2017 Public Health Legislation

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Budget Items of Interest to Public Health

Appropriations Act of 2017 – S.L. 2017-57 (S 257)

> *Note: This legislation was vetoed by Governor Roy Cooper on June 27, 2017. The Governor's veto message is available here. The Governor's veto was overridden on June 28, 2017.*

The Appropriations Act, commonly known as the budget bill, sets out North Carolina's spending plan for the biennium encompassing state fiscal years 2017-18 and 2018-29. The plan will likely be modified in 2018's legislative session, but the basic framework for both years is set out in the 2017 legislation. The budget bill is accompanied by a joint conference committee report that describes the appropriations by governmental function or department. As in past years, the budget included special provisions that provide additional information about how funds must be spent, as well as some changes to substantive law. This section summarizes special provisions and appropriations that may be of particular interest to local health departments.

DHHS to coordinate health information technology. Section 11A.1 of the budget bill creates new G.S. 143B-139.4D, directing the NC Department of Health & Human Services to coordinate the state's health information technology policies and programs, in cooperation with the state's Chief Information Officer. The purposes of the coordination include reducing duplications of effort and assuring certain state and national goals are met. Among other things, those goals include ensuring the security of patient information, improving the coordination of information among health care providers through secure health information exchange, improving public health services, facilitating early detection of public health threats, and promoting the early detection and management of chronic diseases. The Department must also establish and direct a health information technology management structure, in cooperation with the Department of Information Technology.

NC Health Information Exchange connection date. North Carolina local health departments are among the health care providers who will be required to connect to NC HealthConnex, an electronic health information exchange system operated by the NC Health Information Exchange Authority (NC HIEA). In 2015, the mandatory connection date was set at February 1, 2018 for all Medicaid providers, and June 1, 2018 for all other entities that receive state funds for health care services. Section 11A.5 of the budget bill changed the mandatory dates by which providers must be connected and submitting data, as follows:

- Hospitals, physicians, physicians' assistants, and nurse practitioners who provide Medicaid services and have an electronic health record must begin submitting demographic and clinical data by June 1, 2018.

- Local management entities/managed care organizations, as defined in G.S. 122C-3, must submit encounter and claims data by June 1, 2020.
- Entities that are "prepaid health plans" as defined in S.L. 2015-245 (Medicaid transformation) must submit encounter and claims data by the commencement of their contract with the Division of Health Benefits for the delivery of Medicaid and NC Health Choice services.
- All other providers of Medicaid and state-funded health care services must submit demographic and clinical data by June 1, 2019.

G.S. 90-414.4 was amended to reflect the new dates, and to authorize NC HIEA to establish a process to grant limited extensions to the deadlines for providers who request an extension and demonstrate a good-faith effort to take the necessary steps to establish a connection and begin data submission. A new subsection (c) was added to G.S. 90-414.4, to clarify that providers who have patient records that are subject to the federal substance abuse confidentiality regulations in 42 C.F.R. Part 2 are exempt from the connection and data submission requirements, but only with respect to those particular records.

School nurses. Section 11E.1 creates new G.S. 130A-4.3, which addresses the use of state funds for school nurses. The new statute requires the NC Department of Health and Human Services to use state funds that are appropriated for the State Nurse Funding Initiative to supplement and not supplant other state, local, or federal funds allocated for that purpose, and specifies that the funds may not be used to support nurses for state agencies. The statute sets out the factors that must be taken into account in the development of a formula for distributing school nurse funds to local health departments. Finally, it directs the Division of Public Health to ensure that school nurses who are funded with state funds do not assist in any instructional or administrative duties associated with a school's curriculum, but perform specified duties, including providing health information and counseling.

Lead poisoning prevention. Because exposure to lead during childhood can cause great harm to neurological development, North Carolina has had a childhood lead program in place for many years. Among other things, it identifies children with elevated levels of lead in their blood, and the subset of those children who have confirmed lead poisoning. Section 11E.6 of the budget bill changed North Carolina's childhood lead poisoning program to conform with federal standards for determining that blood lead levels are elevated or that lead poisoning is confirmed, and to extend the services of the program to pregnant women. The section amends G.S. 130A-131.7 (definitions) as follows:

- "Confirmed lead poisoning" is defined as a blood lead concentration of 10 micrograms per deciliter or greater (was, 20 micrograms/deciliter).
- "Elevated blood level" is defined as a blood lead concentration of five micrograms per deciliter or greater (was, 10 micrograms/deciliter).

