BOARD MEETING MINUTES

September 16-18, 2026

3127 Smoketree Court
Raleigh, North Carolina

General Session Minutes of the North Carolina Medical Board (NCMB) Meeting held September 16-18, 2026.

The September 16-18, 2026 meeting of the North Carolina Medical Board was held in person at 3127 Smoketree Court, Raleigh, NC 27604. Certain closed portions of the meeting were conducted virtually, including licensing and investigative interviews. Anuradha Rao-Patel, MD, President, called the meeting to order. Board members in attendance were Robert L. Rich, Jr., MD, President-Elect; Mark A. Newell, MD, MMM; Secretary/Treasurer; Earic R. Bonner, MD, MBA; J. Nelson Dollar, MA; Lisa Ehrler, DO; Vickie A. Harry; Sharona Y. Johnson, PhD, FNP-BC; Shannon R. Joseph; Gregory S. McCarty, MD; Miguel A. Pineiro, PA-C, MHPE; Anthony R. Plunkett, MD; Devdutta G. Sangvai, MD, JD, MBA.

PRESIDENTIAL REMARKS

Dr. Anuradha Rao-Patel reminded the Board members of their duty to avoid conflicts of interest with respect to any matters coming before the Board as required by the State Government Ethics Act. Reported conflicts were included within individual committee reports.

ANNOUNCEMENTS and UPDATES

Dr. Rao-Patel recognized new staff as they were introduced by their perspective manager. Staff promotions were also recognized by their perspective manager.

NORTH CAROLINA PROFESSIONALS HEALTH PROGRAM REPORTS (NCPHP)

A motion passed to close the session pursuant to Section 143-318.11(a) of the North Carolina General Statutes to prevent the disclosure of information that is confidential pursuant to Sections 90-8, 90-14, 90-16, and 90-21.22 of the North Carolina General Statutes and not considered a public record within the meaning of Chapter 132 of the General Statutes and/or to preserve attorney/client privilege.

Dr. Joseph Jordan, CEO, North Carolina Professionals Health Program (NCPHP), gave the NCPHP Compliance Committee report. The specifics of this report are not included because the information contained in the report is confidential and non-public.

A motion passed to return to open session.

NCMB LEGAL DEPARTMENT REPORT

Mr. Brian Blankenship, Chief Legal Officer, gave the Legal Department Report on Friday, September 18, 2026.

Open session:

Mr. Blankenship updated the Board on the schedule of October 2026 and December 2026 hearings and hearing assignments.

A motion passed to close the session pursuant to N.C. Gen. Stat. §143-318.11(a) to prevent the disclosure of information that is confidential pursuant to Sections 90-8, 90-14, 90-16, and/or 90-21.22 of the North Carolina General Statutes and not considered public records within the meaning of Chapter 132 of the General Statutes and/or to preserve attorney/client privilege.

Within the closed session:

Mr. Blankenship provided information within the attorney-client privilege regarding an outside litigation matter.

The Legal Department Report was concluded.

The Board accepted the report as information.

NCMB COMMITTEE REPORTS

Executive Committee Report

Members present were: Anuradha Rao-Patel, MD, Chair; J. Nelson Dollar, MA; Mark A. Newell, MD, MMM; Robert L. Rich, MD.; Devdutta G. Sangvai, MD, JD, MBA

Financial Update

a. Year-To-Date Financials

The Committee reviewed the following financial reports through July 31, 2026: Balance Sheet, Profit & Loss Comparison, and the Profit & Loss – Budget vs. Actuals with the accounting team.

Committee Recommendation: Accept the financial information as reported.

Board Action: Accept Committee recommendation. Accept the financial information as reported.

b. Investment Account Update

The Committee reviewed the investment statements for July and August 2026 with the accounting team.

Committee Recommendation: Accept the investment statements as reported.

Board Action: Accept the Committee recommendation. Accept the investment statements as reported.

c. Proposed FY2027 Budget

The Committee reviewed the proposed budget and memoranda for fiscal year 2027. The new fiscal year begins November 1, 2026.

Committee Recommendation: Approve the proposed budget for fiscal year 2027.

Board Action: Accept the Committee recommendation. Approve the proposed budget for fiscal year 2027.

Old Business:

a. Board Retreat Debrief

Mr. Thomas W. Mansfield, NCMB CEO, led a debrief of the Board retreat and gave Board members an opportunity to provide comments. It was determined that the Board would hold a retreat in 2027 in the central part of the state, possibly Pinehurst.

Committee Recommendation: Accept the debrief as information.

Board Action: Accept the Committee recommendation. Accept the debrief as information.

Licensing Committee Report

Members present were Earic R. Bonner, MD, MBA, Chair; Vickie A. Harry; Mark A. Newell, MD, MMM; Miguel A. Pineiro, PA-C, MHPE; Robert L. Rich, MD

A motion passed to close the session pursuant to Section 143-318.11(a) of the North Carolina General Statutes to prevent the disclosure of information that is confidential pursuant to Sections 90-8, 90-14, 90-16, and 90-21.22 of the North Carolina General Statutes and not considered a public record within the meaning of Chapter 132 of the General Statutes and/or to preserve attorney-client privilege.

a. Twelve applications were submitted to the License Committee members for review. No Applications were extracted for discussion and there were no recusals.

The License Committee recommendations are included at the end of this report.

Committee recommendations: Accept as Information.

Board action: Accept License Committee recommendation. Accept as information.

A motion passed to return to open session.

License Interview Report

A motion passed to close the session pursuant to Section 143-318.11(a) of the North Carolina General Statutes to prevent the disclosure of information that is confidential pursuant to Sections 90-8, 90-14, 90-16, and 90-21.22 of the North Carolina General Statutes and not considered a public record within the meaning of Chapter 132 of the General Statutes and/or to preserve attorney-client privilege.

Ten licensure interviews were conducted virtually. A written report was presented for the Board's review. The Board adopted the Committee's recommendation to approve the written report. The specifics of this report are not included because these actions are not public information.

