HOUSE BILL 125:
NC Health & Human Services Workforce Act.

2023-2024 General Assembly

Committee:	Senate Rules and Operations of the Senate	**Date:**	June 21, 2023
Introduced by:	Reps. White, Bradford, Riddell	**Prepared by:**	Trina Griffin
Analysis of:	Fourth Edition		Staff Attorney

OVERVIEW: House Bill 125 would do the following:

- ***Authorize the North Carolina Medical Board to issue a military relocation license and an internationally-trained physician employee license, subject to an application fee of $400.***
- ***Make modifications to the State Hearing Aid Dealers and Fitters Board related to over-the-counter hearing aids.***
- ***Add the Qualified Applied Behavior Analysis Credentialing Board as a certifying entity for behavior analysts.***
- ***Modify optometry laws to change the annual renewal deadline for licenses, increase license fees, modify Board authority and criteria related to mental or physical illnesses or substance use, amend the duty to report certain actions, allow optometrists to register with the Board of Pharmacy to dispense certain drugs, and authorize the Board of Pharmacy to charge a fee.***
- ***Require development of a plan to transition the Nurse Aide I education and training program from the Department of Health and Human Services to the Board of Nursing.***
- ***Enact the Hospital Violence Protection Act, increase the penalty for violating a protective order issued upon the request of a hospital, increase the penalties for assault and assault with a firearm on certain personnel, and make it an aggravating factor if a criminal offense is committed on the property of a hospital.***
- ***Modernize and expand physician-pharmacist collaborative practice and require insurers to pay for medical services rendered by pharmacists within the scope of their practice.***
- ***Allow the Office of Emergency Medical Services to permit non-EMT credentialled ambulance drivers for up to one year after the end of a public health emergency.***

CURRENT LAW/BILL ANALYSIS:

Part I. Military Relocation License

Section 1.1(a) adds a new section to Article 1 (Practice of Medicine) of Chapter 90 (Medicine and Allied Occupations), authorizing the North Carolina Medical Board (Medical Board) to issue a military relocation license to a physician or physician assistant who meets all the following requirements:

- Is a servicemember or the spouse of a servicemember who resides in North Carolina pursuant to military orders.
- Holds a current license in another jurisdiction that has equivalent licensure requirements.
- Holds a license in good standing with no disciplinary actions within 5 years.

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

- Has actively practiced medicine an average of 20 hours per week for the last two years.

The military relocation license would remain active for the duration of military orders and may be converted to a full license by completing an application.

Section 1.1(b) would impose a $400 fee to apply for the military relocation license established in this section or to apply for the internationally-trained physician employee license established in Section 2.2 of the bill.

Section 1.1(c) provides that this section becomes effective October 1, 2023.

Part II. Internationally-Trained Physician Employee License

Section 2.1(a) adds a new section to Article 1 (Practice of Medicine) of Chapter 90, authorizing the Medical Board to issue an "internationally-trained physician employee license" to an applicant who meets all the following requirements:

- Has been offered full-time employment as a physician in a North Carolina hospital or in a medical practice located in a rural county with a population of less than 500 people per square mile under the supervision of a licensed physician.
- Is currently licensed to practice medicine in a foreign country or had such license expire no more than five years prior to the application submission.
- Has completed education at a medical school listed in the World Directory of Medical Schools and has, after graduation, either:
    - Completed two years of training in a medical education program accredited by an agency with the World Federation for Medical Education Recognition Status.
    - Practiced medicine in the country of licensure for at least ten years.
    - Has either:
        - Demonstrated competency to practice medicine by:
            - Passing one of two specified examinations;
            - Receiving specialty board certification; or
            - Submitting to a Board-approved assessment demonstrating clinical competence;

          or, if the Board waives this requirement,
        - Has passed either the Special Purpose Examination or Post-Licensure Assessment Systems within one year after being issued a temporary license by the Board.
- Has had no license revoked, suspended, restricted, denied, or otherwise acted against in any jurisdiction and is the subject of no pending investigations.
- Has had no convictions involving moral turpitude or violation of law involving the practice of medicine or equivalent to a felony.
- Has practiced medicine for at least 5 years, is proficient in English, and is legally authorized to work in the U.S.