The section also amends G.S. 130A-131.9A and 130A-131.9C to expressly extend lead program services to pregnant women.

Study transfer of on-site water protection branch well inspection program to DEQ. Section 13.25 of the budget bill directs the Department of Health and Human Services and the Department of Environmental Quality (DEQ) to study the feasibility of transferring public health drinking water well inspection and

permitting programs to DEQ. The Departments must convene a stakeholders group and make a recommendation regarding program transfer by March 1, 2018.

Controlled Substances Reporting System. The Controlled Substances Reporting System (CSRS) was created in 2005 (S.L. 2005-276, sec. 10.36) to maintain information about prescriptions for controlled substances. Its initial purpose was to help health care providers identify patients who may be overusing controlled substances or diverting their prescription medications to others. It can also be used to identify health care providers who may be over-prescribing controlled substances. Section 11A.6 of the budget bill appropriated $1.2 million in recurring funds to the DHHS central management budget to make improvements to the CSRS, including improvements described in another new law, the STOP Act (summarized below, under the heading "Opioids").

State public health lab. The State Laboratory for Public Health received funds to address a structural budget deficit. The budget provided a $1 million recurring appropriation, and a $2 million non-recurring appropriation for FY 17-18 only.

Communicable disease testing. The budget provided $300,000 in recurring funds and $300,000 in non-recurring funds testing for hepatitis C and other priority communicable diseases. These funds may also be used to provide access to treatment for individuals who test positive for communicable diseases. The non-recurring funds will be provided in both years of the biennium.

Tobacco cessation and prevention. The budget appropriated $500,000 in recurring funds for North Carolina's tobacco quitline and for a program for pregnant women called "You Quit, Two Quit." An additional $500,000 in non-recurring funds for each year of the biennium was provided for tobacco prevention programs for youth.

Funds for private organizations that provide crisis pregnancy services. The NC Division of Public Health's budget includes non-recurring funding in the amount of $1.3 million for each year in the biennium for the Carolina Pregnancy Care Fellowship, a private non-profit organization and coalition of pregnancy care centers that advocate adoption and discourage abortion. The funds are to be used primarily to provide funds for the purchase of durable medical equipment, such as ultrasound equipment, to clinics that submit applications for such funding to the Fellowship. A portion of the appropriation, $300,000, was earmarked for the Human Coalition for a continuum of care project in its Raleigh clinic. Additional non-recurring grants of state funds for FY 17-18 only were provided to specific pregnancy centers in Beaufort county and Union county.

Opioids

Strengthen Opioid Misuse Prevention (STOP) Act – S.L. 2017-74 (H 243)

Since 1999, over 12,000 North Carolinians have died from opioid overdose. The rate of overdose death has increased nearly four-fold. Data from 2014 indicate that for each death, there were almost three hospitalizations for opioid poisoning, nearly four more treated in hospital emergency departments, and

an estimated 380 people who misused opioids.[1] The overuse of opioids has been recognized as a public health crisis, and has been attributed in large part to the overprescription of opioid pain relievers in the late 1990s and early 2000s. In addition, the use of illicit opiates such as heroin has been increasing since the early 2000s, perhaps as a result of individuals who became addicted to prescription opioids switching to illicit drugs, which can be less expensive and easier to obtain.

North Carolina's initial legislative response to this crisis was the creation of the Controlled Substances Reporting System (CSRS) in 2005.[2] The intent of this legislation was to help health care providers identify patients who may be overusing controlled substances or diverting their own prescription drugs to others. It was also viewed as a potential method for identifying providers who over-prescribe medication.

In the years since, North Carolina's legislative activity around opioids has increased and has focused on harm reduction measures. In 2013, the General Assembly adopted legislation (S.L. 2017-23) to increase the availability of naloxone, a prescription medication that reverses overdose when administered timely, by permitting physicians to prescribe naloxone to individuals at risk of experiencing overdose or other persons who may be in a position to assist a person who has overdosed. The 2013 law also provide limited immunity from prosecution for certain drug-related offenses for those who seek emergency assistance for an overdose.[3]

