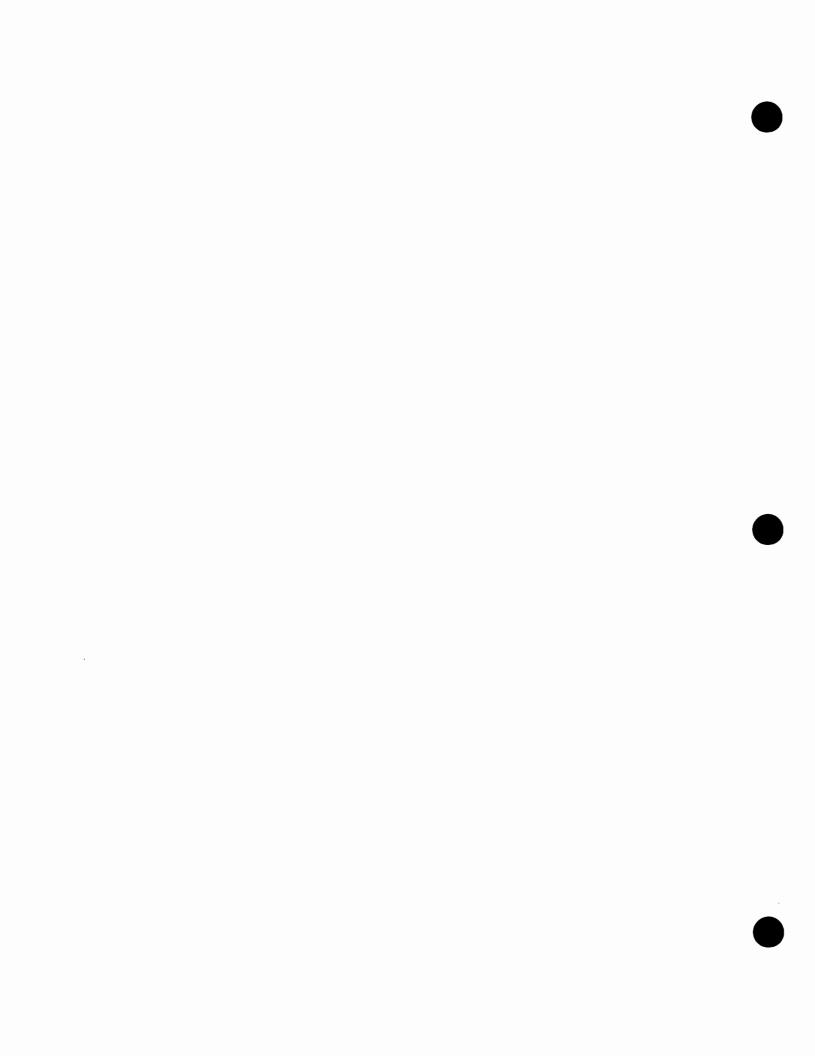
Representative Bert Jones, Chair

Presiding

Theresa Lopez, Committee Clerk



Date: 02/22/2018		Caraint Times (Ma Caraint Time)
	3 ▼ Time: 10:00 AM 🕏	Special Time: (No Special Time)
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resentations on th	ne Community Dental Health Coodinato	or Program and Lyme Disease. A more detailed Agenda will be sent out closer



House Committee on Health Wednesday, September 22nd, 10:00 a.m. Room 643

AGENDA

Welcome and Opening Remarks

Presentations

- I. Community Dental Health Coordinator
 - Community Dental Health Coordinator: A Strategy for Dental Care Case Management in Rural Communities

Dr. M. Alec Parker, DMD CAE

Dr. Algie Gatewood, President, Alamance Community College

Mr. David Freeze, Dean of health & Public Services, Alamance Community College

Ms. Janelle Christopher, Dental Assisting Department Head, Alamance Community College

II. Lyme Disease

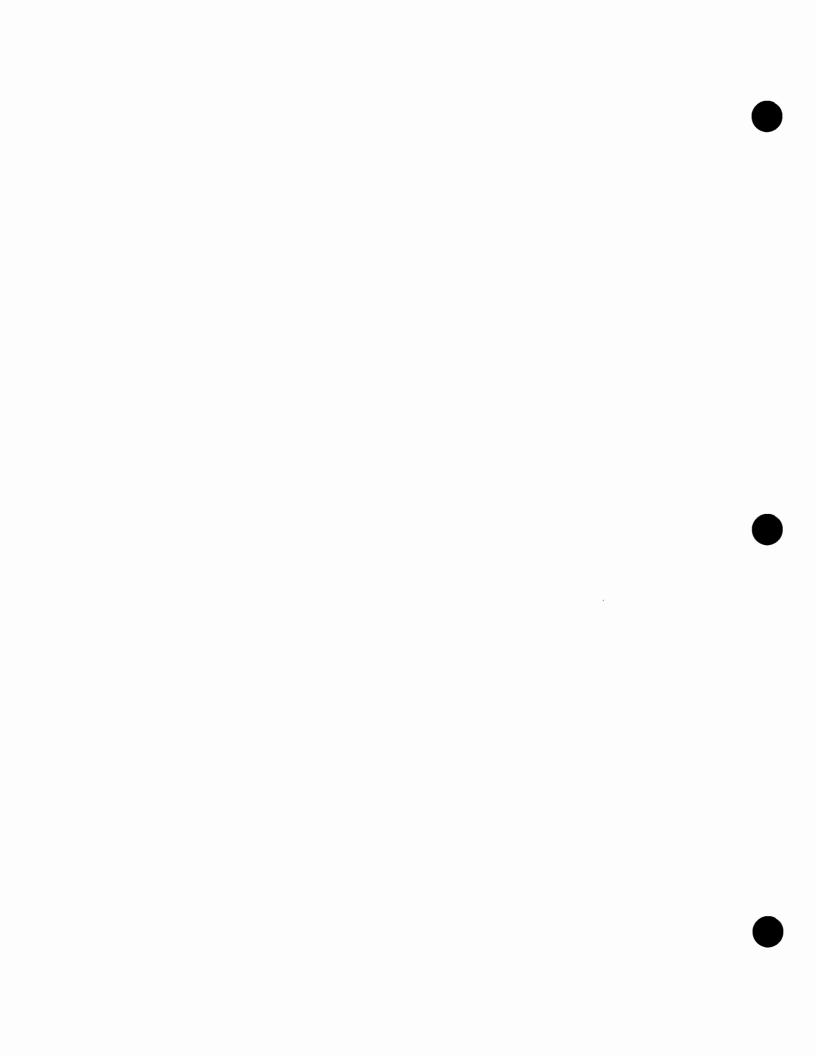
• The Lyme Dilemma – Starting a Conversation

Dr. William C. Rawls, Jr. MD,

• A Patient's Perspective

Mrs. Nia Davenport

Adjournment



ATTENDANCE HEALTH

DATES	08/22/2018								
DOBSON, Josh - Chair	X								
DOLLAR, Nelson - Chair	X								
JONES, Bert - Chair	X								
LAMBETH, Donny - Chair									
MURPHY, Greg - Chair			-		-				
BRISSON, William – Vice-Chair									
EARLE, Beverly – Vice-Chair	X								
FARMER-BUTTERFIELD, Jean – Vice-Chair	X						-		
ADCOCK, Gale									
BALL, Cynthia	X								
BLACKWELL, Hugh									
BOSWELL, Beverly									
BURR, Justin									
CARNEY, Becky									
CUNNINGHAM, Carla	X								
DULIN, Andy									
FORD, Carl	X								
HOWARD, Julia									
HUNTER, Howard									
INSKO, Verla									
JACKSON, Darren									
LEWIS, David									
LUCAS, Marvin	X								
MALONE, Chris									

ATTENDANCE

HEALTH

DATES										
POTTS, Larry	X									
ROGERS, David										
SETZER, Mitchell										
SHEPARD, Phillip										
SZOKA, John										
WHITE, Donna										
WRAY, Michael										
YARBOROUGH, Larry										
ZACHARY, Lee							_			
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HOUSE CLERKS										
Theresa Lopez										
Julie Ryan										
Anne Harvey Smith				-						
HOUSE COMMITTEE STAFF										
Theresa Matula										
Jason Moran-Bates										-
Jessica Boney										
Jennifer Hillman										
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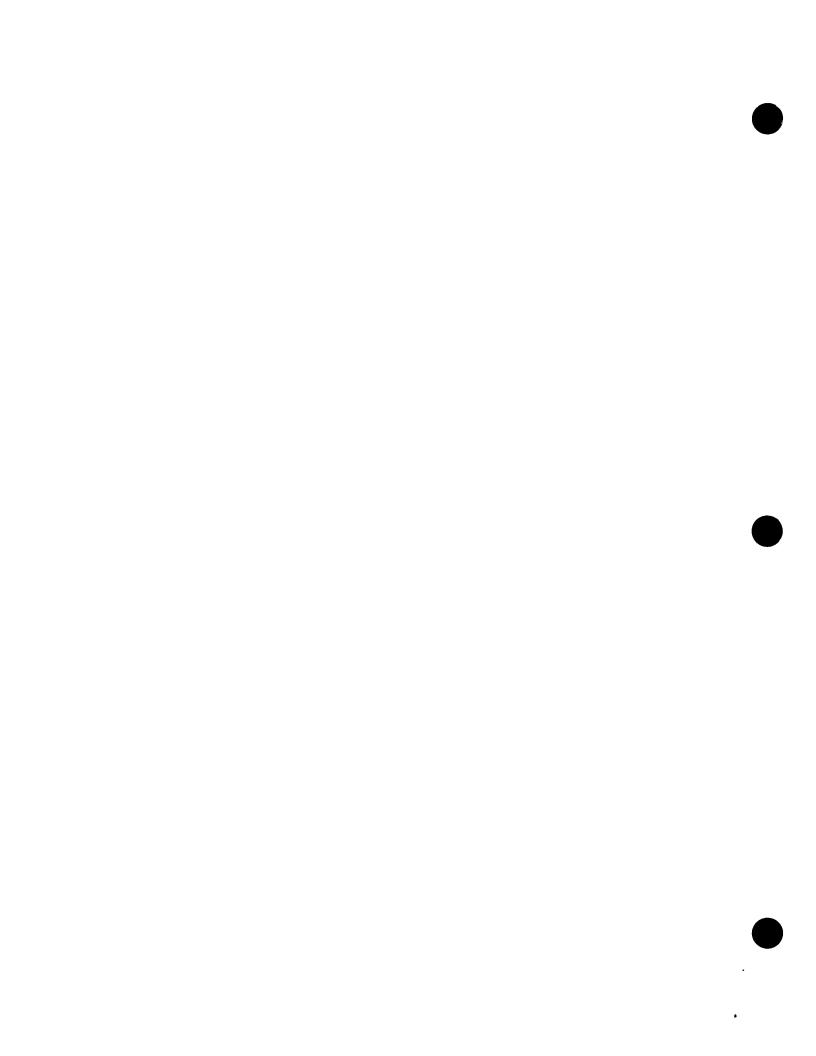
CDHC Community Dental Health Coordinator

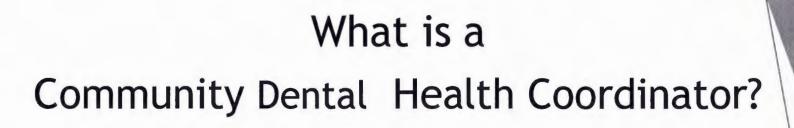
Partnering with our communities for better health....



American Dental Association

Attachment 1



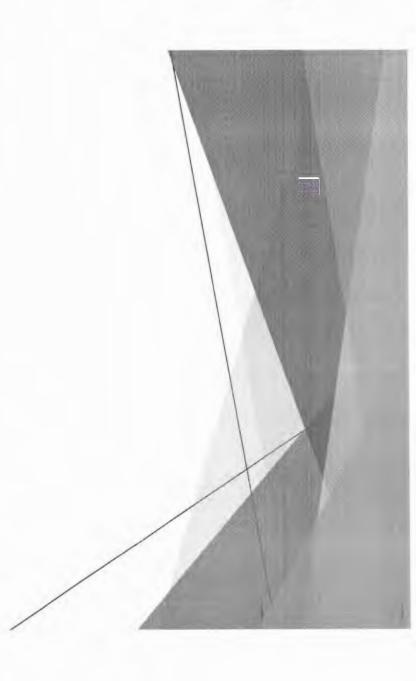


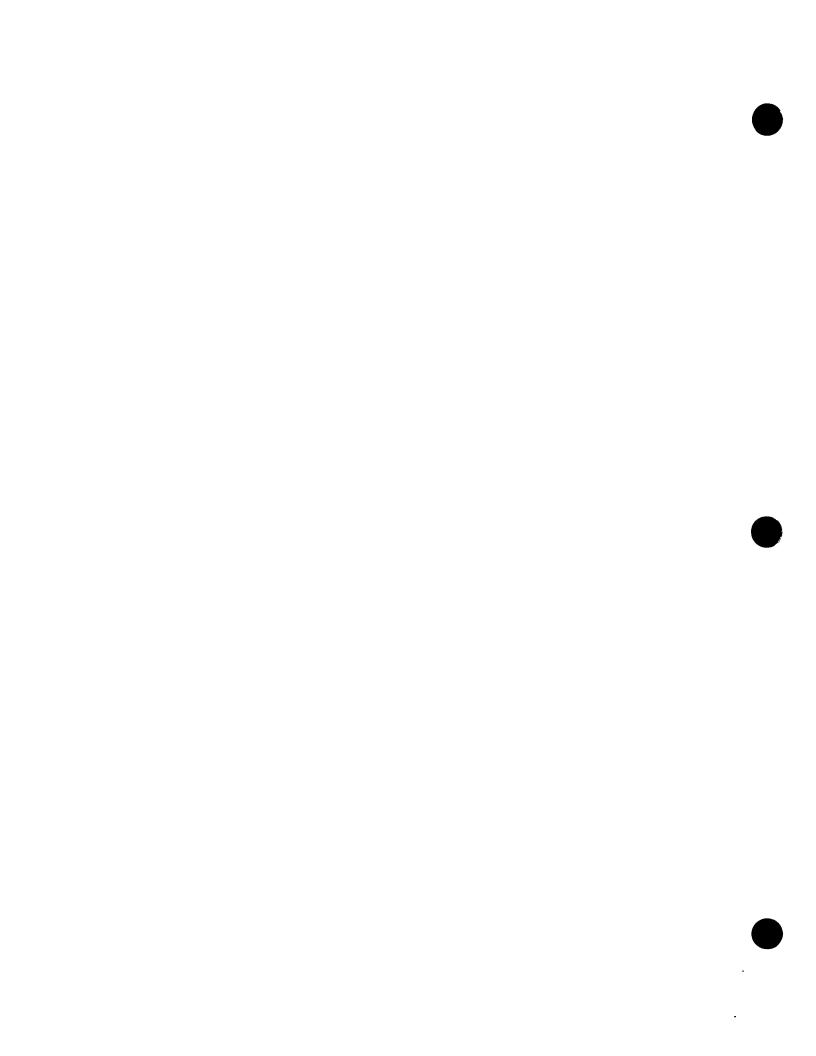
- > Community Health Worker Training focuses on Oral Health
- > Located in underserved communities
- > Education
- Navigation
- > Break barriers that prevent Oral Health Care Treatment



Common Barriers

- > Shortage of providers/rural areas
- ▶ Transportation
 - ▶ Physically isolated
 - ▶ Disabilities
- ► Financial resources & lack of funding
- ► Health Care Literacy
 - ▶ Patient knowledge & attitudes/resources
- ► Cultural & social economical differences
 - ► Cultural insensitivity