Disciplinary (Investigative) Committee Report

Members present were: Mark A. Newell, MD, MMM, Chair; J. Nelson Dollar, MA; Vicki A. Harry; Sharona Y. Johnson, PhD, FNP-BC; Miguel A. Pineiro, PA-C, MHPE; Robert L. Rich, MD. Member absent: Devdutta G. Sangvai, MD, JD, MBA

A motion passed to close the session pursuant to Section 143-318.11(a) of the North Carolina General Statutes to prevent the disclosure of information that is confidential pursuant to Sections 90-8, 90-14, 90-16, and 90-21.22 of the North Carolina General Statutes and not considered a public record within the meaning of Chapter 132 of the General Statutes and/or to preserve attorney-client privilege.

The Disciplinary (Investigative) Committee reviewed 80 investigative cases. A written report was presented for the Board's review. The Board adopted the recommendations and approved the written report. The specifics of this report are not included because these actions are not public information.

A motion passed to return to open session.

Disciplinary (Complaints) Committee Report

Members present were: Mark A. Newell, MD, MMM, Chair; J. Nelson Dollar, MA; Vicki A. Harry; Sharona Y. Johnson, PhD, FNP-BC; Miguel A. Pineiro, PA-C, MHPE; Robert L. Rich, MD. Member absent: Devdutta G. Sangvai, MD, JD, MBA

A motion passed to close the session pursuant to Section 143-318.11(a) of the North Carolina General Statutes to prevent the disclosure of information that is confidential pursuant to Sections 90-8, 90-14, 90-16, and 90-21.22 of the North Carolina General Statutes and not considered a public record within the meaning of Chapter 132 of the General Statutes and/or to preserve attorney-client privilege.

The Disciplinary (Complaints) Committee reviewed 48 complaint cases. A written report was presented for the Board's review. The Board adopted the Committee's recommendation to approve the written report. The specifics of this report are not included because these actions are not public.

A motion passed to return to open session.

Disciplinary (Compliance) Committee Report

Mark A. Newell, MD, MMM, Chair; J. Nelson Dollar, MA; Vicki A. Harry; Sharona Y. Johnson, PhD, FNP-BC; Miguel A. Pineiro, PA-C, MHPE; Robert L. Rich, MD. Member absent: Devdutta G. Sangvai, MD, JD, MBA

A motion passed to close the session pursuant to Section 143-318.11(a) of the North Carolina General Statutes to prevent the disclosure of information that is confidential pursuant to Sections 90-8, 90-14, 90-16, and 90-21.22 of the North Carolina General Statutes and not considered a public record within the meaning of Chapter 132 of the General Statutes and/or to preserve attorney-client privilege.

The Disciplinary (Compliance) Committee reviewed 13 investigative cases. A written report was presented for the Board's review. The Board adopted the recommendations and approved the written report. The specifics of this report are not included because these actions are not public information.

A motion passed to return to open session.

Disciplinary (Malpractice) Committee Report

Members present were: Mark A. Newell, MD, MMM, Chair; J. Nelson Dollar, MA; Vicki A. Harry; Sharona Y. Johnson, PhD, FNP-BC; Miguel A. Pineiro, PA-C, MHPE; Robert L. Rich, MD. Member absent: Devdutta G. Sangvai, MD, JD, MBA

A motion passed to close the session pursuant to Section 143-318.11(a) of the North Carolina General Statutes to prevent the disclosure of information that is confidential pursuant to Sections 90-8, 90-14, 90-16, and 90-21.22 of the North Carolina General Statutes and not considered a public record within the meaning of Chapter 132 of the General Statutes and/or to preserve attorney-client privilege.

The Disciplinary (Malpractice) Committee reviewed 48 cases. A written report was presented for the Board's review. The Board adopted the Committee's recommendation to approve the written report. The specifics of this report are not included because these actions are not public information.

A motion passed to return to open session.

Disciplinary (Department of Health and Human Services or DHHS) Committee Report

Members present were: Mark A. Newell, MD, MMM, Chair; J. Nelson Dollar, MA; Vicki A. Harry; Sharona Y. Johnson, PhD, FNP-BC; Miguel A. Pineiro, PA-C, MHPE; Robert L. Rich, MD. Member absent: Devdutta G. Sangvai, MD, JD, MBA

A motion passed to close the session pursuant to Section 143-318.11(a) of the North Carolina General Statutes to prevent the disclosure of information that is confidential pursuant to Sections 90-8, 90-14, 90-16, and 90-21.22 of the North Carolina General Statutes and not considered a public record within the meaning of Chapter 132 of the General Statutes and/or to preserve attorney-client privilege.

The Disciplinary (DHHS) Committee reviewed three cases. A written report was presented for the Board's review. The Board adopted the Committee's recommendation to approve the written report. The specifics of this report are not included because these actions are not public.

A motion passed to return to open session.

Investigative Interview Report

A motion passed to close the session pursuant to Section 143-318.11(a) of the North Carolina General Statutes to prevent the disclosure of information that is confidential pursuant to Sections 90-8, 90-14, 90-16, and 90-21.22 of the North Carolina General Statutes and not considered a public record within the meaning of Chapter 132 of the General Statutes and/or to preserve attorney-client privilege.

Ten investigative interviews were conducted virtually. A written report was presented for the Board's review. The Board adopted the recommendations and approved the written report. The specifics of this report are not included because these actions are not public information.

A motion passed to return to open session.

Advanced Practice Providers & Allied Health Committee Report

Members present were: Miguel Pineiro, PA-C, MHPE, Chair; Anthony R. Plunkett, MD, Vice-Chair; Earic R. Bonner, MD, MBA; Lisa Erhler, DO; Vicki A. Harry; Gregory S. McCarty, MD.