In 2015, the 2013 naloxone law was amended to allow pharmacists to dispense naloxone pursuant to a physician's standing order (S.L. 2015-94, sec. 3). This allowed individuals to obtain naloxone without having to first visit a physician for a prescription. Because there was variability across the state in the use of standing orders for this purpose, in 2016, the legislature authorized the State Health Director to issue a standing order that would be valid for pharmacists statewide (S.L. 2016-17).[4]

Also in 2016, the legislature authorized governmental and non-governmental organizations to operate needle and syringe exchange programs (S.L. 2016-88, sec. 4). While these programs do not treat opioid addiction, they are considered an important harm reduction strategy for opioid users because they prevent the transmission of bloodborne pathogens, such as HIV and hepatitis viruses.[5]

In 2017, the legislature took its next step in addressing the crisis by adopting the STOP Act. The STOP Act defines the term "targeted controlled substance" to mean controlled substances listed in G.S. 90-90(1) or (2), or G.S. 90-91(d). These are essentially the opioids that fall under Schedules II and III of North Carolina's Controlled Substances Act (G.S. Chapter 90, Article 5). The main provisions of the STOP Act can be categorized into three parts: provisions affecting the prescribing of targeted controlled substances, provisions affecting the dispensers of targeted controlled substances, and other provisions

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[1] These data are from North Carolina's Opioid Action Plan (June 2017), at https://files.nc.gov/ncdhhs/NC%20Opioid%20Action%20Plan%208-22-2017.pdf.
[2] Jill Moore, *Chapter 12: Health*, in North Carolina Legislation 2005 (UNC School of Government), at 150-51.
[3] Jill Moore, *Legislative Summary: S.L. 2013-23 (S 20). Good Samaritan Law/Naloxone Access*, at https://www.sog.unc.edu/resources/legal-summaries/sl-2013-23-s-20-good-samaritan-lawnaloxone-access.
[4] Jill Moore, *2016 Public Health Legislation Highlights*, Coates' Canons Local Government Law Blog (July 28, 2016), at https://canons.sog.unc.edu/2016-public-health-legislation-highlights/.
[5] *Id.*

to address the opioid crisis. The different provisions have different effective dates, with some to be determined, as they are contingent upon the completion of improvements to the CSRS.

Provisions affecting prescribing. Targeted controlled substances may be prescribed by health care providers with prescribing authority under law. This includes doctors, dentists, and some practitioners who are required to work under the supervision of a physician, such as nurse practitioners and physicians' assistants. The STOP Act:

- Limits the quantity of targeted controlled substances that may be prescribed to outpatients for acute pain to a 7-day supply for post-operative patients and a 5-day supply for others. This limitation does not apply to patients with chronic pain. This provision is effective January 1, 2018.
- Requires prescribers of targeted controlled substances to check the CSRS at the time of the initial prescription, and every 90 days thereafter if the prescription continues. This provision will be effective after specified CSRS improvements are achieved.
- Requires that targeted controlled substances be prescribed electronically in most cases. There are limited exceptions for certain facilities and circumstances, and for veterinarians. This provision is effective January 1, 2020.
- Requires that certain physicians' assistants and nurse practitioners personally consult with their supervising physician before prescribing targeted controlled substances if use of the targeted controlled substance will exceed thirty days. This provision applies only with respect to patients being treated by a facility that primarily engages in the treatment of pain by prescribing narcotic medications, or that advertises its pain management services. It is effective July 1, 2017.

Provisions affecting dispensers. Controlled substances may be dispensed by pharmacies or by certain providers whose authority to prescribe includes the authority to dispense. The STOP Act:

- Requires all dispensers of Schedule II, III, and IV controlled substances to register with the CSRS. There are some exceptions to this requirement, including for veterinarians, and for hospitals that dispense these substances only for inpatients. This provision will be effective after specified CSRS improvements are achieved.
- Requires a dispenser of targeted controlled substances to consult the CSRS if the dispenser suspects illicit drug-seeking, which means drug-seeking for other than treatment purposes. The dispenser must also contact the prescriber in certain circumstances. This provision will be effective after specified CSRS improvements are achieved.
- Requires pharmacies to report prescriptions of controlled substances to the CSRS by the close of the next business day. Previously, pharmacies were required to report prescriptions within three business days. This provision is effective September 1, 2017.
- Provides for monetary penalties for a pharmacy that does not report correct data after being informed that the data reported by the pharmacy was missing or incomplete. This provision is effective September 1, 2017.