Employment Opportunities

- ► Rural Dental Practices & Clinics
- ► Federally Qualified Health Centers
- ► Hospital Emergency Rooms
- ► Nursing Homes & Senior Centers
- ▶ Head Start Centers

CDHC Job Responsibilities

CDHC in a clinic setting:

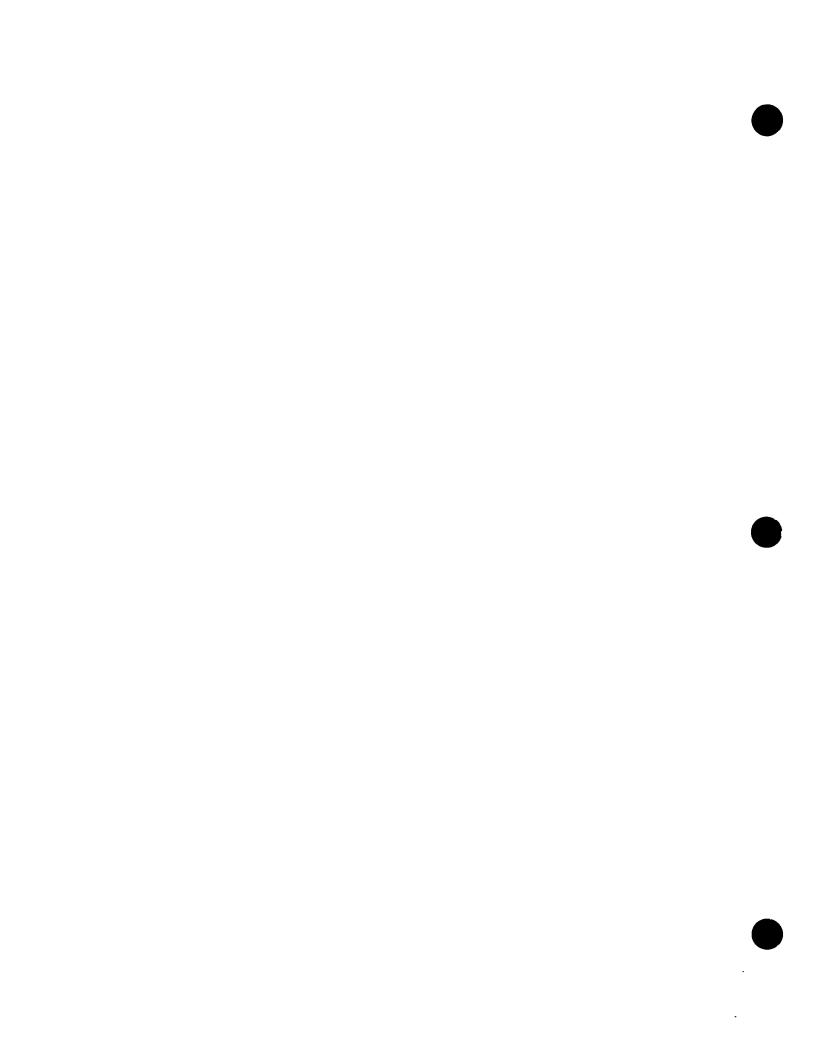
- ▶ Oral Cancer Screenings
- ▶ Fluoride Treatments
- X-rays
- Sealants
- Coronal Polishing
- ▶ Sterilization
- Schedule Appointment
- Maintaining Patient Records

CDHC in the Community:

- ► An Oral Health Advocate
- ▶ A Peer Counselor
- A Navigator
- ► An Oral Health Educator

*duties that comply with NC Dental State Practice Act





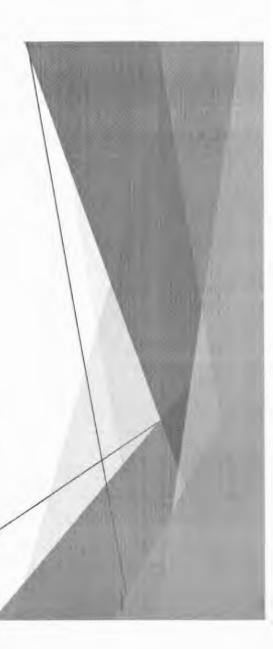
CDHC Training

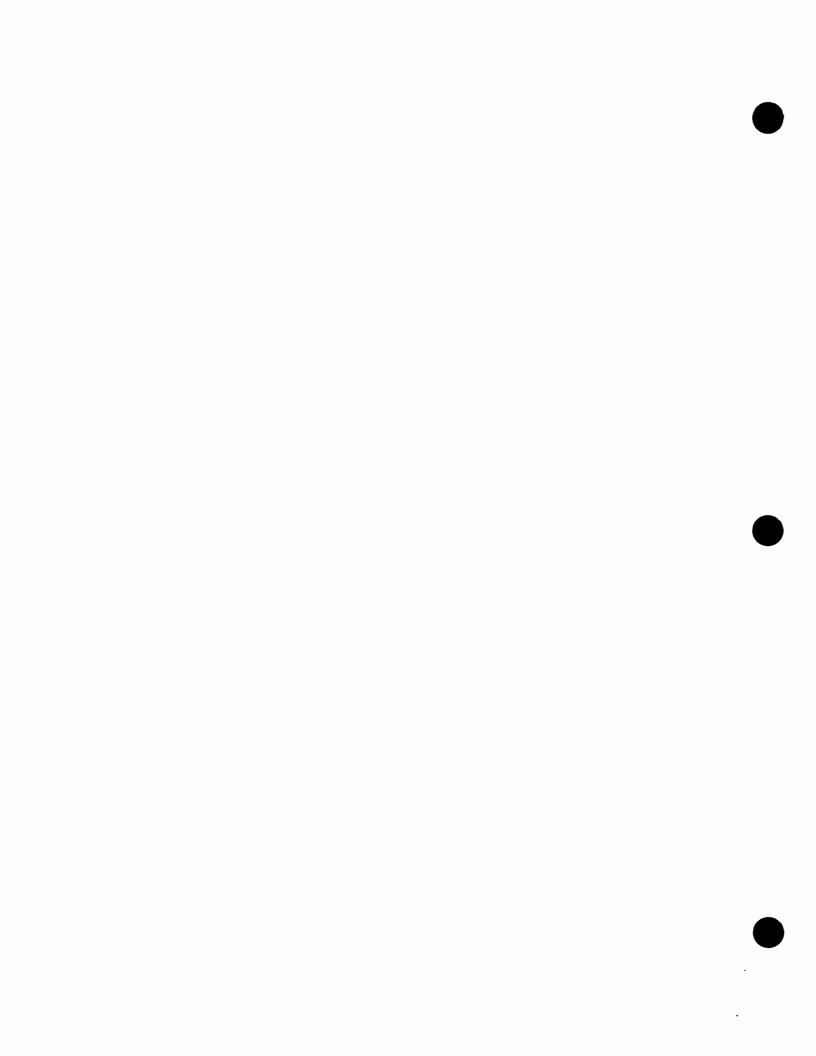
▶ Focuses on community outreach, care coordination, educational/ social interventions and prevention

CDHCs are trained to:

- Collect diagnostic information to triage patients
- Provide dental health education
- Coordinate care & navigation
- Address social, environmental, and health literacy issues
- ▶ Provide clinical services

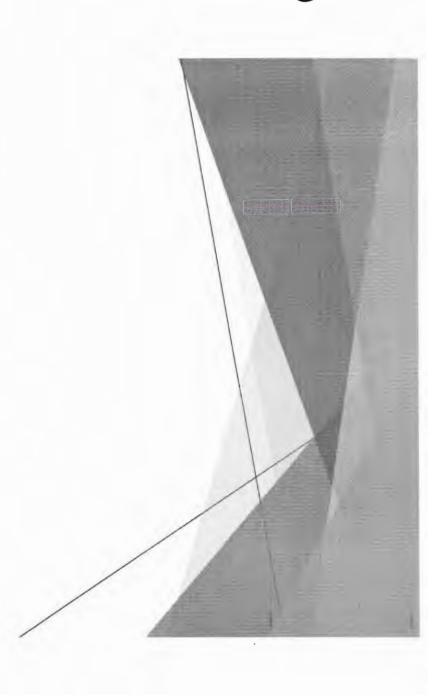
*under supervision of a licensed dentist





National CDHC Program Statistics

- ▶ 18 Schools approved to offer CDHC program
- ▶ 275 graduates to date
- ▶ Over 100 plus students currently enrolled
- ► CDHC's are working in over 26 states

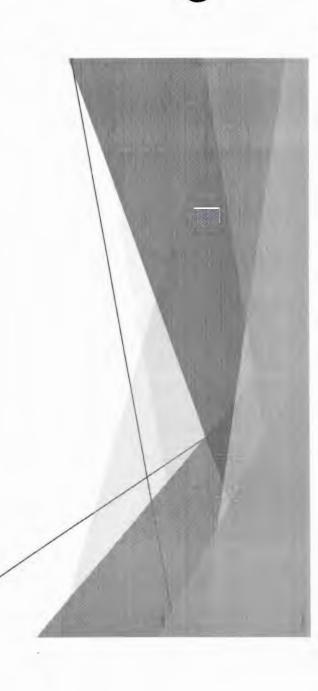


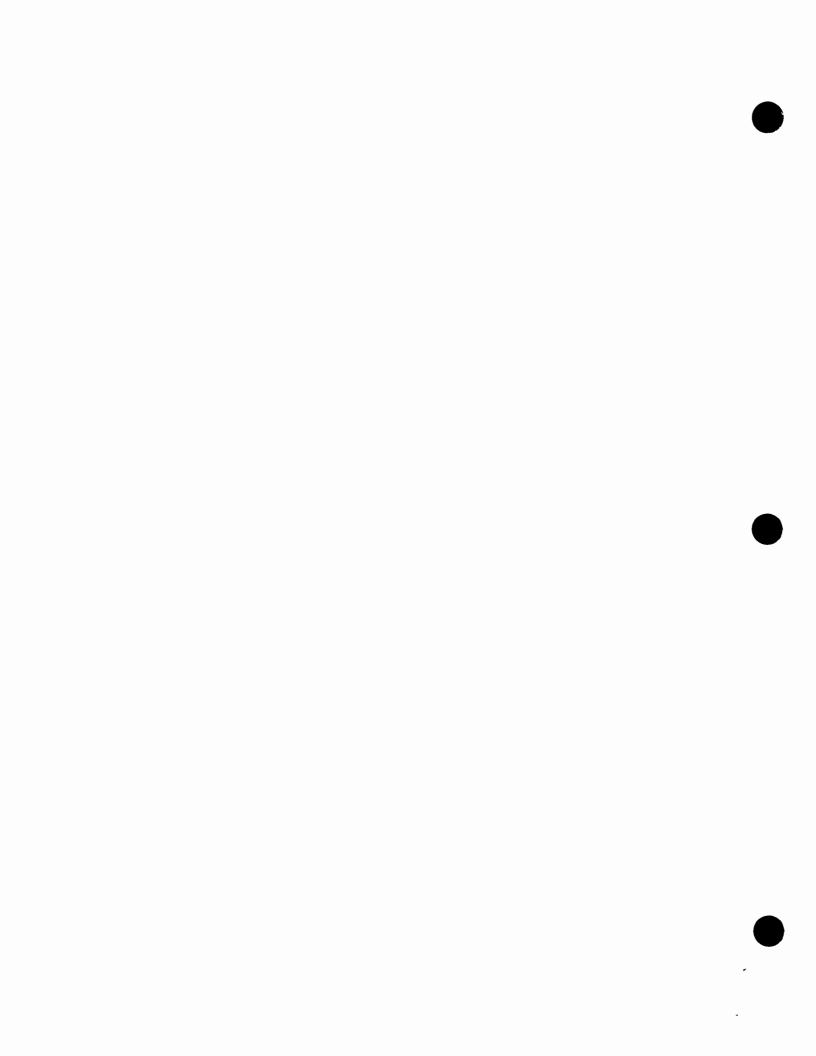


CDHC Curriculum at ACC

- Dental Health Advocacy and Outreach
- 2. Interviewing Skills for the Dental Advocate
- 3. Dental Health Legal and Ethics Issues
- 4. Communication and Cultural Competence
- 5. Dental Care Finance
- 6. Prevention of Oral Cancer
- 7. Internship

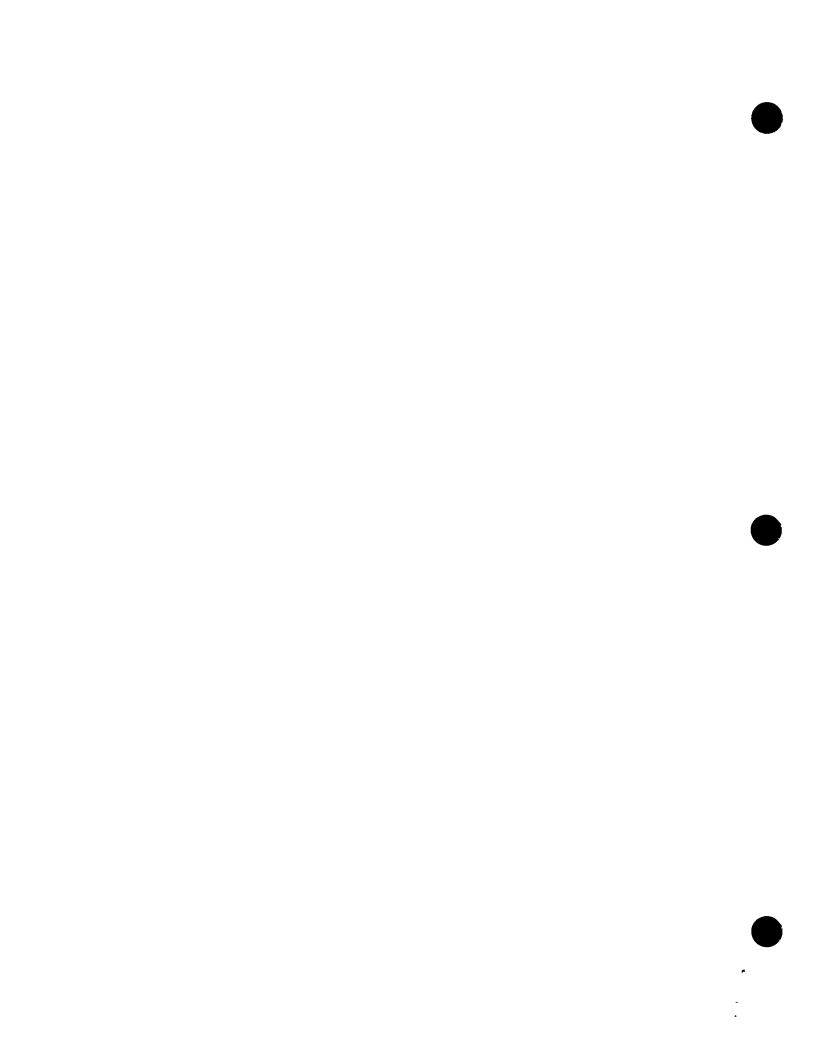
*as of August 2018





CDHC Curriculum at ACC

- ▶ Participants are required to be DAII's or RDH per NC State Dental Practice Act
- ▶ 8 month online program
- ► Low cost
- ▶ 12 week internship (144 hours)/completed anywhere
- ► Partnerships with ECU and UNC-CH
 - ► Clinical sites
 - ► POHP program (Prenatal Oral Health Program)



Where can this lead health care?