Old Business:

a. Proposed Changes to Rule 21 NCAC 32T .0101 – Clinical Pharmacist Practitioner (Appendix A)

Staff reviewed proposed changes to Rule 21 NCAC 32T .0101 regarding Clinical Pharmacist Practitioners. Last year, the General Assembly passed SL 2025-37 titled "An Act to Enact Healthcare Workforce Reforms ("Act") and the governor signed it into law. Part VII of the Act authorized clinical pharmacist practitioners to provide health care services under the supervision of a physician pursuant to a collaborative practice agreement. The Act directed the Medical Board and the Board of Pharmacy to develop rules to implement the new law.

The two boards formed an *ad hoc* committee to consider the proposed rule changes. The committee met on July 17, 2026, with Drs. Rao-Patel, Bonner, and McCarty representing the Board. The *ad hoc* committee recommended approval of the rule changes.

Committee Recommendation: Approve the Board's proposed changes to Rule 21 NCAC 32T .0101 as written.

Board Action: Accept Committee recommendation. Approve the Board's proposed changes to Rule 21 NCAC 32T .0101 as written.

New Business:

a. Midwifery Joint Committee - Reappointment of Alan Rosenbaum, MD, MSCR, MSBME, FACOG (Current term expires October 31, 2026)

Staff discussed the reappointment of Dr. Alan Rosenbaum to the Midwifery Joint Commission. Dr. Rosenbaum has served one term and is eligible to serve a second term. Dr. Rosenbaum is willing to serve a second term.

Committee Recommendation: Approve reappointment of Dr. Alan Rosenbaum to the Midwifery Joint Committee.

Board Action: Accept Committee recommendation. Approve reappointment of Dr. Alan Rosenbaum to the Midwifery Joint Committee.

A motion passed to close the session pursuant to Section 143-318.11(a) of the North Carolina General Statutes to prevent the disclosure of information that is confidential pursuant to Sections 90-8, 90-14, 90-16, and 90-21.22 of the North Carolina General Statutes and not considered a public record within the meaning of Chapter 132 of the General Statutes and/or to preserve attorney-client privilege.

The Joint Subcommittee Panel recommendations from May and July 2026 were reviewed. Staff explained that Joint Subcommittee members may extract cases for discussions prior to the Joint Subcommittee making its recommendations.

Committee Recommendation: Accept as Information.

Board Action: Accept Committee recommendation. Accept as information.

A motion passed to return to open session.

Policy Committee Report

Members present were: Robert L. Rich, Jr., M.D., Chair; J. Nelson Dollar, M.A.; Shannon R. Joseph; Gregory S. McCarty, M.D.; and Anthony R. Plunkett, M.D.; Devdutta G. Sangvai, M.D., J.D., MBA.

Old Business:

a. 9.1.3: Licensee Employment (Appendix B)

   As directed by the Committee during its July 2026 meeting, staff discussed with stakeholders a proposed revision regarding expectations for the retention of, and access to, records by employed licensees after leaving employment.

   During the September 2026 meeting, staff updated the Committee on those discussions. Stakeholders expressed concern that the proposed language was likely unnecessary and may not comply with HIPAA requirements for covered entities. Accordingly, the Committee agreed to make no changes to the current position statement and accepted the review of the position statement as information.

Committee recommendation: Accept review of the position statement as information.

Board Action: Accept Committee recommendation. Accept review of the position statement as information.

New Business:

a. 7.1.1: Child Maltreatment (Appendix B)

   The Committee reviewed and supported the revision to the position statement updating the link and title of the online training referenced in the position statement.

Committee recommendation: Adopt and publish the revised position statement.

Board Action: Accept Committee recommendation. Adopt and publish the revised position statement.

b. 6.1.4: Clinician Obligation to Complete a Certificate of Death Miscellaneous: Position Statement Review Chart

   The Committee reviewed minor revisions to quotations within the position statement to align with the language used in the applicable statutes. The Committee and staff also discussed incorporating language regarding the authority of the Department of Health and Human Services to impose administrative fines for willfully and knowingly violating electronic death certificate filing requirements. Additionally, the Committee discussed the need to clarify the Board's timeframe expectations, as the applicable statutes reference both three- and five-day timeframes. The Committee instructed staff to draft proposed revisions, circulate to the Board members for comments, and bring back for review at a later meeting, with an anticipated date of November 2026.

Committee recommendation: Staff to incorporate discussed revisions, circulate to Committee members, and bring back for review at a later meeting, with an anticipated date of November 2026.

Board Action: Accept Committee recommendation. Staff to incorporate discussed revisions, circulate to Committee members, and bring back for review at a later meeting, with an anticipated date of November 2026.

c. 3.2.1: MEDICAL RECORDS – Documentation, Electronic Health Records, Access, and Retention (Appendix C)

   The Committee reviewed and supported the revision to the position statement to remove language that no longer appears in the applicable statute.

Committee recommendation: Adopt and publish the revised position statement.

Board Action: Accept Committee recommendation. Adopt and publish the revised position statement.

Miscellaneous:

a. Position Statement Review Chart

   The Committee reviewed the position statement review chart and determined that, in addition to bringing back revisions to position statement 6.1.4: Clinician Obligation to Complete a Certificate of Death, the Committee will review position statement 4.1.3: Policy for the Use of Opioids for the Treatment of Pain. Staff will circulate position statements to the Committee members for consideration and comment prior to the November 2026 meeting.

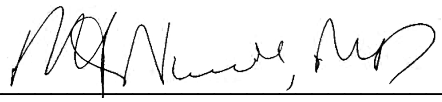
Committee recommendation: Accept as information.

Board Action: Accept Committee recommendation. Accept as information.

ADJOURNMENT

The Medical Board officially adjourned at 11:15 a.m. on Friday, September 18, 2026.

The next meeting of the Medical Board will be in person, November 18-20, 2026



Mark A. Newell, MD, MMM, Secretary/Treasurer

21 NCAC 32T .0101 is proposed for amendment as follows:

SECTION .0100 – CLINICAL PHARMACIST PRACTITIONER

21 NCAC 32T .0101 CLINICAL PHARMACIST PRACTITIONER

(a) ~~Definitions as used in the Rule:~~ A pharmacist may serve as a clinical pharmacist practitioner (or "CPP") pursuant to G.S. 90-18(c)(3a) and 90-18.4 as set forth in this rule.