Other provisions. The remaining provisions address a variety of issues. All of these provisions are effective July 1, 2017. They include:

- Community distribution of naloxone by entities with a standing order: The STOP Act allows governmental and non-governmental entities and their agents to distribute opioid antagonists

to community members, so long as the entity has a standing order from a physician for the distribution. There is limited immunity from liability for this action.

- Use of public funds for syringe exchange program supplies: The 2016 legislation that made syringe exchange programs lawful prohibited the use of "public" funds to purchase needles, syringes, and other injection supplies for the programs. The STOP Act amended this provision by changing it to "state" funds. This means that, while state public funds still may not be used for these programs, local public funds may be.
- Hospice providers' role in promoting safe disposal of medications: The STOP Act requires in-home hospice providers to educate families about how to properly dispose of medications.

Environmental Health

Private Drinking Water Well Permits – S.L. 2017-10 (S 131), § 1.3

Local health departments in North Carolina are required to have a program for permitting, inspecting, and testing private drinking water wells with a designed capacity of less than 100,000 gallons per day. G.S. 87-97. (Private drinking water wells with a designed capacity of 100,000 gallons per day or greater are permitted by the NC Department of Environmental Quality, pursuant to regulations adopted by the Environmental Management Commission. G.S. 87-88.) In the last two years, G.S. 87-97 has been amended to provide that a permit issued by a local health department is deemed to include authorization for a certified well contractor to install, construct, maintain, or repair electrical wiring or other electrical equipment and piping for certain purposes. S.L. 2015-246, sec. 3.5.(a); S.L. 2016-113, sec. 16.(b). The 2015 legislation also required the local health department to notify the appropriate building inspector when a well permit is issued. These recent provisions have created some concern and confusion, as environmental health specialists do not inspect or approve the electrical and piping matters deemed to be authorized by the health department's permit; rather, the health department's activities are focused on assuring that drinking well water is safe to drink.

The 2017 legislation, a section of the Regulatory Reform Act, attempts to clarify the roles of the local health department versus the building inspector. It amends G.S. 87-97 to:

- State that local health departments are the exclusive authority for permitting wells and well systems that are described in a new provision of the building code, G.S. 143-318(b17)(2). The new provision describes a well system as including "the well, the pressure tank, the pressure switch, and all plumbing and electrical equipment in the well and between the well, pressure tank, and pressure switch."
- Provide that the building inspector may request an opportunity to inspect the electrical and piping activities authorized by the permit. The building inspector's inspection must occur before the local health department's final inspection, or else the building inspections department will be responsible for any additional costs associated with the inspection and any damages to the well system.

New G.S. 143-138(b17) also states that no permit shall be required under the state building code or any local variant for the electrical and plumbing activities associated with the installation, construction, maintenance, or repair of a private drinking water well whose scope of work includes only the

connection or disconnection of a well system (as defined above) to either the plumbing or the electrical service that serves the system.

S.L. 2017-10, sec. 1.3 was effective May 4, 2017. On May 23, 2017, the North Carolina Division of Public Health (DPH) issued a position statement on the legislation. DPH stated that although local health departments have exclusive permitting authority for these wells, the responsibility for plumbing or electrical inspections still resides with local building inspections offices. The statement adds that local environmental health specialists, who are acting as authorized agents of the state when they conduct well inspections, "shall not inspect plumbing and electrical components since they fall outside of the authorized agent's scope." The DPH position statement is available at http://ehs.ncpublichealth.com/docs/position/SL-2017-10-S-131-WellSystemsPermittingInspectionPosSt052317.pdf.

Outdoor Grills at Restaurants – S.L. 2017-18 (S 24)

This legislation amends G.S. 130A-248 by adding a new subsection (c2), which authorizes food establishments to use an outdoor grill in their food preparation, if certain criteria are met. Among other things, the grill must be continuously supervised while in use; it must meet the sanitation requirements for equipment in a food establishment; it must be protected from environmental contamination when not in operation; and raw meat, poultry, or fish that are cooked on the grill must be prepared in a pre-portioned or ready-to-cook form inside the food establishment. The legislation was effective May 24, 2017. On July 12, 2017, the NC Division of Public Health (DPH) issued a guidance document on this new law for local health departments that enforce the food sanitation laws. The guidance document is available at https://ehs.ncpublichealth.com/docs/position/OutdoorGrillsatFoodEstablishmentsPositionStatement-12July2017.pdf.