- ▶ Community-based care
 - ▶ Integration of medical, dental, and public health services
- ▶ Utilization of tele-dentistry
 - ► Share data for diagnosis & treatment
- ▶ Build relationships, utilize resources, get the community involved
- ► Expand and enhance access to health care
 - Oral health care treatment/prevention = alleviate chronic illness
- ► Increase preventative health services=lower the cost of care

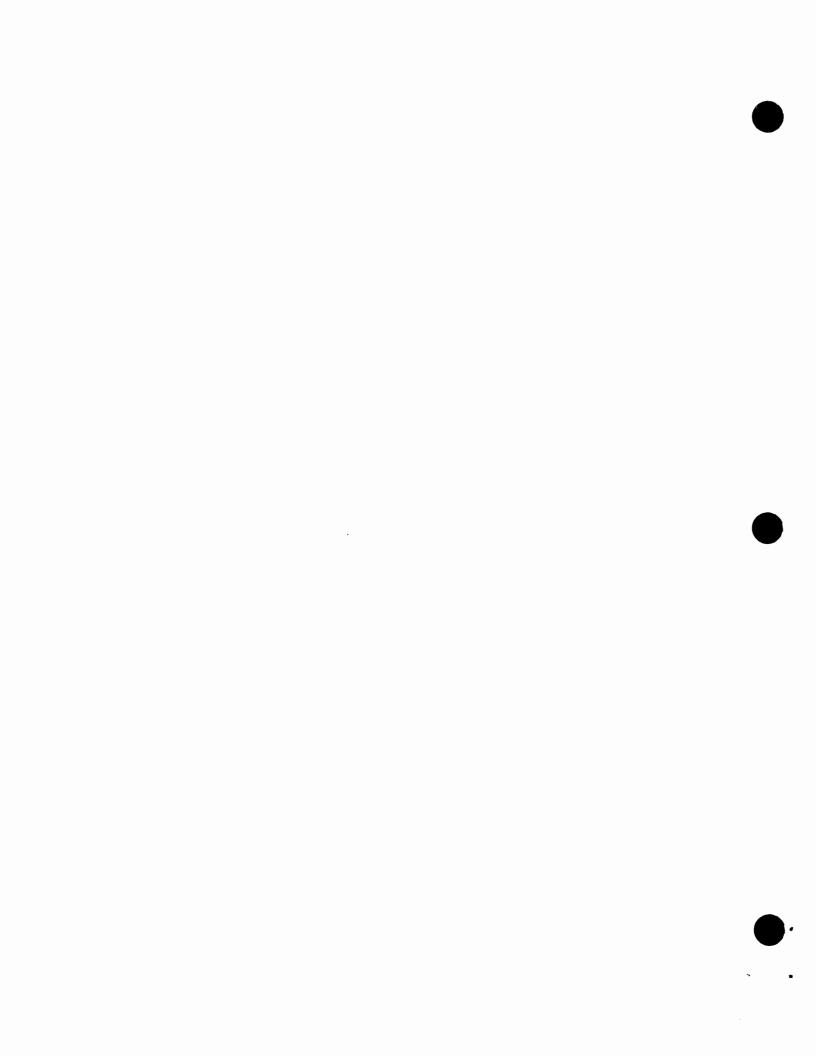
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THE LYME DILEMMA

Starting a Conversation

BY DR. BILL RAWLS

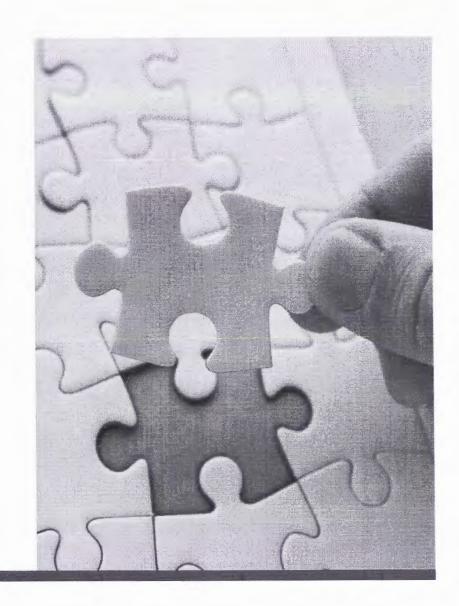


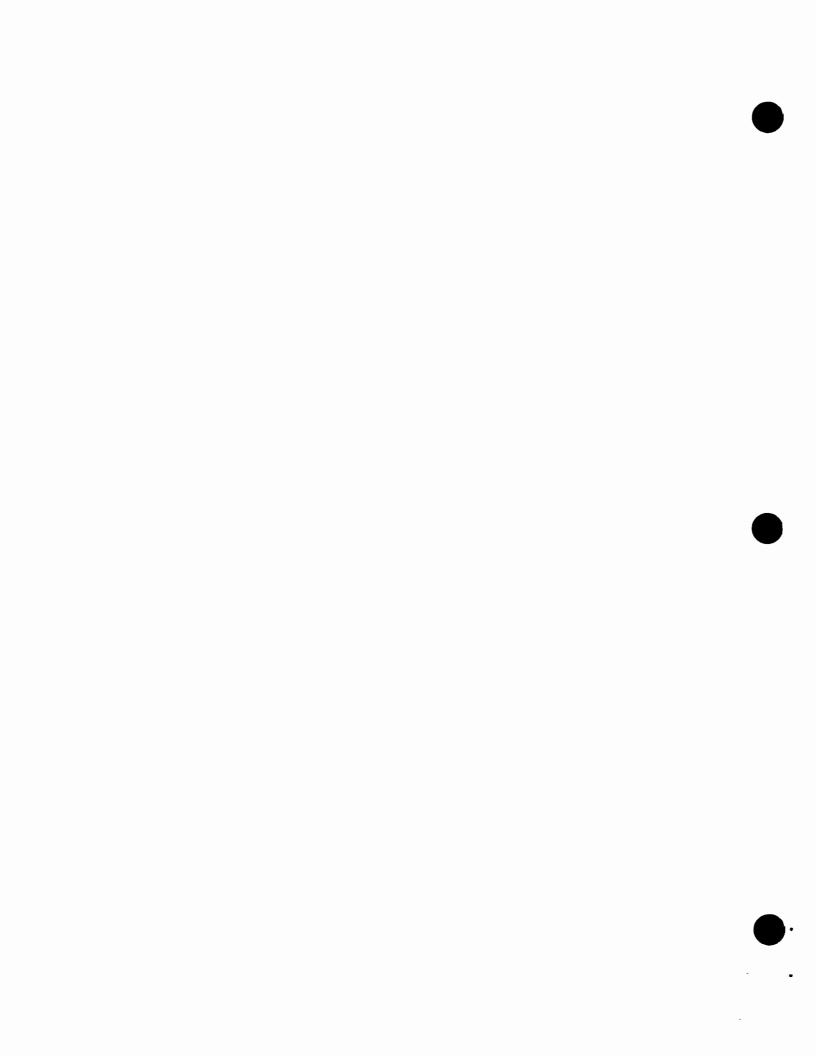


My Story



Solving the Lyme disease problem is like putting together a jigsaw puzzle without the benefit of the picture on the box.

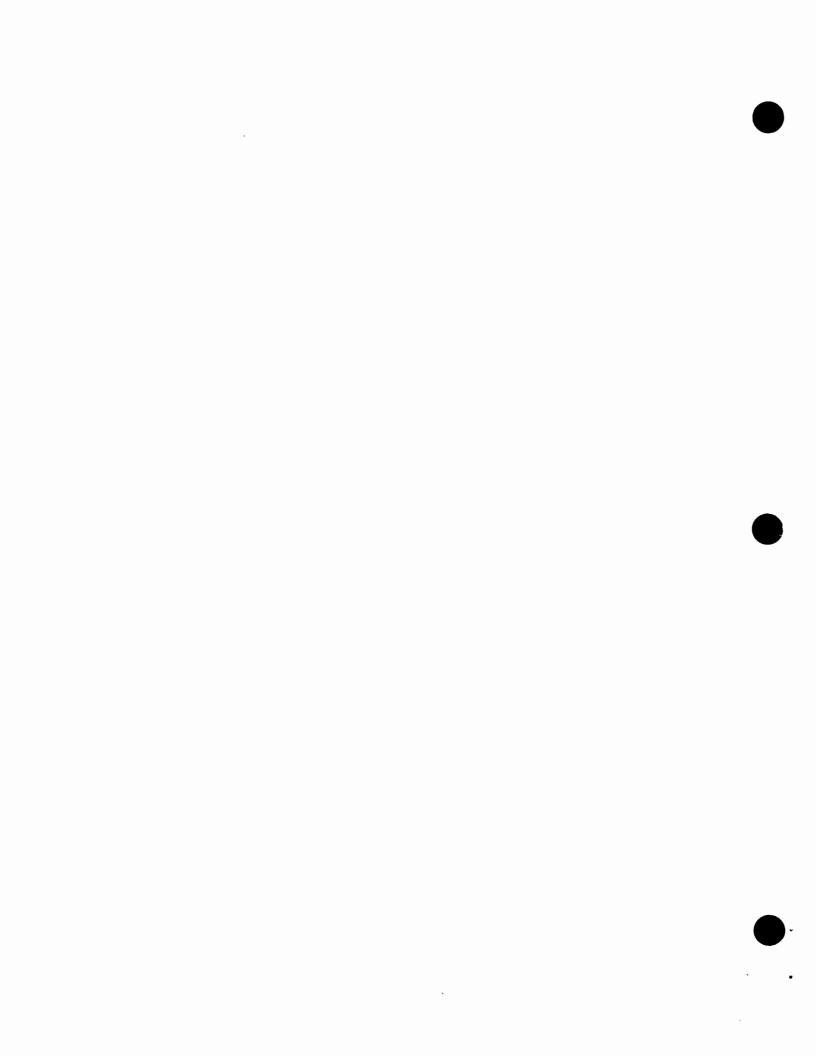




Lyme, CT — November 1975

51 people (39 children, 12 adults) became sick with a mysterious illness

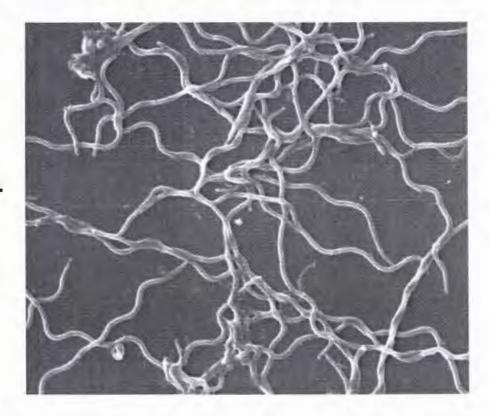


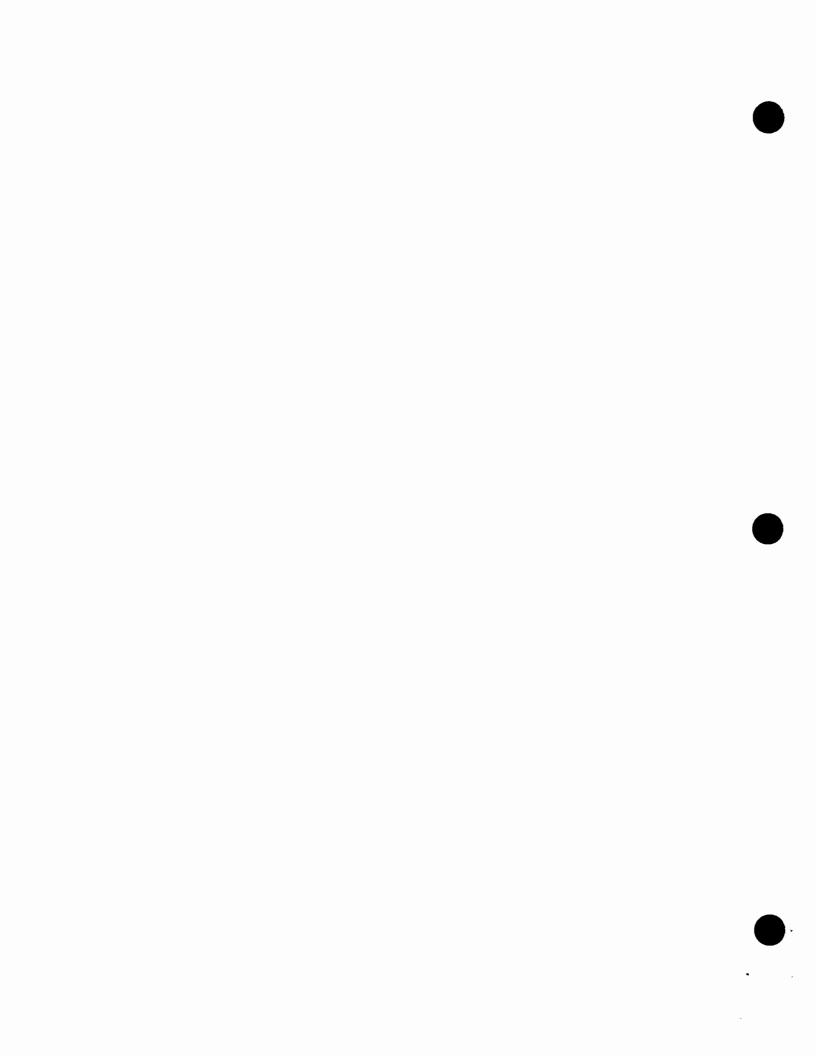


Hamilton, MT — November 1981

Dr. Willy Burgdorfer and colleagues identified and isolated a corkscrew-like bacteria (called a spirochete).

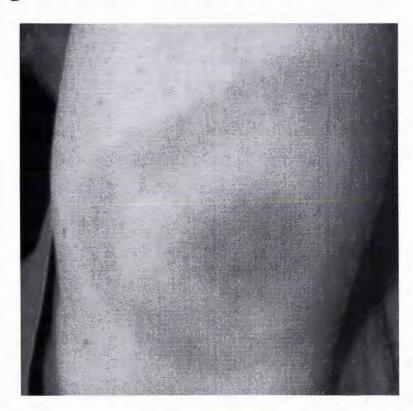
The microbe is named after him: **Borrelia burgdorferi**