~~(1) "Medical Board" means the North Carolina Medical Board.~~

~~(2) "Pharmacy Board" means the North Carolina Board of Pharmacy.~~

~~(3) "Clinical Pharmacist Practitioner" or "CPP" means a licensed pharmacist who is approved to provide drug therapy management, including controlled substances, under the direction or supervision of a Supervising Physician pursuant to a CPP Agreement Only a pharmacist approved by the Pharmacy Board and the Medical Board may legally identify himself as a CPP.~~

~~(4) "Supervising Physician" means a licensed physician who, by signing the CPP Agreement, is held accountable for the on-going supervision and evaluation of the drug therapy management performed by the CPP as defined in written CPP Agreement. This term includes both Primary Supervising Physician and Back-up Supervising Physician.~~

~~(5) "Primary Supervising Physician" means the Supervising Physician who shall provide on-going supervision, collaboration, consultation, and evaluation of the drug therapy management performed by the CPP as defined in the CPP Agreement.~~

~~(6) "Back-up Supervising Physician" means a Supervising Physician who shall provide supervision, collaboration, consultation, and evaluation of the drug therapy management performed by the CPP as defined in the CPP Agreement when the Primary Supervising Physician is not available.~~

~~(7) "Approval" means authorization by the Medical Board and the Pharmacy Board for a pharmacist to practice as a CPP in accordance with this Rule.~~

~~(8) "Continuing Education or CE" is defined as courses or materials which have been approved for credit by the American Council on Pharmaceutical Education.~~

~~(9) "Clinical Experience approved by the Boards" means work in a pharmacy practice setting which includes experience consistent with the following components as listed in Parts (b)(2)(A), (B), (C), (D), (E), (H), (I), (J), (N), (O), and (P) of this Rule. Clinical experience requirements must be met only through activities separate from the certificate programs referred to in Parts (b)(1)(B) of this Rule.~~

~~(10) "CPP Agreement" means a written agreement between the CPP, Primary Supervising Physician and any Back-Up Supervising Physician by which the Supervising Physician(s) have provided written instructions to the CPP for patient-specific and disease-specific drug therapy, which may include ordering, changing, or substituting therapies or ordering tests.~~

(b) ~~CPP application for approval.~~ A pharmacist may serve as a CPP only after the Medical Board and the Board of Pharmacy (collectively, "the Boards") approve a pharmacist who meets each of the following requirements:

(1) ~~The requirements for application for CPP approval include that the pharmacist:~~ The pharmacist has an unrestricted and current license to practice as a pharmacist in North Carolina;

(2)~~(A) has an unrestricted and current license to practice as a pharmacist in North Carolina;~~ The pharmacist meets one of the following qualifications:

~~(B)~~(A) ~~meets one of the following qualifications:~~ has earned Board Certification from the Board of Pharmaceutical Specialities;

(B) has completed a residency program accredited by the American Society of Health System Pharmacists; or

(C) holds an undergraduate professional degree in pharmacy as defined in Rule .1317 of this Section and has acquired two years of full-time practice of pharmacy in a clinical pharmacy practice setting that includes experience consistent with the health care services to be provided under the collaborative practice agreement. This clinical experience must be acquired following graduation with an undergraduate professional degree in pharmacy.

~~(i) has earned Certification from the Board of Pharmaceutical Specialties, is a Certified Geriatric Pharmacist as certified by the Commission for Certification in Geriatric Pharmacy, or has completed an American Society of Health System Pharmacists (ASHP) accredited residency program with two years of Clinical Experience approved by the Boards; or~~

~~(ii) holds the academic degree of Doctor of Pharmacy, has three years of Clinical Experience approved by the Boards, and has completed a North Carolina Center for Pharmaceutical Care (NCCPC) or American Council on Pharmaceutical Education (ACPE) approved certificate program in the area of practice covered by the CPP Agreement; or~~

~~(iii) holds the academic degree of Bachelor of Science in Pharmacy, has five years of Clinical Experience approved by the Boards, and has completed two NCCPC or ACPE approved certificate programs with at least one program in the area of practice covered by the CPP Agreement;~~

~~(C) submits the required application and fee to the Pharmacy Board;~~

~~(D) submits any information deemed necessary by the Pharmacy Board in order to evaluate the application; and~~

~~(E) has a signed CPP Agreement.~~

(3) The pharmacist certifies that he or she is a party to a signed collaborative practice agreement that meets the requirements of G.S. 90-8(c)(3a) and 90-18.4 and this Rule, and identifies the supervising physician and (if applicable) the institution or group practice that is a party to the agreement.

(4) The pharmacist submits any information required by the Boards in order to evaluate whether the requirements of the Rule have been met.

(5) The pharmacist pays the required fee. The fee provided in G.S. 90-8.2(b) as the maximum fee that the Boards are entitled to charge and collect for a request for approval is hereby established as the fee. No portion of that fee is refundable.

~~If for any reason a CPP discontinues working under an approved CPP Agreement, the clinical pharmacist practitioner shall notify the Pharmacy Board in writing within 10 days, and the CPP's approval shall automatically terminate or be placed on inactive status until such time as a new application is approved in accordance with this Subchapter.~~

~~(2) All certificate programs referred to in Subpart (b)(1)(B)(i) of this Rule must contain a core curriculum, including the following components:~~

~~(A) communicating with healthcare professionals and patients regarding drug therapy, wellness, and health promotion;~~

~~(B) designing, implementing, monitoring, evaluating, and modifying or recommending modifications in drug therapy to insure effective, safe, and economical patient care;~~

~~(C) identifying, assessing, and solving medication related problems and providing a clinical judgment as to the continuing effectiveness of individualized therapeutic plans and intended therapeutic outcomes;~~

~~(D) conducting physical assessments, evaluating patient problems, and ordering and monitoring medications and laboratory tests;~~