A holder of an internationally-trained physician employee license who practices outside the confines of the hospital or medical practice by whose employment the holder was qualified to receive the license shall be guilty of a Class 3 misdemeanor and subject to a fine of not more than $500.00 per offense.

An internationally-trained physician employee license becomes inactive when its holder:

- Ceases to be employed in a North Carolina hospital or rural medical practice.
- Is issued any other license to practice medicine by the Board.

Section 2.1(b) requires the Medical Board to adopt rules implementing the internationally-trained physician employee license and authorizes the Medical Board to establish a time limit on the term of the license.

Section 2.1(c) provides that Section 2.1(a) becomes effective October 1, 2023.

Part III. Over-The-Counter Hearing Aid Modifications

Section 3.1(a) amends the definitions found in G.S. 93D-1, applicable to the North Carolina State Hearing Aid Dealers and Fitters Board, to include a definition for an "over-the counter hearing aid" as it is defined in 21 C.F.R.§ 800.30(b):

> An over-the-counter (OTC) hearing aid is an air-conduction hearing aid that does not require implantation or other surgical intervention, and is intended for use by a person age 18 or older to compensate for perceived mild to moderate hearing impairment. The device, through tools, tests, or software, allows the user to control the hearing aid and customize it to the user's hearing needs. The device may use wireless technology or may include tests for self-assessment of hearing loss. The device is available over-the-counter, without the supervision, prescription, or other order, involvement, or intervention of a licensed person, to consumers through in-person transactions, by mail, or online, provided that the device satisfies the requirements in this section.

Section 3.1(b) amends the scope of practice for a hearing aid specialist to include prescribing or ordering the use of hearing aids.

Section 3.1(c) provides that provisions regulating hearing aid dealers and fitters do not apply to persons selling over-the-counter hearing aids.

Part IV. Behavior Analyst Credentialing Modification

Section 4.1(a) amends the definitions found in Article 43 (Behavior Analyst Licensure) of Chapter 90 to amend the definition of "certifying entity" to include the nationally accredited Qualified Applied Behavior Analysis Credentialing Board (QABA) or its successor. The QABA was established in 2012 and oversees certification of Applied Behavior Analysis Technicians, Qualified Autism Services Practitioners, and Qualified Behavior Analysts.

Part V. Optometry Law Modifications

Section 5.1(a) changes the application deadlines for optometrist license renewals and provides that an inactive license not renewed by December 31 will expire and be ineligible for renewal.

Section 5.1(b) increases the following license optometry fees:

- General optometry license application: $1,000.00 (currently $800.00)
- General optometry license renewal: $500.00 (currently $300.00)
- Provisional license: $300.00 (new fee)
- Provisional license renewal: $100.00 (new fee)
- Branch office application or renewal: $200.00 (currently $100.00)

Section 5.1(c) modifies the criteria by which the North Carolina Board of Examiners in Optometry (Optometry Board) determines that a licensee is unable to practice optometry with reasonable skill and safety due to substance abuse, a physical or mental illness, or some other limiting condition. This section also gives the Optometry Board the discretion to order an applicant or licensee to submit to a mental or physical examination, the results of which shall be admissible in a hearing before the Optometry Board.

Section 5.1(d) requires all licensed optometrists and applicants to report judgments, awards, payments, and settlements to the Optometry Board within 30 days of their occurrence (currently no report deadline

is specified) by certified mail, a designated delivery service, or emailing the Optometry Board at the public email address and confirming receipt by return email. This section also makes failure to report the specified occurrences unprofessional conduct and grounds for discipline.

Section 5.1(e) amends Article 6, Chapter 90, to require every licensee to report to the Optometry Board any of the following incidents that the licensee reasonably believes to have occurred , within 30 days of learning of the incident: a licensee's sexual misconduct with a patient, or fraudulent prescribing, drug diversion, or theft of controlled substances. The reporting methods are the same as those required under Section 5.1(d). Failure to report these acts, or making a report in bad faith, fraudulently, or maliciously, would constitute unprofessional conduct and grounds for discipline. A person who reports in good faith would be immune from civil liability.