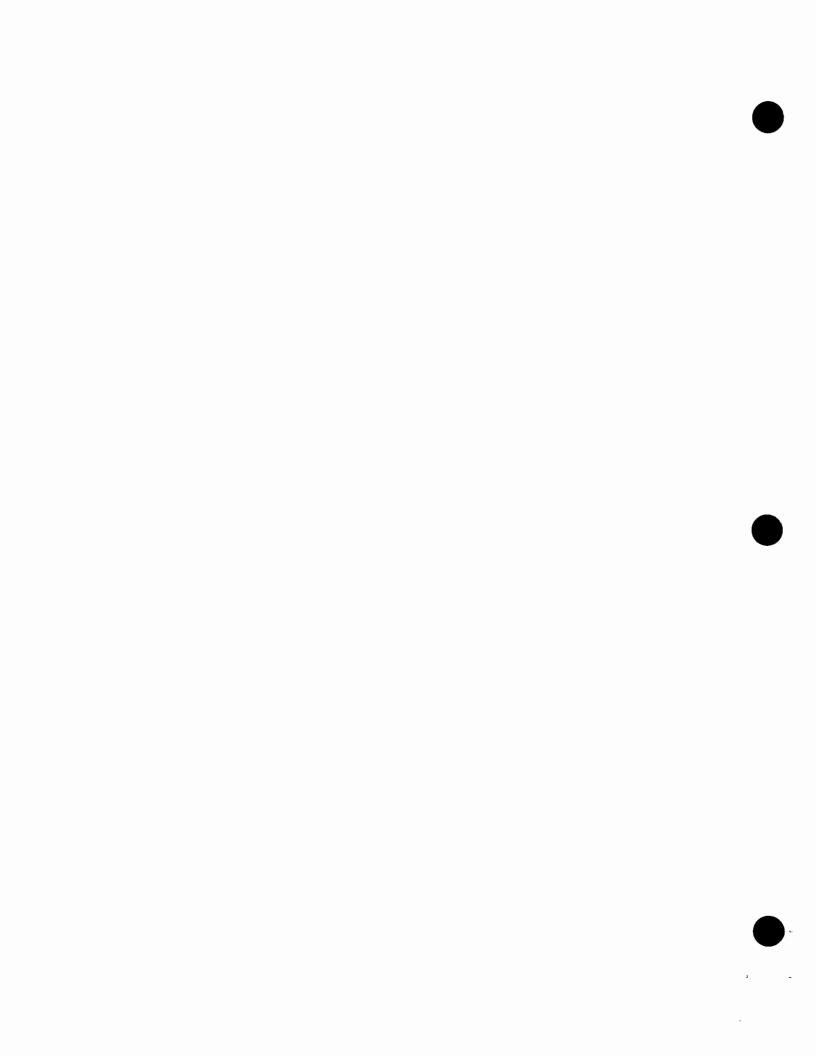




Acute Symptoms of Lyme Disease

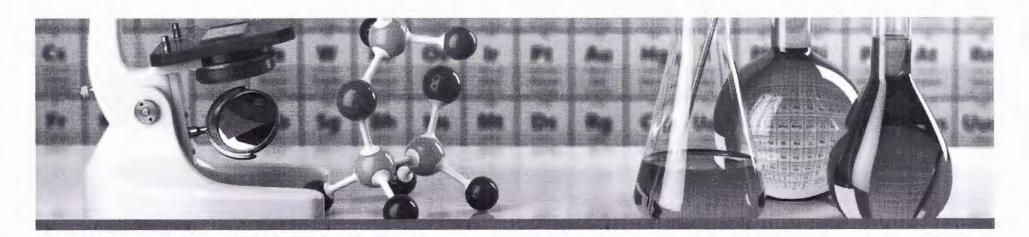
- Fever & chills
- Headache & neck pain
- Fatigue
- Muscle & joint aches
- Swollen lymph nodes
- EM rash (bull's eye rash)

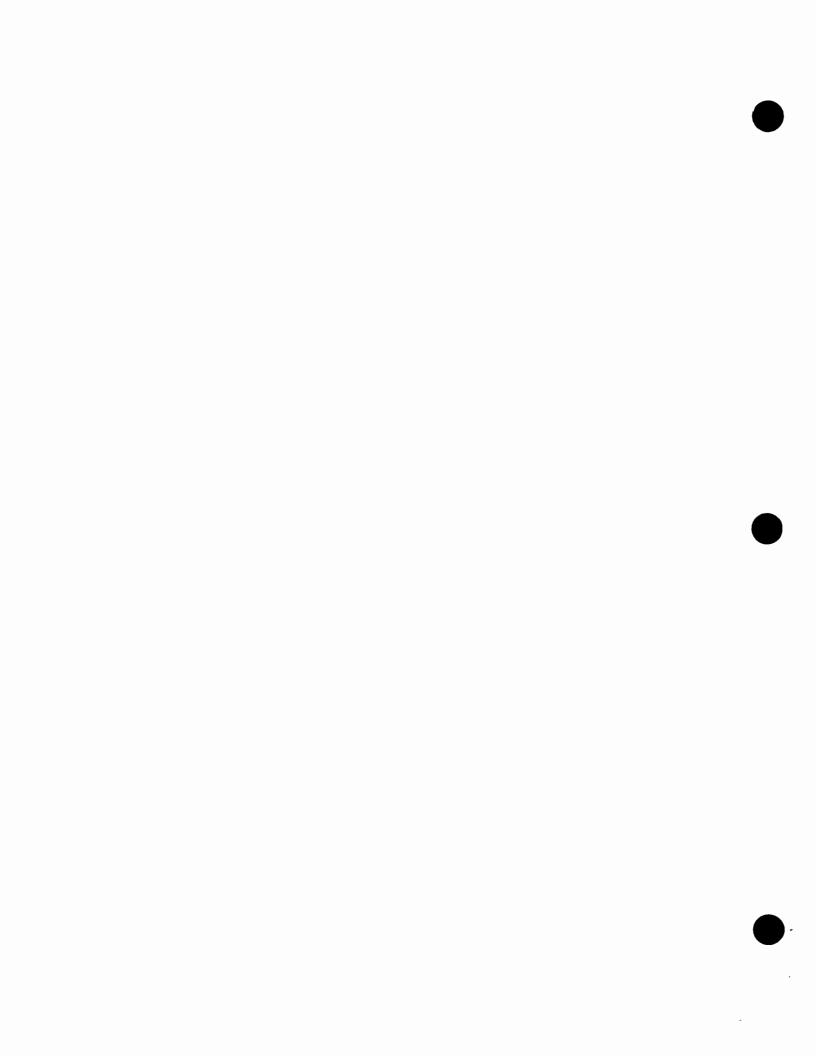




CDC Guidelines for Acute Diagnosis

- Testing is recommended only if symptomatic
- Two-tier testing
 - Enzyme Immunoassay (EIA)
 - Western blot

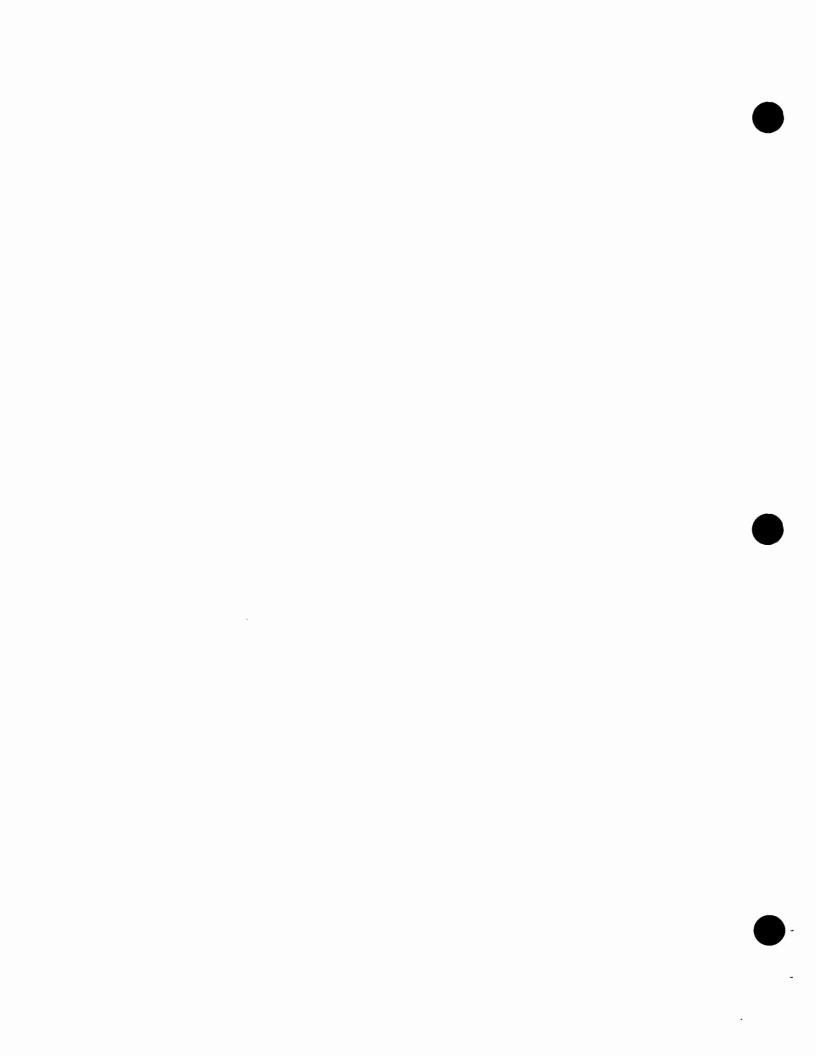




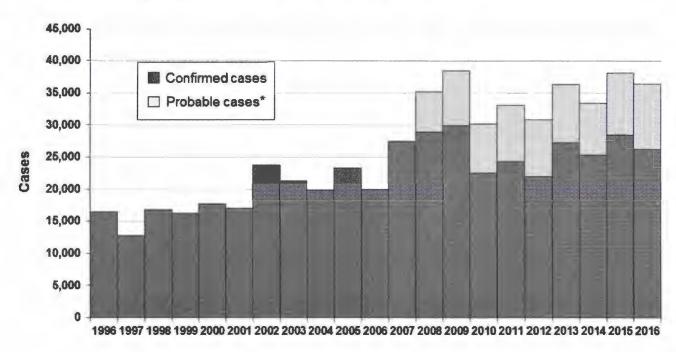
CDC Acute Lyme Treatment Guidelines

- Doxycycline 100mg twice daily for 10-21 days
- Alternative antibiotics: amoxicillin or cefuroxime



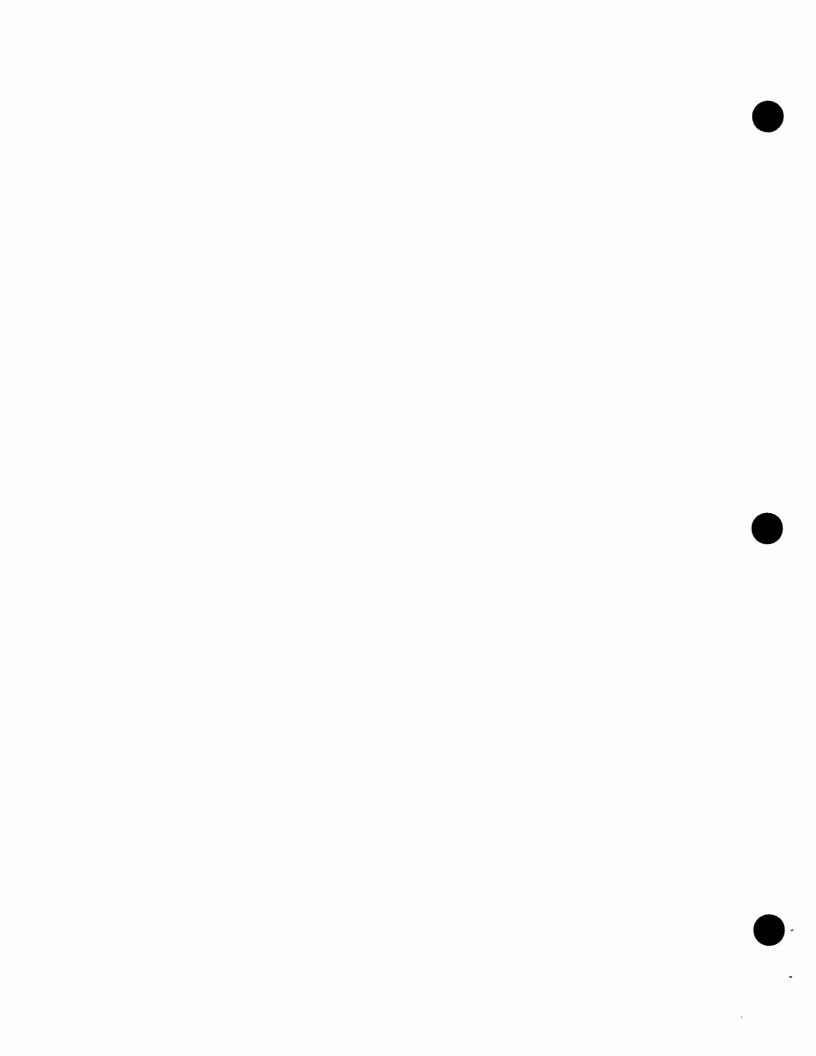


Lyme Disease Incidence

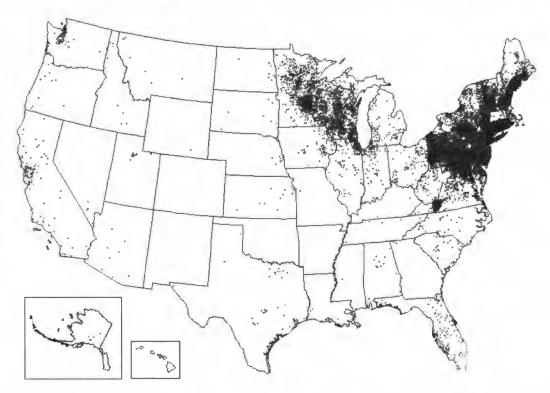


"National Surveillance case definition revised in 2008 to include probable cases; details at http://www.cdc.gov/ncphi/disss/nndss/casedef/lyme_disease_2008.htm

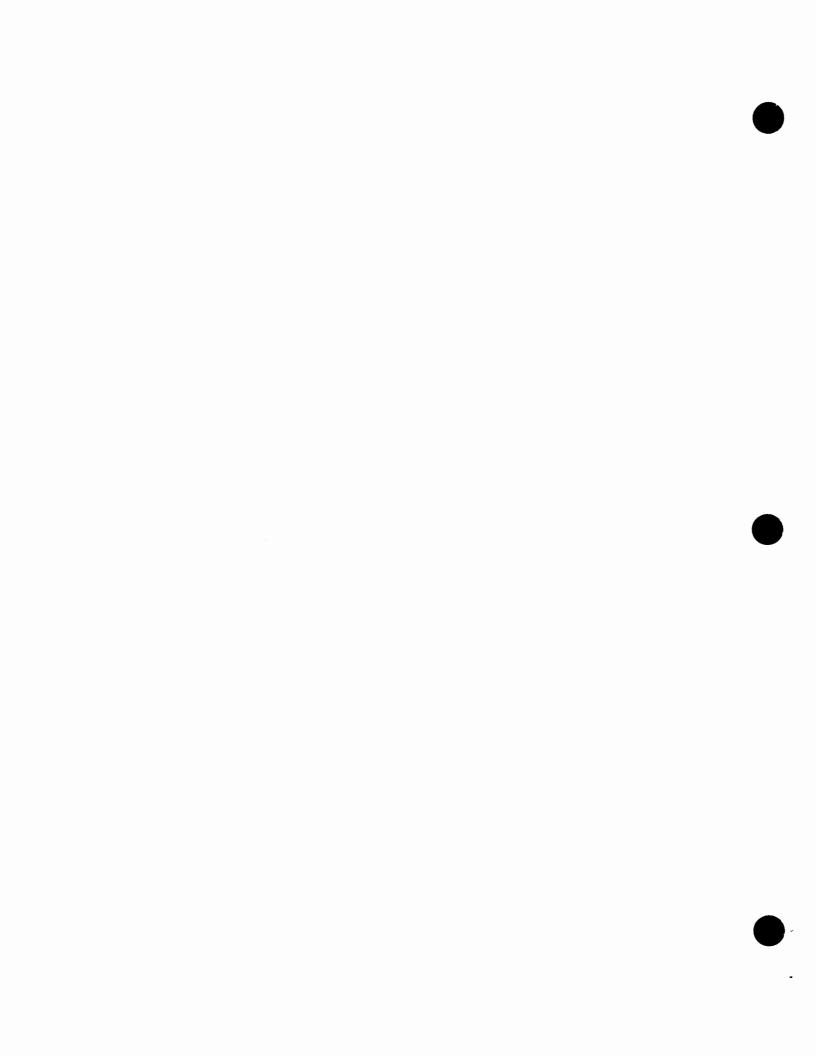




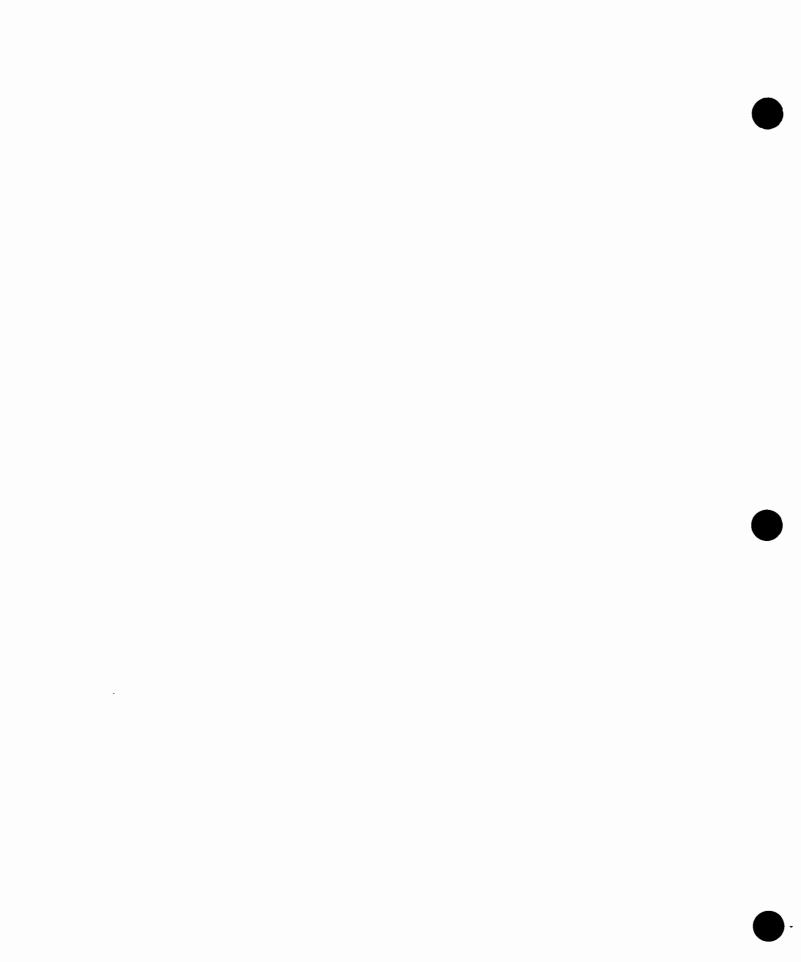
Lyme Disease is found in all 50 states



Quest-Lyme Disease Trends Report | Monday, July 30, 2018 (6:45am) | Quest Diagnostics Health Trends Report: Lyme Disease