~~(E) referring patients to other health professionals as appropriate;~~

~~(F) administering medications;~~

~~(G) monitoring patients and patient populations regarding the purposes, uses, effects, and pharmacoeconomics of their medication and related therapy;~~

~~(H) counseling patients regarding the purposes, uses, and effects of their medication and related therapy;~~

~~(I) integrating relevant diet, nutritional, and non-drug therapy with pharmaceutical care;~~

~~(J) recommending, counseling, and monitoring patient use of non-prescription drugs, herbal remedies, and alternative medicine practices;~~

~~(K) ordering of and educating patients regarding proper usage of devices and durable medical equipment;~~

~~(L) providing emergency first care;~~

~~(M) retrieving, evaluating, utilizing, and managing data and professional resources;~~

~~(N) using clinical data to optimize therapeutic drug regimens;~~

~~(O) collaborating with other health professionals;~~

~~(P) documenting interventions and evaluating pharmaceutical care outcomes;~~

~~(Q) integrating pharmacy practice within healthcare environments;~~

~~(R) integrating national standards for the quality of healthcare; and~~

~~(S) conducting outcomes and other research.~~

~~(3) The completed application for approval to practice as a CPP shall be reviewed by the Pharmacy Board upon verification of a full and unrestricted license to practice as a pharmacist in North Carolina. The Pharmacy Board shall:~~

~~(A) approve the application and, at the time of approval, issue a number which shall be printed on each prescription written by the CPP;~~

~~(B) deny the application; or~~

~~(C) approve the application with restrictions, in the even that restrictions are appropriate in order to protect the public health, safety, and welfare in light of information received and reviewed in the CPP application in Subparagraph (b)(1) of this Rule.~~

(c) ~~Annual Renewal.~~ The Boards may deny CPP approval for failure to comply with G.S. 90-18(c)(3a) or 90-18.4 or this Rule, or for any grounds stated in Paragraph (h) of this rule. In the alternative to either granting or denying CPP approval, the Boards may approve CPP status with restrictions, in the event that restrictions are appropriate in order to protect the public health, safety, and welfare in light of the information received and reviewed by the Boards.

~~(1) Each CPP shall register annually on or before December 31 by:~~

~~(A) verifying that the CPP holds a current Pharmacist license;~~

~~(B) submitting the renewal fee as specified in Subparagraph (j)(2) of this Rule;~~

~~(C) completing the Pharmacy Board's renewal form; and~~

~~(D) reporting continuing education credits as required by subsection (d) of this Rule.~~

~~(2) If the CPP has not renewed the CPP's annual registration pursuant to Subparagraph (c)(1) of this Rule, within 60 days of December 31, the approval to practice as a CPP shall lapse.~~

(d) ~~Continuing Education.~~ The CPP may provide health care services pursuant to a collaborative practice agreement so long as both the agreement and the operation of the agreement meet the requirements of G.S. 90-18(c)(3a) and 90-18.4 and this Rule:

(1) ~~Each CPP shall earn 35 hours of practice relevant CE each year, approved by the Pharmacy Board.~~ The agreement must specify the health care services that the CPP is authorized to provide.

(2) ~~Documentation of these hours shall be kept at the CPP practice site and made available for inspection by agents of the Medical Board or Pharmacy Board.~~ The agreement must be approved and signed by the CPP and either the supervising physician or the institutional or group practice through which the CPP provides health care services, and a copy shall be maintained in each practice site for inspection by agents of either Board upon request.

(3) Any practice site must be within the State of North Carolina.

(4) The agreement must have a supervising physician who:

(A) Agrees to perform on-going supervision and evaluation of the health care services performed by the CPP under the agreement and to be held accountable for doing so. The agreement must be in writing, by the supervising physician either signing the agreement or signing a separate acknowledgement of having reviewed the agreement and agreeing to serve as supervising physician. Any acknowledgement must be maintained in the same location as the agreement and must be renewed upon any amendments to the agreement;

(B) Has an unrestricted and current license to practice medicine in North Carolina and spends the majority of the physician's time in practice located physically within the State;

(C) Is engaged in clinical practice;

(D) Is not serving in a postgraduate medical training program;

(E) Specifies the site or sites to which the collaborative practice agreement applies, and is readily available for consultation with the CPP;

(F) Possesses a registration for a schedule or schedules of controlled substances equal to or greater than the CPP's DEA registration; and

(G) If not identified to the Board at the time of any approval or renewal, is identified within 10 days after the physician becomes a supervising physician.

(5) The agreement must include a pre-determined plan for emergency services.

(6) The agreement must incorporate a policy for oversight and evaluation of the CPP by the supervising physician, including a periodic review and evaluation of the health care services provided by the CPP. For the first six months, the CPP and supervising physician must meet at least monthly to review the operation of the collaborative practice agreement, the health care services provided by the CPP, and measures to improve the health care services provided by the CPP. Thereafter, the CPP and supervising physician must meet to perform these tasks at least once every six months. Documentation of the meetings between the CPP and the supervising physician shall:

~~(e) A Supervising Physician who has a CPP Agreement with a CPP shall be readily available for consultation with the CPP and, at the meetings required by Subparagraph (f)(6) of this Rule, shall review each order written by the CPP.~~

~~(f) The CPP Agreement shall:~~

~~(1) be approved and signed by the Primary Supervising Physician, and Back-Up Supervising Physician, and the CPP, and a copy shall be maintained in each practice site for inspection by agents of either Board upon request;~~

~~(2) be specific in regards to the physician, the pharmacist, the patient, and the disease;~~

~~(3) specify the predetermined drug therapy, which shall include the diagnosis and product selection by the patient's physician and any modifications which may be permitted, dosage forms, dosage schedules and tests which may be ordered;~~

~~(4) prohibit the substitution of a chemically dissimilar drug product by the CPP for the product prescribed by the physician without first obtaining written consent of the physician;~~

~~(5) include a pre-determined plan for emergency services;~~

~~(6) for the first six months of the CPP Agreement include a plan and schedule for monthly meetings to discuss the operation of the CPP Agreement and quality improvement measures between the Primary Supervising Physician and CPP, and thereafter include a plan and schedule for meetings between the Primary Supervising Physician and CPP at least once every six months to discuss the operation of the CPP Agreement and quality improvement measures. Documentation of the meetings between the CPP and the Primary Supervising Physician shall:~~

(A) identify clinical issues discussed and actions taken;

(B) be signed and dated by those who attended; and

(C) be retained by both the CPP and Primary Supervising Physician and be available for review by members or agents of either Board for five calendar years;

(7) ~~require that the patient be notified of the collaborative relationship under the CPP Agreement; and~~ The agreement must require that the evaluation and supervision of the CPP remain with the supervising physician, regardless of whether other physicians or advanced practice providers are parties to the collaborative practice agreement.