Section 5.1(f) modifies the current requirement that patients who have received an eye exam must be given, upon request, a copy of the patient's spectacle prescription, by requiring this to be done consistent with Federal Trade Commission rule and guidelines.

Section 5.1 (g) adds a new statutory section (G.S. 90-127.4) to allow an optometrist to register with the North Carolina Board of Pharmacy (Pharmacy Board) to dispense certain legend or prescription drugs only to their own patients for diagnosis and treatment of abnormal conditions of the eye and associated parts of the eye. Compounding medications and dispensing controlled substances is prohibited. To dispense certain drugs, the dispensing optometrist must pay a fee to and register with the Pharmacy Board.

Sections 5.2(a) and (b) amend Article 4A of Chapter 90 (Pharmacy Practice Act). Section 5.2(a) adds a new statutory section (G.S. 90-85.26B) that requires dispensing optometrists to register with the Pharmacy Board. Section 5.2(b) adds for dispensing optometrists an annual registration fee of $75, and a $75 reinstatement of registration fee.

Section 5.3 allows the Optometry Board and the Pharmacy Board to adopt rules to implement the provision of the Part.

Section 5.4 provides that Section 5.3 is effective when it becomes law, and the remainder of the Part becomes effective October 1, 2023.

Part VII. Develop Plan to Transition the Nurse Aide I Education and Training Program to the Board of Nursing.

Section 7.1(a) requires the NC Board of Nursing and the Department of Health and Human Services (DHHS), Division of Health Service Regulation, to develop a plan to relocate the Nurse Aide I education and training program from DHHS to the Board of Nursing. The relocation plan must ensure a seamless transition and ensure the program continues to meet federal requirements. This transfer will allow the Board of Nursing to provide oversight for all nurse aide programs, regardless of title.

Section 7.1(b) provides that DHHS will maintain control of registries as required by Article 15, Chapter 131E.

Section 7.1(c) requires the Board of Nursing and DHHS to provide a report to the Joint Legislative Oversight Committee on Health and Human Services by February 1, 2024. The report must include a relocation plan, a transition timeline, and recommendations for statutory changes.

Part VIII. Protect Healthcare Workers from Violence

Section 8.1(a) would enact Part 3A (Hospital Violence Protection Act) in Article 5 (Hospital Licensure Act) of Chapter 131E (Health Care Facilities) of the General Statutes, which would:

- Require each hospital that has an emergency department (ED) to conduct a security risk assessment and develop and implement a security plan.
- Require DHHS to report annually by December 1 to the Joint Legislative Oversight Committee on Health and Human Services (JLOC-HHS) based on data obtained from hospitals by September 1 relating to workplace violence incidents at the hospital during the preceding calendar year.

Hospital Security Risk Assessment and Security Plan Requirements

A hospital with an ED that is not an academic medical center teaching hospital (as defined by the State Medical Facilities Plan) and is located in a county with fewer than 300,000 residents (based on the 2020 census) may determine based on the security risk assessment that it is not necessary to have at least one law enforcement officer present in the emergency department or on the hospital campus at all times.

If a hospital meeting these criteria determines that a different level of security is necessary and appropriate based on the security risk assessment, the hospital must develop a security plan and allow DHHS access to the security risk assessment and the security plan Additionally, the hospital must allow the county emergency management director, county sheriff, and municipal police chief if applicable, access to the security plan and notify them that the hospital has determined that at least one law enforcement officer is not required to be present in the emergency department or on the hospital campus at all times.

Hospitals with an ED that does not meet the above criteria must have at least one law enforcement officer present in the ED or on the hospital campus at all times. These hospitals are required to allow DHHS access to the security risk assessment and security plan. Additionally, specific training criteria for law enforcement officers and safety protocols are required.

The hospital security risk assessment and hospital security plan are not public records, regardless of who has custody of them. Every hospital with an ED must provide appropriate hospital workplace violence prevention program training, education, and resources. DHHS is required to maintain a list of the hospitals with emergency departments and the types of security plan they have under the above criteria.