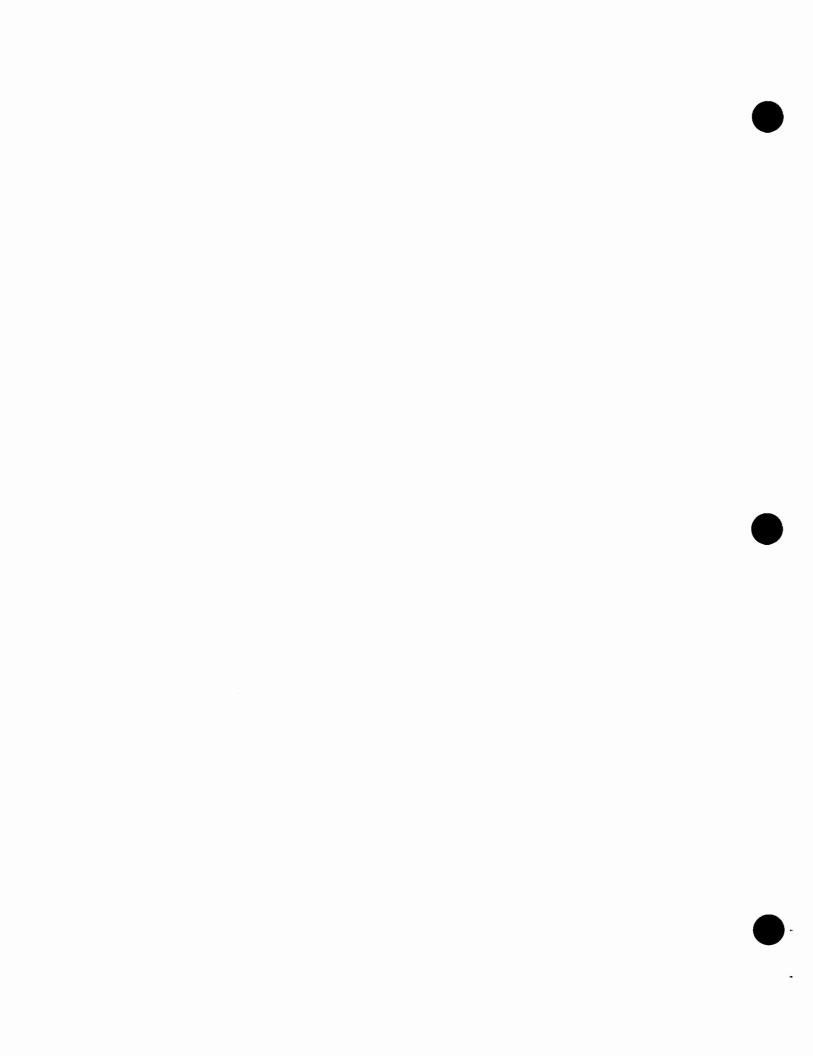


unreliably performed over the past Lyme disease and whether it is on 20 years, the actual incidence of the rise is completely unknown. Because testing has been



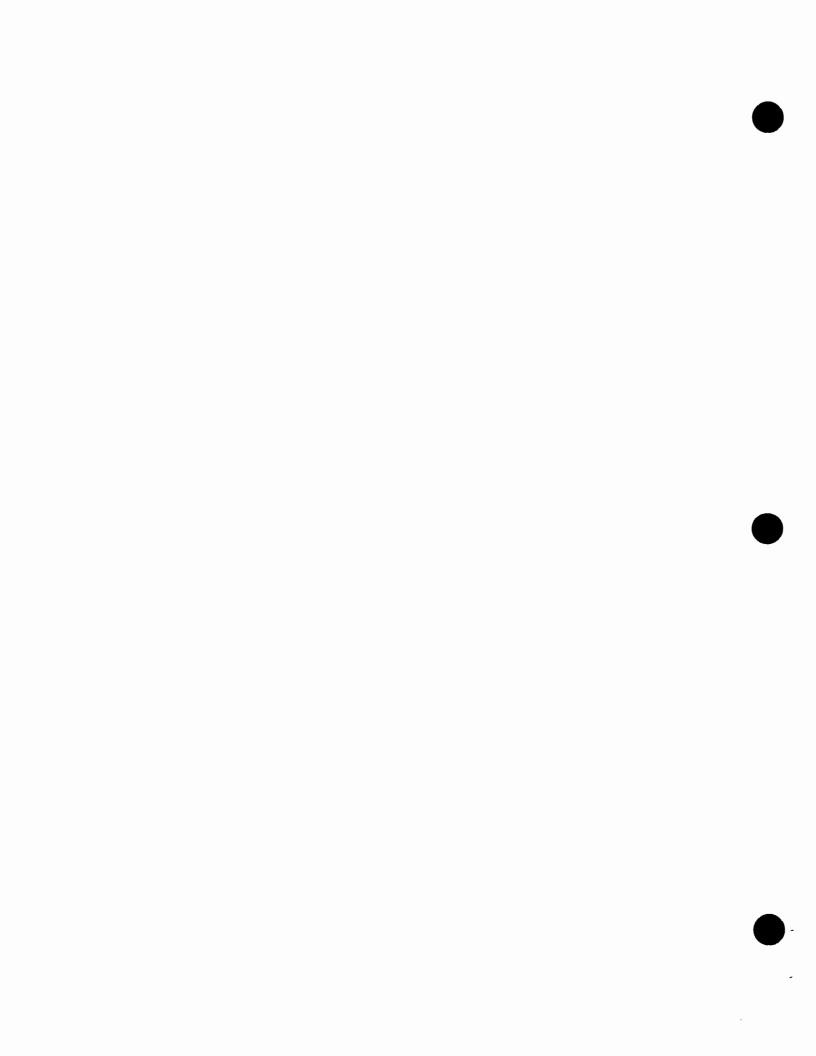
Current Statement from the CDC

"Each year, more than 30,000 cases of Lyme disease are reported nationwide, while studies suggest the actual number of people diagnosed with Lyme disease is more likely about 300,000."



Reasons for Lyme Underdiagnosis

- Acute symptoms are mild or absent
- People often don't recognize the tick bite
- Doctors aren't routinely testing for it
- Silent infection is extremely common
- EM rash occurs in only 40-60% of cases



CDC Statistics

2016 Lyme Incidence

• National: 26,203

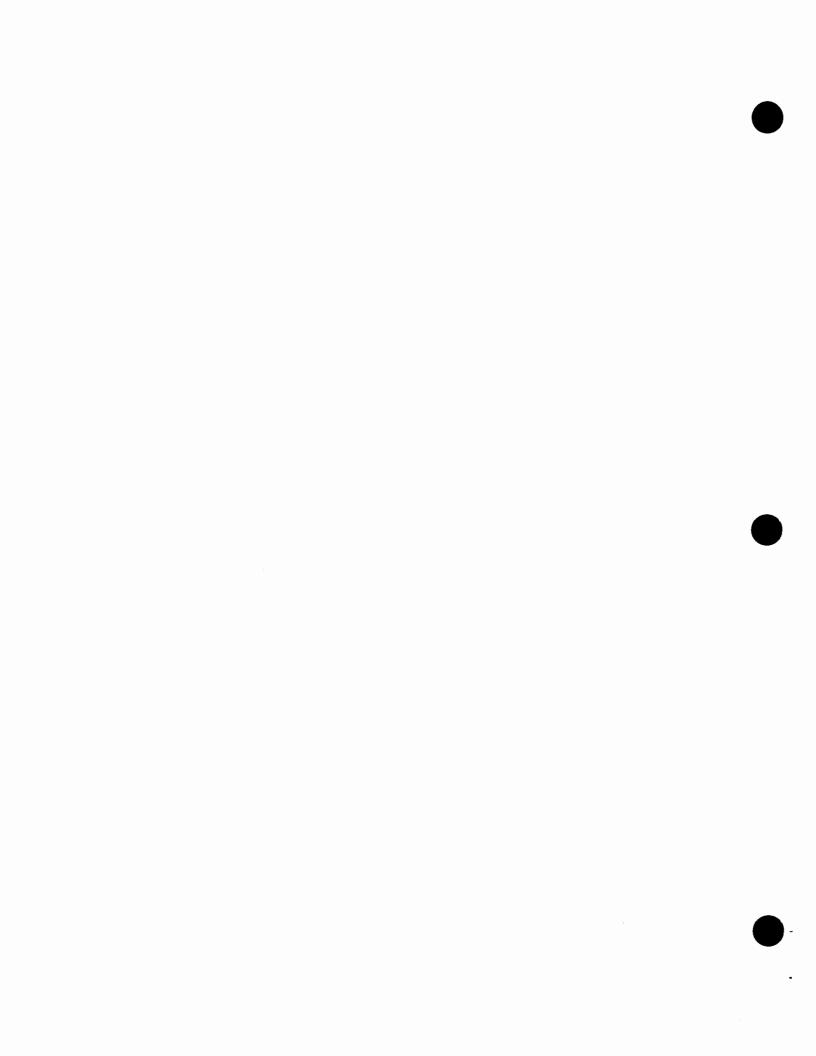
• NC: 32

• Deaths: 0

2014 Ebola Outbreak

• 28,616 cases

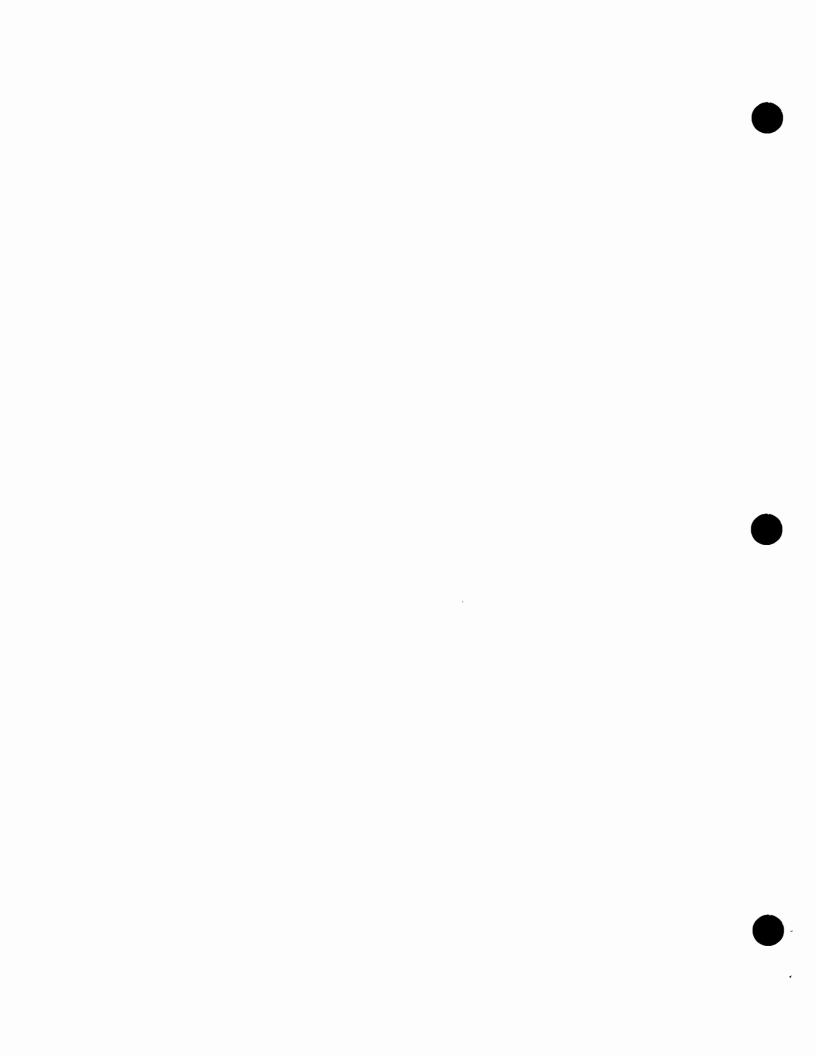
• Deaths: 11,310



Lyme Disease is Not a "New" Illness

EM rashes have been associated with tick bites for hundreds of years.