~~(8) be terminated when patient care is transferred to another physician and new orders will be written by the succeeding physician.~~

~~(g)~~(e) ~~The Supervising Physician of the CPP shall:~~ The CPP shall wear a nametag spelling out the words “Clinical Pharmacist Practitioner” at all times that the CPP provides health care services pursuant to this Rule.

~~(1) be fully licensed with the Medical Board and engaged in clinical practice;~~

~~(2) not be serving in a postgraduate medical training program;~~

~~(3) be approved in accordance with this Subchapter before the CPP supervision occurs; and~~

~~(4) supervise no more than three pharmacists.~~

~~(h)~~(f) ~~The CPP shall wear a nametag spelling out the words "Clinical Pharmacist Practitioner".~~ A CPP may be registered only when actively providing services pursuant to a collaborative practice agreement. If for any reason a CPP discontinues practicing under the agreement or the supervising physician no longer serves under the agreement (and no replacement agrees to serve), the CPP shall notify the Board of Pharmacy in writing within 10 days, and the CPP’s approval shall automatically be placed on inactive status until such time as a new approval is issued in accordance with this Rule.

(g) A CPP must renew CPP status on annual basis by December 31 as follows:

(1) The CPP shall earn 25 hours of practice-relevant continuing education each calendar year that has been approved for credit by the American Council on Pharmaceutical Education or the Accreditation Council for Continuing Medical Education. The hours earned for the continuing education required by Rule .2201 may also count toward these hours, if they also qualify under this Rule. A CPP who prescribes controlled substances shall complete at least one hour of continuing education designed specifically to address controlled substances prescribing practices. Documentation of these hours shall be kept at the CPP practice site and made available for inspection by agents of either Board.

(2) The CPP shall update the information set out in Paragraph (b) of this Rule, certify the required continuing education hours, and submit any information required by the Boards in order to evaluate whether the requirements of the Rule have been met.

(3) The CPP shall pay the required fee. The fee provided in G.S. 90-8.2(b) as the maximum fee that the Boards are entitled to charge and collect for renewal is hereby established as the fee. No portion of that fee is refundable.

(4) Any CPP registration that is not renewed by March 1 of the succeeding year lapses, and it is unlawful to practice as a CPP following that date.

~~(i)~~(h) ~~The~~ A CPP may be ~~censured or reprimanded~~ reprimanded, and his or her ~~or the CPP's~~ CPP approval may be restricted, suspended, revoked, ~~annulled, denied, or terminated by the Medical Board or the Pharmacy Board.~~ Or denied by either of the Boards. In addition or in the alternative, the pharmacist may be ~~censured or reprimanded or~~ reprimanded, the pharmacist's license may be restricted, suspended, revoked, ~~annulled,~~ or denied, ~~or terminated~~ or the pharmacist may be required to successfully complete remedial education by the ~~Pharmacy Board,~~ Board of Pharmacy, in accordance with provisions of ~~G.S. 150B.~~ G.S. 90-85.38. The ~~Pharmacy Board or the Medical Board~~ Boards may take the actions set forth in this Paragraph with respect to the pharmacist, the CPP approval, or the pharmacist's license, if either Board finds one or more of the following:

(1) ~~the~~ The CPP has held himself or herself out as, or permitted another to represent that the CPP is, a licensed ~~physician;~~ physician or other health care provider that the CPP is not.

~~(2) the CPP has engaged or attempted to engage in the provision of drug therapy management other than at the direction of, or under the supervision of, a physician licensed and approved by the Medical Board to be that CPP's Supervising Physician;~~

~~(3)~~(2) ~~the~~ The CPP has provided or attempted to provide ~~medical management~~ health care services outside the ~~approved CPP Agreement~~ collaborative practice agreement or for which the CPP is not qualified by education and training to ~~provide;~~ provide.

(3) The CPP has not satisfied the terms of the collaborative practice agreement.

(4) The CPP commits any act prohibited by any provision of G.S. 90-85.38 as determined by the ~~Pharmacy Board~~ Board of Pharmacy or G.S. 90-14(a)(1), (a)(3) through (a)(14) and (c) as determined by the Medical ~~Board; or~~ Board.

(5) The CPP or anyone else operating under the collaborative practice agreement has modified the CPP's provision of health care services for financial gain.

~~(5)~~(6) ~~the~~ The CPP has failed to comply with any of the provisions of ~~this Rule.~~G.S. 90-18(c)(3a) or 90-18.4 or this Rule.

This does not limit the grounds upon which the Board can discipline a pharmacist serving as a CPP on the same basis as it could any other pharmacist.

~~Any modification of treatment for financial gain on the part of the Supervising Physician or CPP shall be grounds for denial of Board approval of the CPP Agreement.~~

~~(j) Fees:~~

~~(1) An application fee of one hundred dollars ($100.00) shall be paid at the time of initial application for approval and each subsequent application for approval to practice as a CPP.~~

~~(2) The fee for annual renewal of approval, due at the time of annual renewal pursuant to Paragraph (c) of this Rule, is fifty dollars ($50.00).~~

~~(3) No portion of any fee in this Rule is refundable.~~

History Note *Authority G.S. 90-8.2(b); 90-18(c)3a; 90-18.4;*

Eff. April 1, 2001;

Pursuant to G.S. 150B-21.3A rule is necessary without substantive public interest Eff. March 1, 2026;

Amended Eff. July 1, 2016; March 1, 2007; October 1, 2001.