DHHS Data Gathering and Reporting Requirements

By September 1, of each year, DHHS would be required to collect the following data from each hospital for the preceding calendar year:

- The number of assaults occurring in the hospital or on hospital grounds that required the involvement of law enforcement, whether the assaults involved hospital personnel, and how those assaults were pursued by the hospital and processed by the judicial system,
- The number and impact of incidences where patient behavioral health and substance use issues resulted in violence in the hospital and the number that occurred specifically in the emergency department.
- The number of workplace violence incidences occurring at the hospital that were reported as required by accrediting agencies, the Occupational Safety and Health 10 Administration, and other entities.

By December 1 of each year DHHS would be required to present a compilation of the workplace violence data obtained from hospitals, including any recommendations to decrease the incidences of violence in hospitals and to decrease the assaults on hospital personnel, in a report to the JLOC-HHS. The first report would be due on or before December 1, 2025.

Section 8.1(b) requires the Administrative Office of the Courts (AOC) to report annually by September 1 to the DHHS Division of Health Service Regulation, the number of persons charged and convicted during

the preceding calendar year of a crime under G.S. 14-34.6 (Assault or affray on a firefighter, an emergency medical technician, medical responder, and hospital personnel), and requires DHHS to incorporate this information from AOC in the annual DHHS report to the JLOC-HHS.

Section 8.1(c) makes the first AOC report required by Section 8.1(b) due by October 1, 2025, and provides that this AOC reporting requirement expires October 30, 2030.

Section 8.1(d) requires DHHS to notify all hospitals licensed under Article 5 of Chapter 131E about the new security requirements, including the reporting requirements, by October 1, 2023.

Section 8.1(e) provides that the first required reports regarding incidences of violence in hospitals are due on or before September 1, 2025, and the first required DHHS report to the Joint Legislative Oversight Committee on Health and Human Services is due on or before December 1, 2025.

Section 8.1(f) provides that except for Section 8.1(b), which becomes effective when it becomes law, the remainder of the section would become effective October 1, 2024.

Section 8.2(a) updates the definitions in G.S. 95-260 to define "hospital" as defined in G.S. 131E-76.[1]

Section 8.2(b) provides that a violation of a valid protective order pursuant to Article 23 (Workplace Violence Prevention) is punishable as contempt of court, except as provided in G.S. 95-269A (added by Section 8.2(c)).

Section 8.2(c) amends Article 23 (Workplace Violence Prevention) of Chapter 95 (Labor Regulations) to add new G.S. 95-269A pertaining to the violation of a protective order issued upon the request of a hospital. Currently, Article 23 allows an employer to file an action for a civil no-contact order in district court if an employee has suffered unlawful conduct from any individual that can reasonably be construed to be carried out, or to have been carried out at the employee's workplace. A violation of this civil no-contact order currently is punishable only as contempt of court.

New G.S. 95-269A makes it a Class A1 misdemeanor to knowingly violate a valid protective order issued upon the request of a hospital, except as otherwise provided by law. It is not a violation of a protective order issued at the request of a hospital for a person to enter the hospital seeking treatment for an emergency medical condition. The section also provides more severe penalties when violation of the protective order occurs concurrently with the commission of other crimes.

Section 8.2(d) provides that this section becomes effective December 1, 2023, and applies to offenses committed on or after that date.

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[1] G.S. 131E-76(3) defines "hospital" as follows:

> "'Hospital' means any facility which has an organized medical staff and which is designed, used, and operated to provide health care, diagnostic and therapeutic services, and continuous nursing care primarily to inpatients where such care and services are rendered under the supervision and direction of physicians licensed under Chapter 90 of the General Statutes, Article 1, to two or more persons over a period in excess of 24 hours. The term includes facilities for the diagnosis and treatment of disorders within the scope of specific health specialties. The term does not include private mental facilities licensed under Article 2 of Chapter 122C of the General Statutes, nursing homes licensed under G.S. 131E-102, adult care homes licensed under Part 1 of Article 1 of Chapter 131D of the General Statutes, and any outpatient department including a portion of a hospital operated as an outpatient department, on or off of the hospital's main campus, that is operated under the hospital's control or ownership and is classified as Business Occupancy by the Life Safety Code of the National Fire Protection Association as referenced under 42 C.F.R. § 482.41. Provided, however, if the Business Occupancy outpatient location is to be operated within 30 feet of any hospital facility, or any portion thereof, which is classified as Health Care Occupancy or Ambulatory Health Care Occupancy under the Life Safety Code of the National Fire Protection Association, the hospital shall provide plans and specifications to the Department for review and approval as required for hospital construction or renovations in a manner described by the Department."