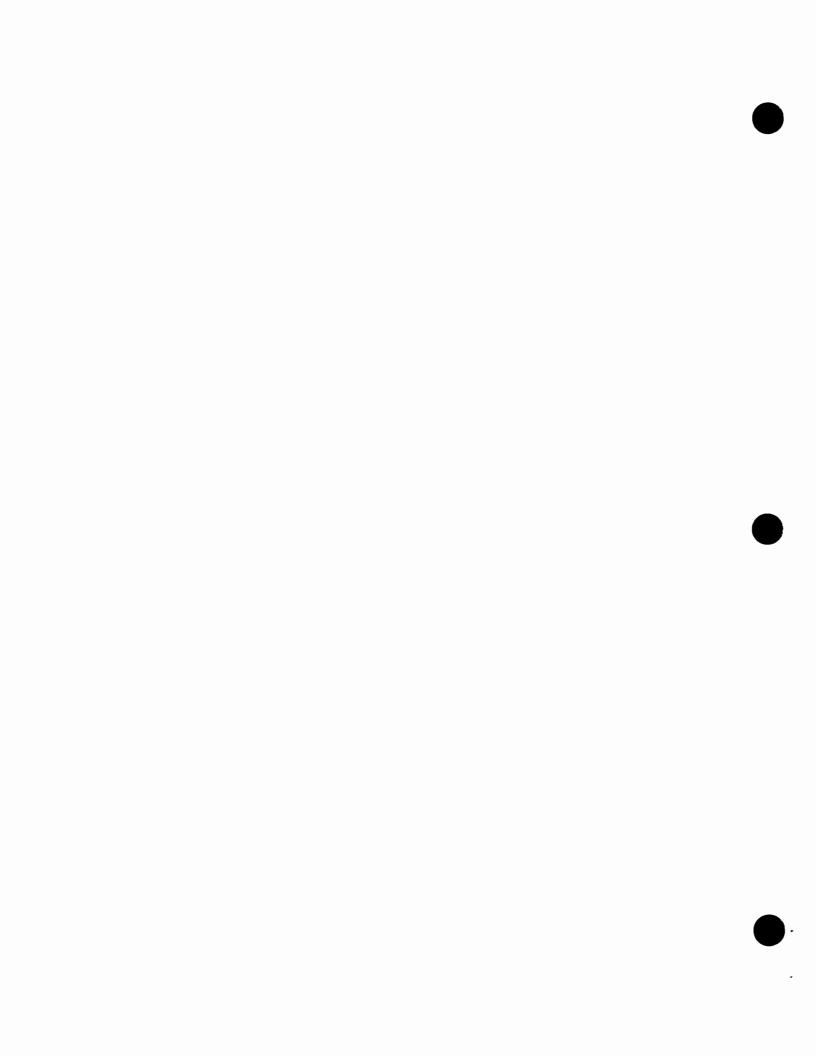




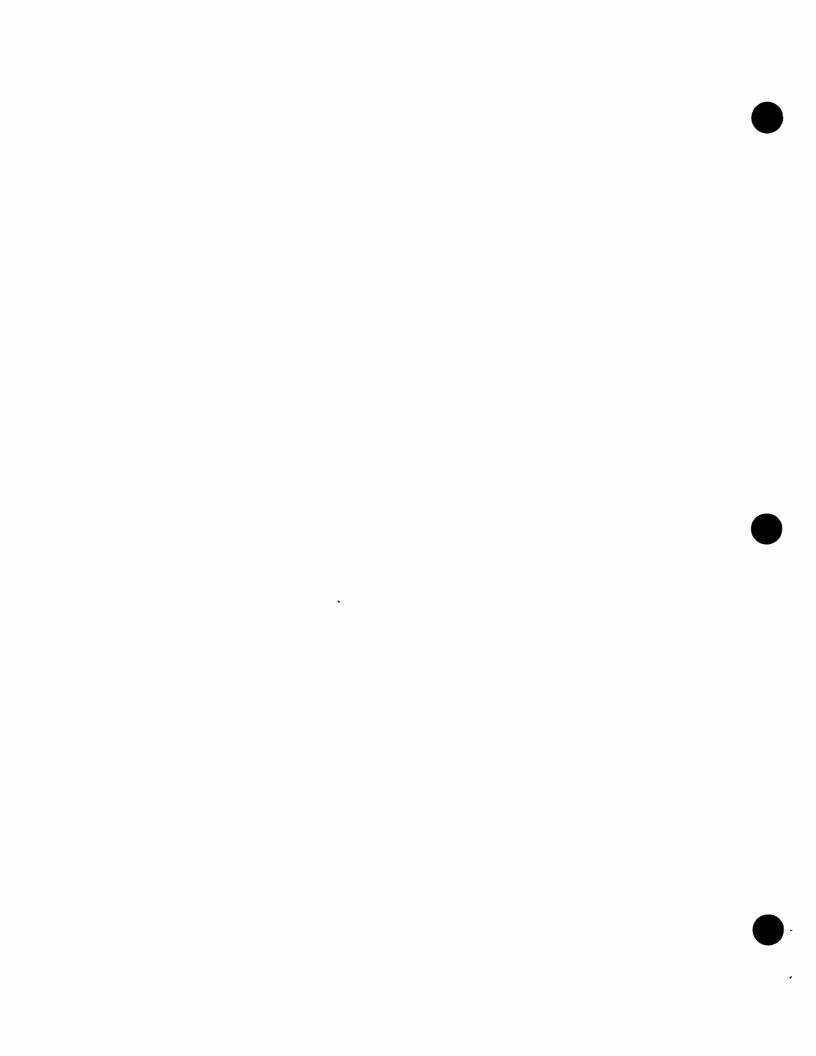
Ixodes scapularis

Borrelia burgdorferi is associated primarily with the *Ixodes scapularis* tick (deer tick or black-legged tick).



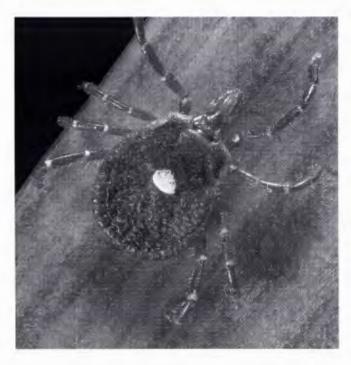


borrelia associated with There are 12 species of Lyme-like illnesses worldwide.

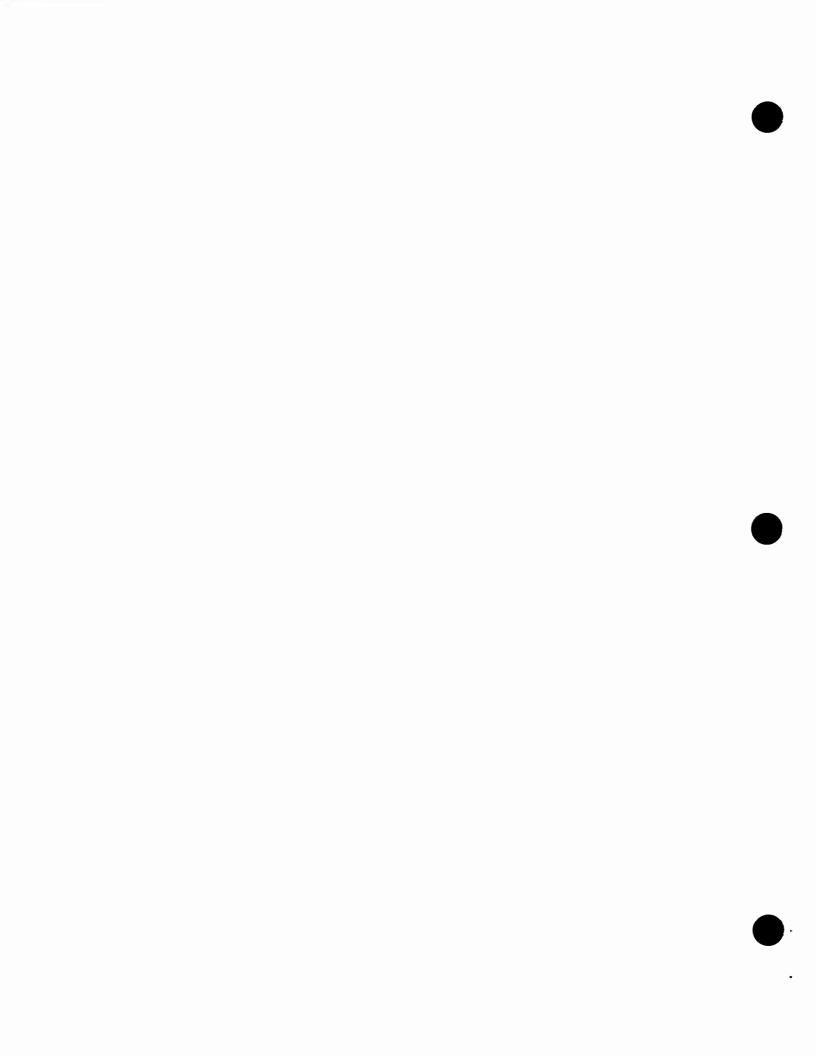


STARI (Southern Tick-Associated Rash Illness)

- Lone star tick (Amblyomma americanum)
- Suspected microbe: Borrelia lonestari (isolated from patients, but elusive to culture — CDC still lists STARI as cause unknown)

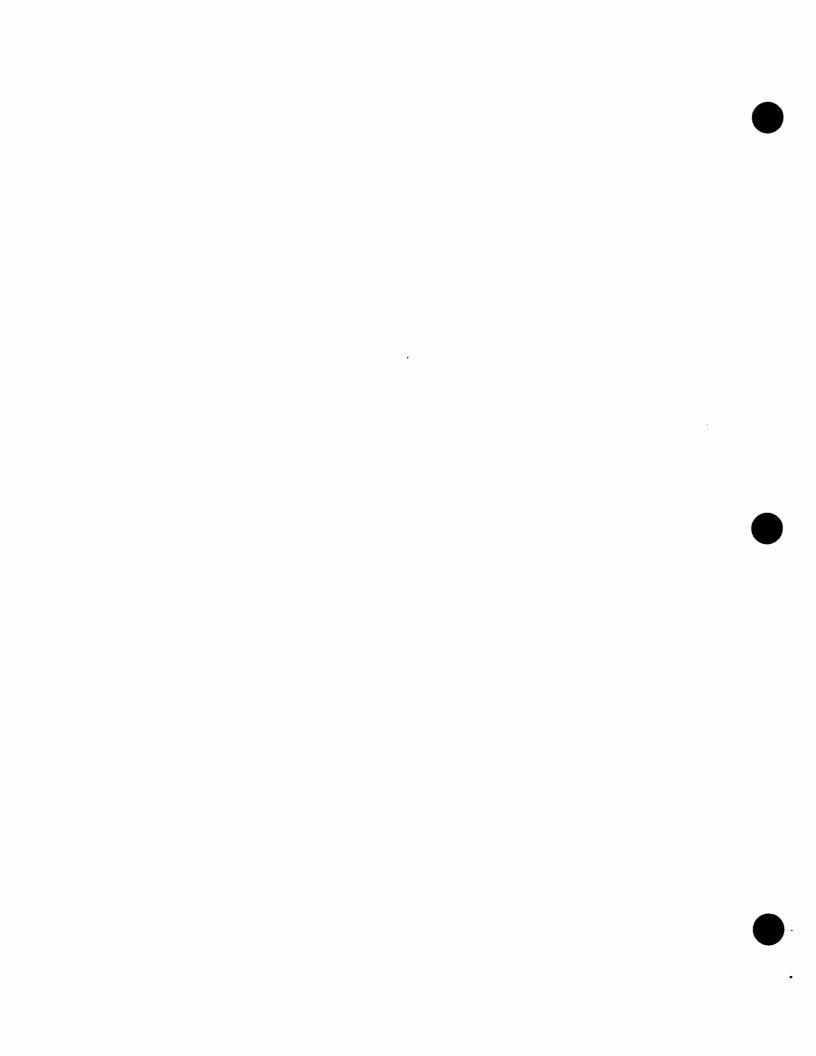


Varela AS et al. First culture isolation of Borrelia Ionestari, putative agent of southern tick-associated rash illness. *J Clin Microbiol.* 2004 Mar;42(3):1163-9.



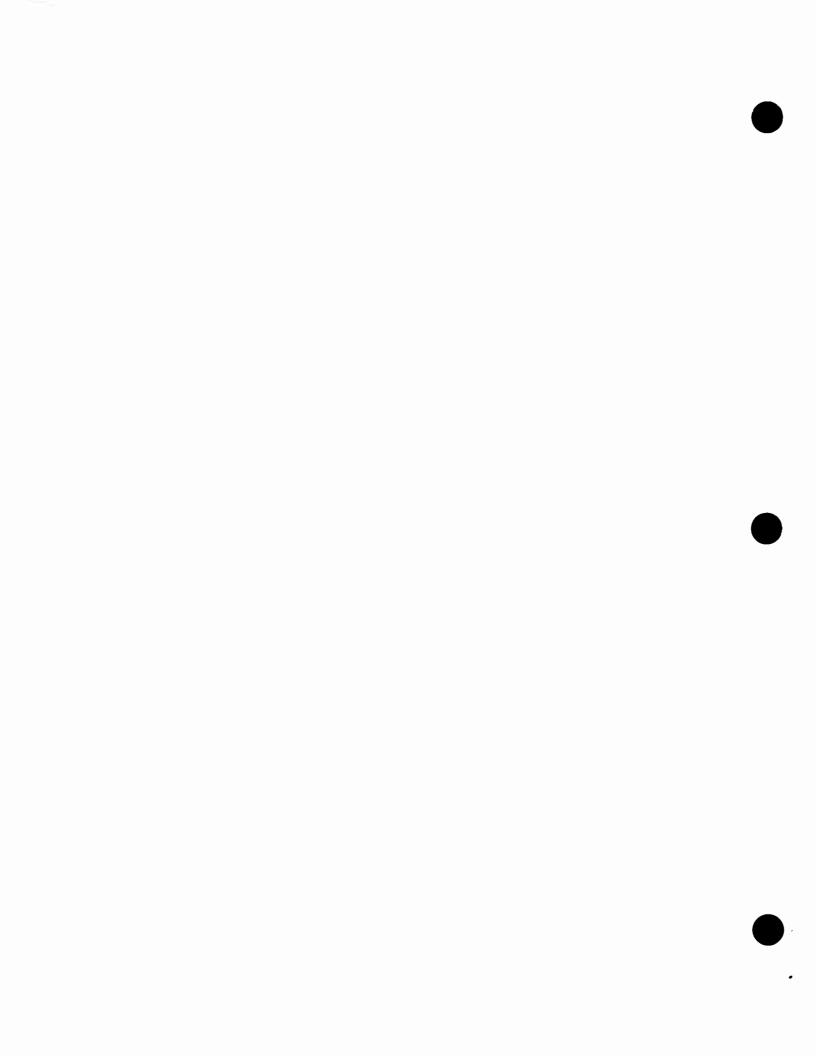
tropics to the Arctic Circle Borrelia occurs wherever there are ticks, from the

Sources. Hyidsten et al. Borrella burgdorferi sensu-lato-infected ixodes ricivous collected from vegetation near the Arctic Circle. Tick Borne



Why Lyme Disease is Controversial

- Most people seeking treatment for Lyme disease have chronic symptoms, not acute ones.
- Testing for chronic illness is unreliable.
- Chronic Lyme disease is not recognized by the CDC or IDSA (Infectious Disease Society of America).
- There's no medical code for "chronic Lyme disease."
- The long-term antibiotic therapy recommended by LLMDs (Lyme literate medical doctors) is costly and not supported by scientific studies.