Amended Eff. April l, 2027.

7.1.1: Child Maltreatment

It is the position of the Board that child maltreatment (abuse and neglect) presents a significant risk to the health and well-being of North Carolinians. The Board's licensees have a legal responsibility to report as soon as practicable "cases involving recurrent illness or serious physical injury to any child under the age of 18 years where the illness or injury appears, in the physician's professional judgment, to be the result of non-accidental trauma." (N.C. Gen. Stat. § 90-21.20(c1)).* It should also be noted that the statute provides civil and criminal immunity for reports made in good faith by physicians and other related personnel or institutions.

This legal and ethical obligation to report requires a licensee to recognize the signs, symptoms, and etiology of child maltreatment. Licensees are also encouraged to learn how to refer children for expert medical evaluations of possible maltreatment.

The following links provide detailed information on the state's reporting requirements and web-based training on recognition of child maltreatment:

Reporting Child Abuse and Neglect in North Carolina (3rd Edition)

Positive Childhood Alliance North Carolina Online Training

*This obligation specific to physicians is in addition to the legal requirement that any person or institution in North Carolina "who has cause to suspect that any juvenile is abused, neglected, or dependent, as defined by N.C. Gen. Stat. § 7B-101, or has died as the result of maltreatment, shall report the case of that juvenile to the director of the department of social services in the county where the juvenile resides or is found." (N.C. Gen. Stat. § 7B-301(a)). This statute also provides criminal penalties for "knowingly or wantonly failing to make a report, or preventing someone else from making a report" when required by law.

3.2.1: MEDICAL RECORDS – Documentation, Electronic Health Records, Access, and Retention

Documentation

An accurate, current, and complete medical record is an essential component of patient care. Licensees shall maintain a medical record for each patient to whom they provide care. The medical record should be legible. When the caregiver does not write legibly, notes should be dictated, transcribed, reviewed, and signed within a reasonable time. It is incumbent upon the licensee to ensure that the transcription of notes is accurate (particularly in those instances where medical records are generated with the assistance of dictation software or artificial intelligence).

The medical record is a chronological document that:

- Records pertinent facts about an individual's health and wellness;
- Enables the treating care licensee to plan and evaluate treatments or interventions;
- Enhances communication between professionals, assuring the patient optimum continuity of care;
- Assists both patient and licensee in communication with third party participants;
- Allows the licensee to develop an ongoing quality assurance program;
- Provides a legal document to verify the delivery of care;
- With appropriate consent, may be used as a source of clinical data for research and education; and
- Assists with compliant billing and coding.

The following required elements should be present in all medical records:

- The purpose of each patient encounter and appropriate information about the patient's history and examination;
- The patient's past medical history including an updated problem list, surgical history, family history, and social history;
- The licensee's clinical decision making including the plan for any treatment and the care and treatment provided;
- Prominent notation of current medications (including all prescribed, recommended, or provided medications, and notation of medications actually taken) and other significant allergies, or a statement of their absence; and
- Clearly documented informed consent obtained from the patient when appropriate.

Licensees are also encouraged to include patient learning needs, barriers to care, and other factors as part of the medical record.

The following additional elements reflect commonly accepted standards for medical record documentation:

- Each page in the medical record contains the patient's name or ID number.
- Include all personal, biographical information such as home address, employer, marital status, and all telephone numbers, including home, work, and mobile phone numbers.

- All entries shall contain the author's identification and the date. Author identification may be a handwritten signature, initials, or a unique electronic identifier.
- All drug therapies are listed, including dosage instructions and, when appropriate, indication of refill limits. Prescription refills should be recorded.
- Appropriate plans and specified times for follow-up care should be included.
- All consultation, laboratory, and imaging reports should be entered into the patient's record, reviewed, and the review documented by the licensee who ordered them. Abnormal reports should be noted in the record, along with corresponding follow-up plans and actions taken.
- An appropriate immunization record is evident and kept up to date.
- Appropriate preventive screening and services are offered in accordance with the accepted practice guidelines.
- When possible, licensees should retain and archive all text messages and email communications with patients within the patient's medical records so that they can be retrieved if needed.

Electronic Health Records

The Board recognizes and encourages the use of electronic health records ("EHR"). The promise and potential of information technology in health care, particularly the use of EHR, presents licensees with distinct challenges. While the Board encourages the adoption and appropriate use of various forms of EHR, there are some unique aspects and problems associated with EHR that have been repeatedly encountered by the Board, some of which are discussed below. This subsection is meant to identify issues which the Board has repeatedly found to be problematic in malpractice and complaint cases coming to the Board's attention. Basic, well-established principles of medical record documentation, as outlined above, apply to all forms of medical record documentation, including EHR.

The following guidelines are offered to assist licensees in meeting their ethical and legal obligations:

- *EHR Deficiencies.* Licensees must be aware of the idiosyncrasies and weaknesses of the EHR system they are using and adjust their practice accordingly. Licensees are ultimately responsible for the adequacy of their EHR entries and documentation.
- *Responsibility of Licensees.* Licensees remain responsible for clinical decision making. EHR are becoming increasingly sophisticated and may provide flags for follow-up care or other clinical decision-making support, such as health maintenance recommendations. While an EHR system may assist in the clinical decision-making process, it is not responsible for decision making. The licensee is. For example, it is not acceptable to blame an EHR because it failed to recommend particular testing or it failed to prompt clinical follow-up. Increasingly elaborate documentation, clinical management, and productivity tools may also result in increased opportunities for errors or omissions. These errors or omissions result from the failure of the licensee to assume appropriate responsibility for the care of the patient. In the end, decision-making responsibility rests solely with the licensee; regardless of the information or notices provided by the EHR.
- *Use of Templates.* The Board cautions against overuse of template content or reliance on EHR software which pre-populates, carries forward, or clones information from one encounter to the next, or from different licensees, without the licensee carefully reviewing and updating all information. Documentation of clinical findings for each patient encounter must accurately and contemporaneously reflect the actual care provided. The use of "copy-and-paste" should only be employed in circumstances when the totality of copied material from prior interactions is pertinent to the current situation.