Section 8.3(a) amends G.S. 14-34.6, which currently provides that a person is guilty of a Class I felony if the person commits an assault or affray causing physical injury to certain emergency personnel, by including within this offense category causing injury to individuals under contract to provide services at a hospital. Section 8.3(a) also changes the felony classification from a Class G to a Class F if the assault inflicts serious bodily injury or involves use of a non-firearm deadly weapon and changes the felony classification from a Class E to a Class D if the assault involves the use of a firearm.

Section 8.3(b) amends Article 5A (Endangering Executive, Legislative, and Court Officers) in Chapter 14 of the General Statutes to change the offense classification for an assault on an executive, legislative, or court officer from a Class F felony to a Class E felony.

Section 8.3(c) amends the definition of "court officer" for purposes of Article 5A of Chapter 14. Currently that definition includes any attorney or other individual employed by or acting on behalf of "the department of social services in proceedings pursuant to Subchapter I of Chapter 7B of the General Statutes." This section would replace the quoted provision with "the county department of social services, as defined in G.S. 108A-24" and would add persons contracted by a department of social services within the definition of "court officer."

Section 8.3(d) provides that this section becomes effective December 1, 2023, and applies to offenses committed on or after that date.

Section 8.4(a) amends the list of aggravating factors in G.S. 15A-1340.16 to add "the defendant committed the offense on the property of a hospital as defined in G.S. 131-76.".

Section 8.4(b) provides that Section 8.4(a) becomes effective December 1, 2023, and applies to offenses committed on or after that date.

PART IX. Modernize and Expand Physician Pharmacist Collaborative Practice.

Section 9.1(a) amends G.S. 90-18(c)(3a) to allow pharmacists to engage in medical acts when authorized by a written collaborative practice agreement with a licensed physician. Previously, pharmacists could only implement and modify drug therapies under a collaborative agreement.

Section 9.1(b) amends G.S. 90-18.4 to establish new parameters for collaborative agreements between supervising physicians and clinical pharmacist practitioners (CPP). The supervising physician must have a written agreement specifically authorizing which medical tasks the CPP can perform. The supervising physician must review and evaluate the services provided by the CPP, and the physician may supervise any number of CPPs that he or she feels can be safely and effectively supervised.

Section 9.1(c) makes conforming changes to G.S. 90-85.3(b2)

Section 9.2(a) requires insurers to provide coverage for healthcare services provided by pharmacists that are within the pharmacists' scope of practice if the plan would have covered the services if performed by another health care provider. Insurers would not be able to apply out-of-network cost-sharing payments to insured unless there was an in-network provider that was reasonably available.

Section 9.2(b) provides that Section 9.2 becomes effective October 1, 2023, and applies to contracts entered into, renewed, or amended on or after that date.

Section 9.3 requires the Medical Board and the Board of Pharmacy to adopt temporary rules to implement the provisions of Section 9.1

PART X. Extend Flexibility for Ambulance Transport Provided Under the Expiring Federal Public Health Emergency Declaration.

Section 10.1(a) would allow the Office of Emergency Medical Services to continue to allow a non-EMT credentialled driver in ambulances for up to one year following the expiration of a public health emergency. When there is not a public health emergency the driver of an ambulance must have EMT credentials.

Section 10.1(b) provides that this Part is effective when it becomes law and expires May 11, 2024.

EFFECTIVE DATE: Except as otherwise provided, the act becomes effective when it becomes law.

**Legislative Analyst Theresa Matula and Staff Attorneys Jason Moran-Bates and Bill Patterson, with the Legislative Analysis Division, substantially contributed to this summary.*