Symptoms Associated with Chronic Lyme

Chronic pain (muscles, joints, lower back, neck)

Morning joint stiffness

Digestive dysfunction (reflux, bloating, gas, abdominal discomfort, constipation, loose stools)

Sleep dysfunction

Brain fog

Depression and anxiety

Mood instability / irritability

Flat emotions

Paresthesia (itching, numbness, tingling, burning, and/or skin-crawling sensation; pain when skin is touched)

Rashes

Headaches

Tooth pain

Jaw pain (TMJ)

Hypersensitivity to sound and light

Chemical sensitivity

Alcohol intolerance

Strange smell sensations

Feeling cold all the time

Increased allergies

Weight changes

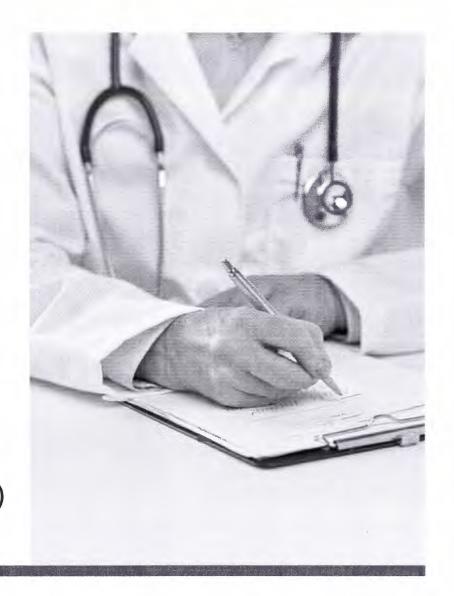
Orthostatic hypotension (fainting with standing)

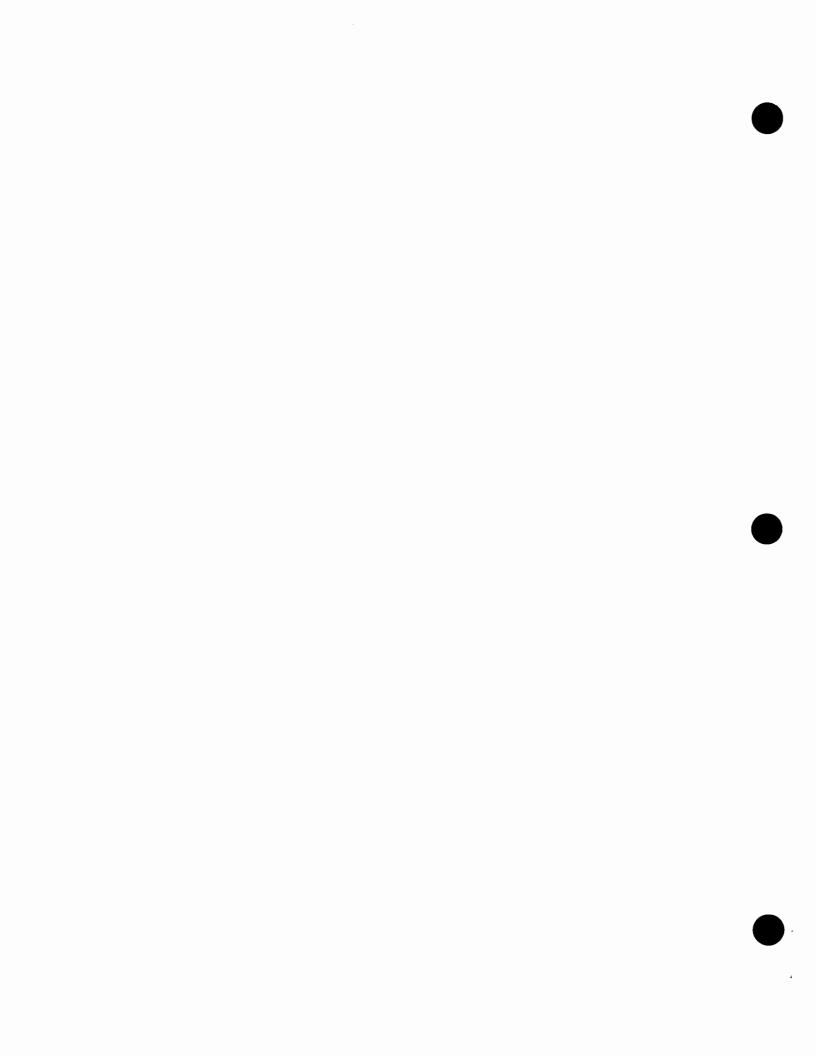
Chronic sore throat

Enlarged lymph nodes

Possible Diagnoses

- Fibromyalgia
- Chronic fatigue syndrome
- Chronic Lyme disease
- Thyroid disease
- Adrenal disease
- Autoimmune disease
- Multiple sclerosis
- Parkinson's disease
- Amyotrophic Lateral Sclerosis (ALS)

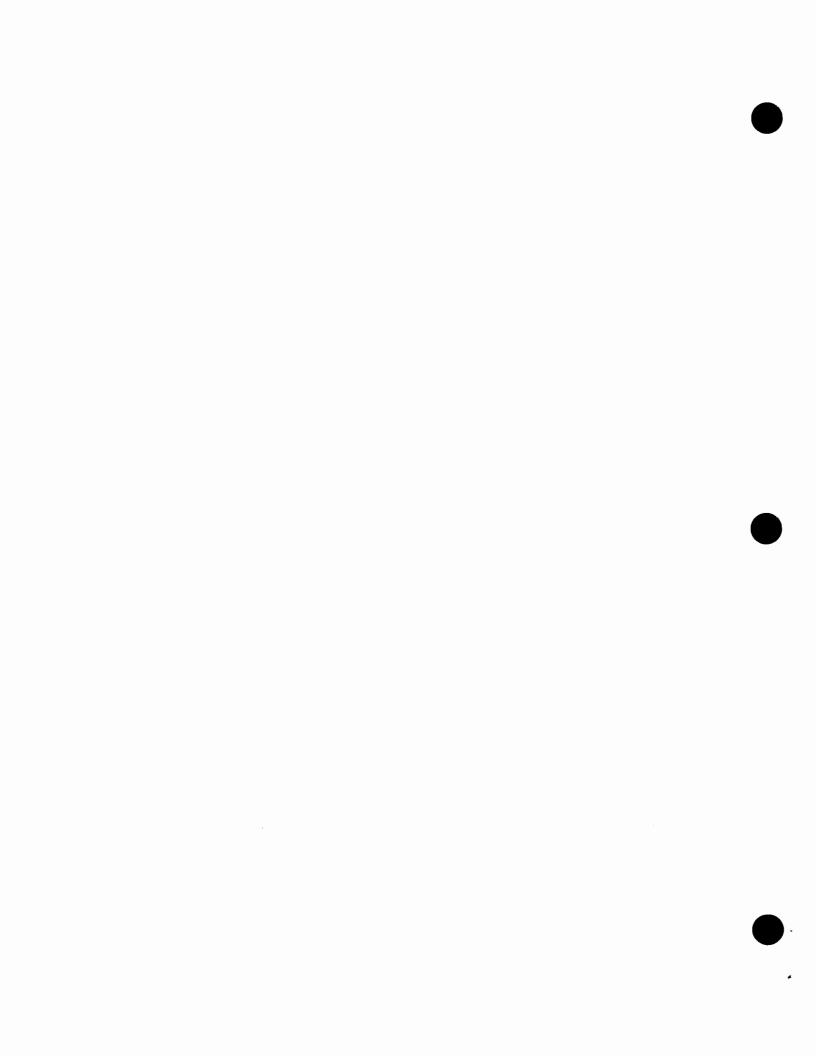




The Real Story of Lyme Disease

- Humans have been bitten by ticks throughout our existence.
- Ticks have been carrying borrelia as long as there have been ticks.
- The microbe has always been extremely common.





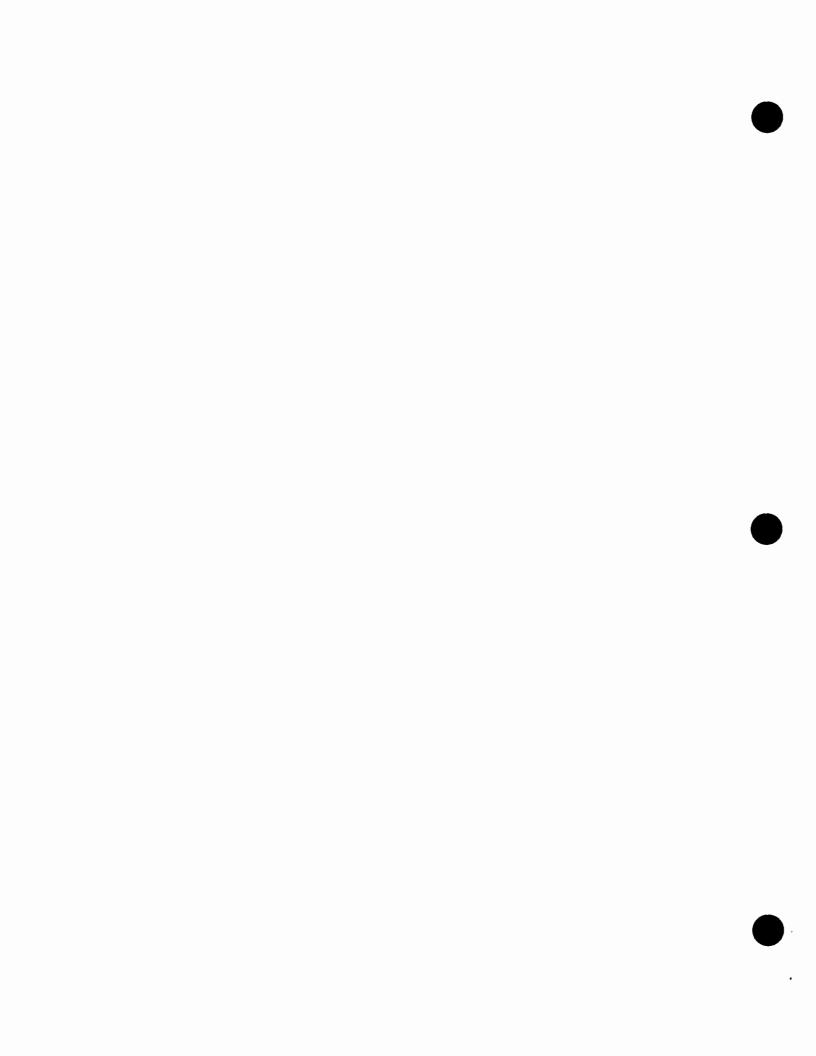
But borrella never travels alone...

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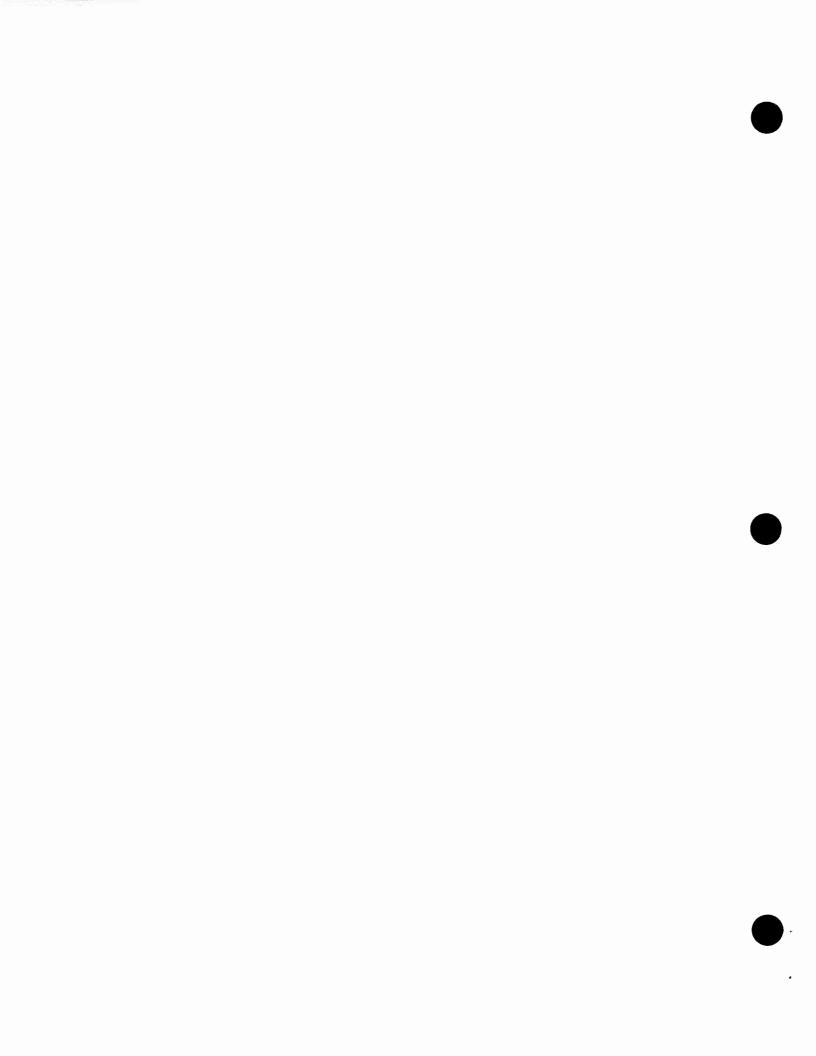
66

It is still possible that (spirochetes) are only markers for Lyme disease, and that the actual disease-causing agent is another microorganism co-introduced with the (spirochete).

— Willie Burgdorfer Ph.D., 1983, Journal of Clinical Investigation

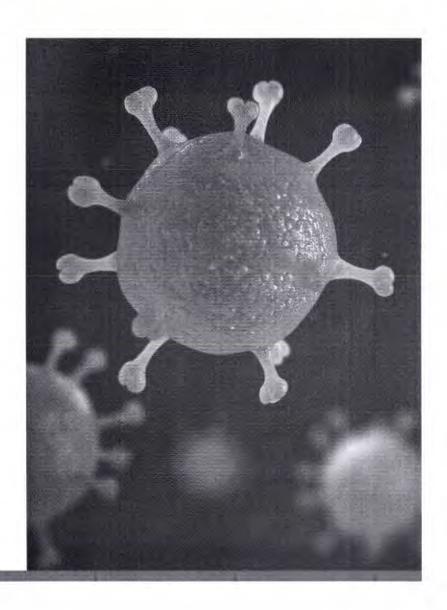


A tick can carry hundreds of different microbes.



Lyme Coinfections

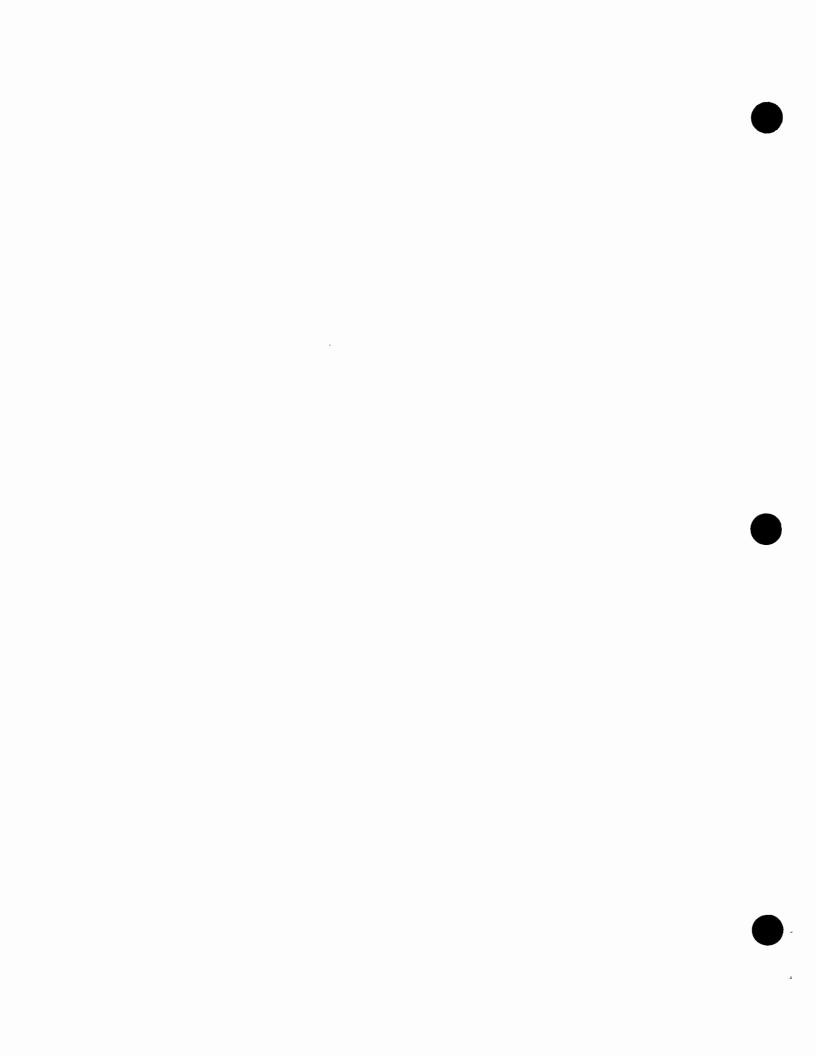
- Mycoplasma
- Bartonella
- Babesia
- Ehrlichia
- Anaplasma
- Rickettsia
- Chlamydia
- Reactivated Epstein-Barr virus
- Other viruses