- *Availability of, or Access to, EHR.* Licensees must be able to provide patient medical records under their control in a timely[1] manner for various situations, such as consultations, transfer of care to another licensee, or practice closure. The Board has encountered situations where licensees were unable to access their patients' medical records due to either fee or other disputes with the EHR vendor. This is particularly common when the medical records are maintained off site (e.g., cloud storage). Licensees must understand provisions of their contract with the EHR vendor in this regard.
- *Breakdown of Patient-Licensee Communication.* Misunderstandings and miscommunications between patients, patient family members, licensed health care professionals, and office staff generate a substantial percentage of complaints received by the Board. Many EHR systems allow direct licensee-patient communication (i.e. via a "patient portal"). While this form of communication can facilitate communication, such as follow-up of lab or x-ray results or medication refills, it also places a responsibility on the licensee to provide timely responses to legitimate requests from patients for feedback or information.
- *Employed Licensees and Independent Contractors*. The Board recommends all employed licensees/independent contractors review their employment agreements regarding ownership of the EHR. There should be explicit provisions which set forth the rights and duties of the practice and the licensee upon termination of employment, with regards to notification of patients and access to medical records.
- *Artificial Intelligence*. Once a licensee chooses to use AI, they accept responsibility for responding appropriately to the AI's recommendations. For example, if a licensee chooses to follow the course of treatment provided by an AI-generated response, then they should be prepared to provide a rationale for why they made that decision. Simply implementing the recommendations of the AI without a corresponding rationale may not be within the standard of care. Alternatively, if the licensee uses AI and suggests a course of treatment that deviates from one delineated by AI, then they should document the rationale behind the deviation and be prepared to defend the course of action. Generally, the reason a licensee provides for disagreeing with any AI recommendation should be because following that recommendation would not be consistent with the applicable standard of care.

Access to Medical Records

A licensee's policies and practices relating to medical records under their control should be designed to benefit the health and welfare of patients, whether current or past, and should facilitate the transfer of clear and reliable information about a patient's care. Such policies and practices should conform to applicable federal and state laws governing health information. These principles of medical record access also apply to licensees practicing via telemedicine.

It is the position of the Board that notes made by a licensee in the course of diagnosing and treating patients are primarily for the licensee's use and to promote continuity of care. Patients, however, have a substantial right of access to their medical records and a qualified right to amend their medical records pursuant to HIPAA privacy regulations.

Medical records are confidential documents and should only be released when permitted by law or with proper written authorization of the patient. Licensees are responsible for safeguarding and protecting the medical records under their direct control and for providing adequate security measures.

[1] In evaluating timeliness, the Board will look at the responsiveness of the licensee and the efforts undertaken to provide the requested records or information to the intended recipient.

Each licensee has a duty on the request of a patient or the patient's representative to facilitate release of a copy of the record in a timely manner to the patient or the patient's representative, unless the licensee believes that such release would endanger the patient's life or cause harm to another person. This includes medical records received from other licensees' offices or health care facilities. A summary may be provided in lieu of providing access to or copies of medical records only if the patient agrees in advance to such a summary and to any fees imposed for its production.

Licensees may charge a reasonable fee for the preparation and/or the photocopying of medical records, keeping in mind that state law limits fees a licensee can charge for copies of medical records. To assist in avoiding misunderstandings, and for a reasonable fee, the licensee should be willing to review the medical records with the patient at the patient's request. Medical records should not be withheld because payment of a patient's account is overdue (including charges for copies or summaries of medical records).

Should it be the licensee's policy to complete insurance or other forms for established patients, then it is the position of the Board that the licensee should complete those forms in a timely manner. If a form is simple, then the licensee should perform this task for no fee. If a form is complex, the licensee may charge a reasonable fee.

To prevent misunderstandings, the licensee's policies or those of the licensee's employer about providing copies or summaries of medical records and about completing forms should be made available in writing to patients when the licensee-patient relationship begins.

Licensees should not relinquish control over their patients' medical records to third parties unless there is an enforceable agreement that includes adequate provisions to protect patient confidentiality and to ensure access by both the licensee and patient to those medical records.*

When responding to subpoenas for medical records, unless there is a court or administrative order, licensees should follow the applicable federal and/or state regulations.

Retention of Medical Records

Licensees have both a legal and ethical obligation to retain patient medical records under their control. The Board, therefore, recognizes the necessity and importance of a licensee's proper maintenance, retention, and disposition of medical records. Patient interests related to present and future healthcare needs should be a licensee's primary consideration when determining how long to retain medical records.

Other Considerations and Board Expectations:

- Patients should be notified regarding how long the licensee will retain medical records.
- In order to preserve confidentiality when discarding old medical records, all medical records should be retained and destroyed in a HIPAA compliant manner, including both paper medical records and EHR. If it is feasible, patients should be given an opportunity to claim the medical records or have them sent to another care licensee before old medical records are discarded.
- The licensee should respond in a timely manner to requests from patients for access to, or copies of, their medical records.
- Licensees should notify patients of the amount, and under what circumstances, the licensee will charge for copies of a patient's medical record.

- Those licensees providing episodic care should attempt to provide a copy of the patient's medical record to the patient, the patient's primary care licensee, or, if applicable, the referring licensee.

It should be noted that these expectations relate solely to Board inquiries and do not preempt other legal or ethical record retention requirements. Licensees are encouraged to seek advice from private legal counsel and/or their malpractice insurance carrier, particularly when responding to a subpoena to produce records.

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*NOTE: Refer also to the Board's Position Statement on "Departures from or Closings of Medical Practices."