Stealth Microbe Characteristics

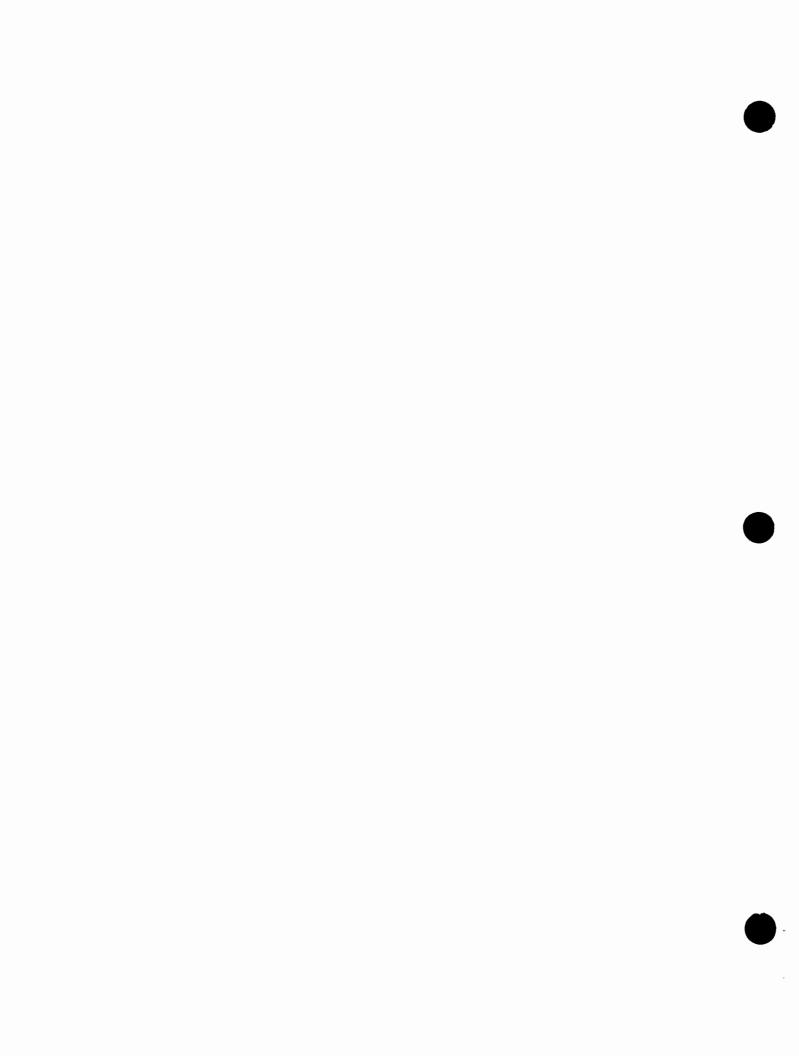
- Initial infection is often mild and unnoticed
- Intracellular (live inside cells)
- Infect WBC and spread throughout all tissues
- Silent infections are very common
- Survive by manipulating the immune system
- Extremely resistant to antibiotic therapy
- Commonly associated with coinfections



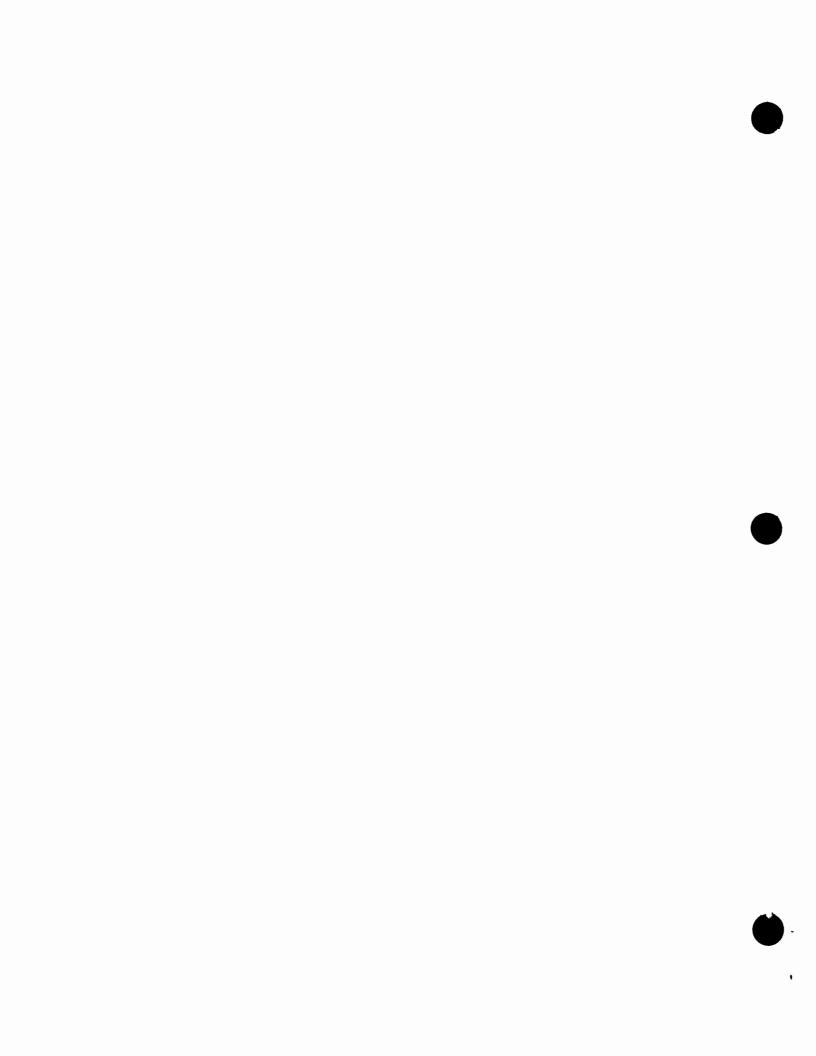
Depressed Immune Function is always part of the underlying problem.



SOLUTIONS



More research?



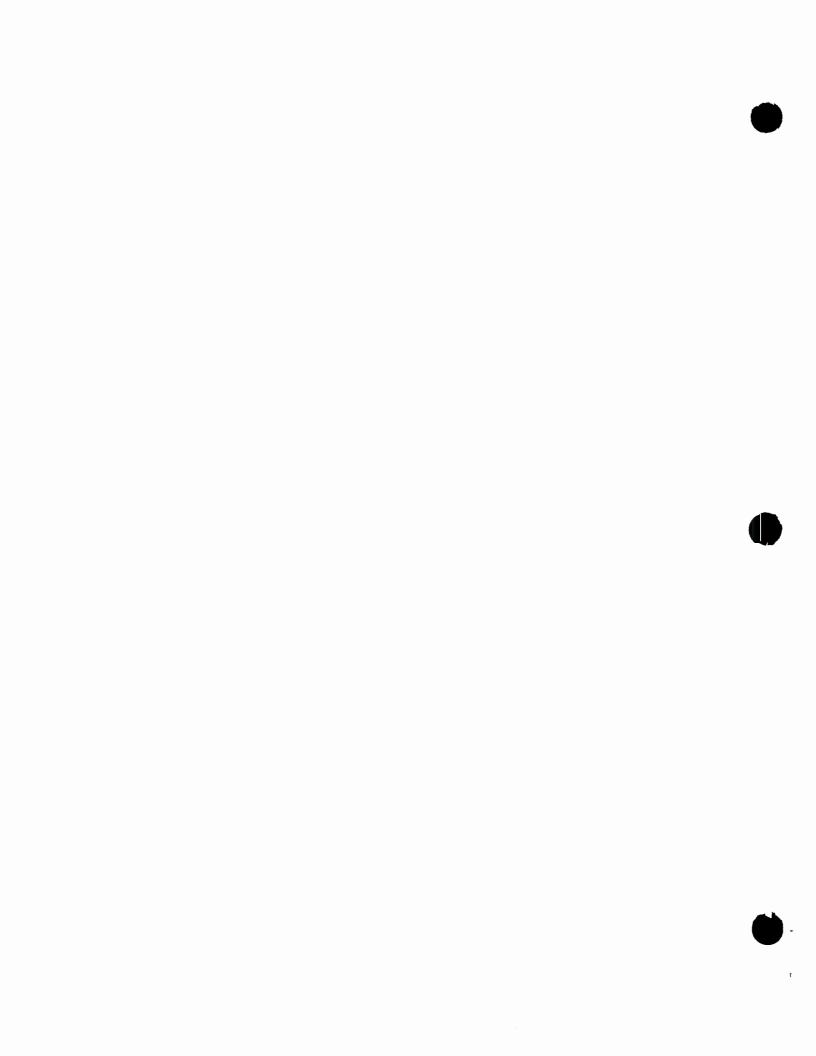
Improved testing?



Most Important

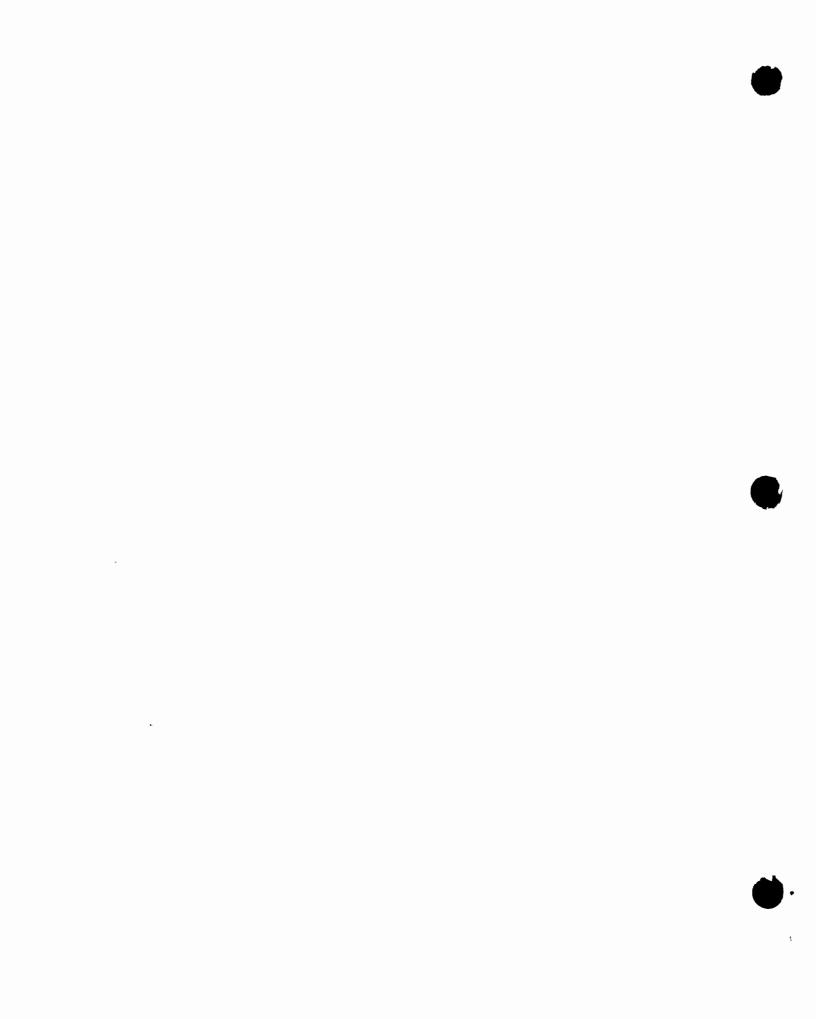
Education of the public and medical community about the complexities of Lyme disease





Necessary Recognition

- Lyme disease is predominantly a chronic illness
- Chronic Lyme disease as a diagnostic code
- Long-term antibiotic therapy alone has marginal value
- Underlying immune dysfunction must be addressed for wellness to be possible
- Restoration of wellness requires a comprehensive approach

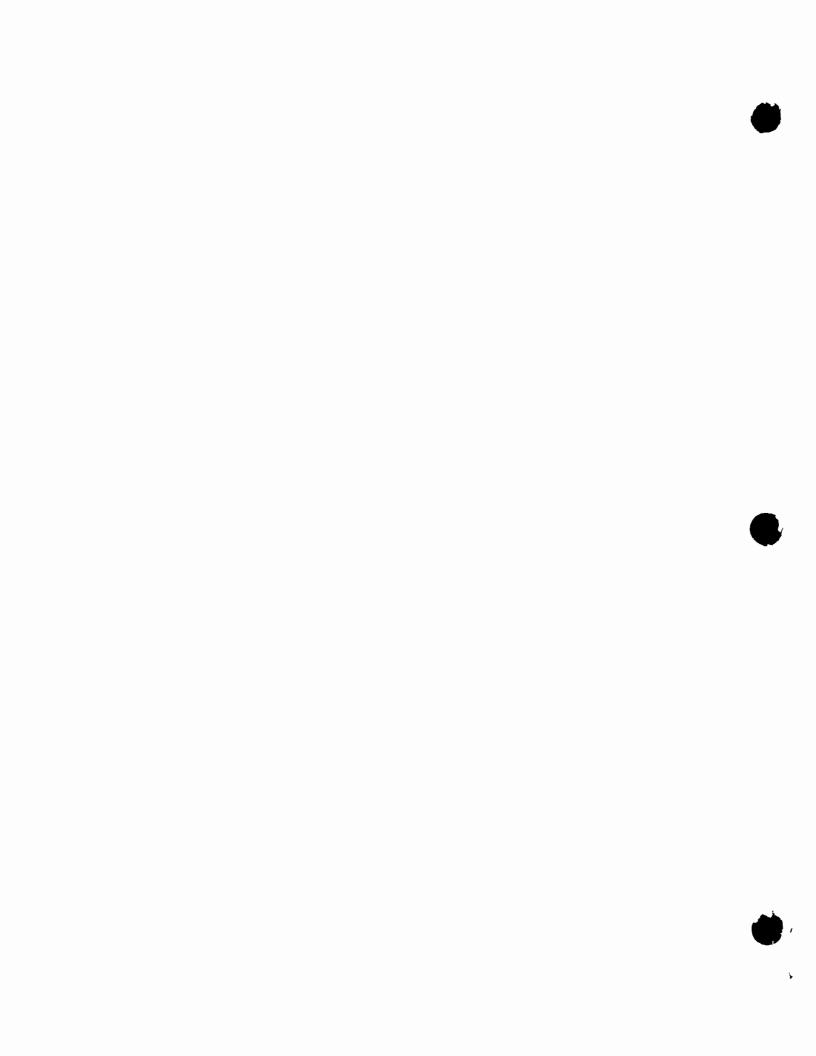


Restorative Therapy is Essential

Heroic Therapy

Symptomatic Therapy

Restorative Therapy



Meet Dr. Bill Rawls

In the middle of his successful OB/GYN career, Dr. Rawls' life was interrupted by Lyme disease. As he struggled to overcome it, he explored every treatment – from conventional medicine to a range of alternative therapies.

In the years since his recovery, Dr. Rawls has helped thousands of patients find their path to healing from Lyme disease. He is the author of the best-selling book *Unlocking Lyme*, and the **Medical Director of Vital Plan**, a B-Corp wellness company.

Learn more at RawlsMD.com »

