NORTH DAKOTA LEGISLATIVE MANAGEMENT

Minutes of the

HEALTH SERVICES COMMITTEE

Thursday, April 12, 2012
Roughrider Room, State Capitol
Bismarck, North Dakota

Senator Judy Lee, Chairman, called the meeting to order at 9:05 a.m.

Members present: Senators Judy Lee, Tim Mathern, Gerald Uglem, John Warner; Representatives Karen Karls, Robert Kilichowski, Vonnie Pietsch, Karen M. Rohr, Mark Sanford, Robin Weisz

Members absent: Senators Spencer D. Berry, Ralph L. Kilzer; Representatives Stacey Dahl, Kathy Hogan, Jon Nelson, Mark S. Owens

Others present: Senator Rich Wardner, member of the Legislative Management, was also in attendance

See Appendix A for additional persons present.

It was moved by Senator Mathern, seconded by Senator Uglem, and carried on a voice vote that the minutes of the January 10, 2012, meeting be approved as distributed.

REGIONAL PUBLIC HEALTH NETWORK PILOT PROJECT STUDY

At the request of Chairman Lee, the Legislative Council staff presented a bill draft [13.0034.01000] relating to changes to the regional public health network program. The Legislative Council staff said the bill draft amends North Dakota Century Code Chapter 23-35.1 relating to regional public health networks. The amendments remove the requirement that participating local public health units share administrative functions, provide that any joint powers agreement include core activities rather than specific types of services, and include outcome measures for the regional public health network program. The bill draft includes the recommendations of the State Department of Health and public health stakeholders, including a $4 million appropriation from the general fund to the State Department of Health to establish, administer, and operate regional public health networks in the state.

Mr. Keith Johnson, Administrator, Custer Health Unit, Mandan, representing the North Dakota State Association of City and County Health Officials, provided information (Appendix B) regarding a proposed timeline and funding needed for continuing the regional public health network program. He recommended changes to the bill draft relating to the criteria for regional public health networks and maintenance of effort funding requirements. He said broader assessment, expansion of service delivery, and the sharing of expertise, especially in the area of computer systems and environmental health, are potential benefits of regional public health network funding. He said voluntary participation allows partnerships based on specific needs rather than geographical boundaries or human service areas. He said increased environmental health capacity was a common benefit identified by public health administrators. He said based on national standards, the state should add six environmental health specialists to meet the minimum of 30 specialists. He said competitive salaries in oil-producing communities make other occupations more attractive to qualified graduates. He said joint powers agreements would facilitate the hiring of environmental health specialists and other needed professionals at competitive salaries and establish standard environmental health services across jurisdictions. He said it may take up to five years to measure health status outcomes in such areas as infant mortality and cardiovascular disease, but local public health unit process outcomes can be assessed in one year to three years. He said performance monitoring will determine if enhanced or improved programs or services are meeting the public's needs and expectations. He said state aid grants to local public health units totaling $3 million during the 2011-13 biennium contribute approximately 5 percent of total local public health funding. He said the additional $4 million appropriation in the bill draft provides an opportunity to achieve consistency in public health services across the state.

In response to a question from Senator Warner, Mr. Johnson said in some states environmental health fees fully support the services provided. He said fees charged in North Dakota are relatively low compared to other states.

Senator Mathern expressed concern regarding the lack of a list of detailed public health services to be shared by regional public health networks in the bill draft. Mr. Johnson said the six core public health activities in the bill draft allow for the measure of ultimate outcomes that are well-defined as opposed to individual process outcomes. He said one of the core public health activities is to assure the quality and accessibility of health services. He said this activity allows public health to provide health services to populations not served by the remedial health community.

Representative Weisz said the bill draft requires the joint powers agreement to identify shared or expanded

services in the core public health activities to qualify as a regional public health network, but the legislation does not limit the activities provided by the participating public health units.

In response to a question from Representative Rohr, Mr. Johnson said local public health is collaborating with community and provider partners to assess the health of population. He said the assessment identifies the present health needs of the population, and intervention strategies are developed with partners. He said every critical access hospital must have an assessment done by March 2013.

Ms. Robin Iszler, Administrator, Central Valley Health District, Jamestown, commented regarding provisions in the bill draft relating to the criteria for regional public health networks. She said the criteria should not penalize public health units that are already regionalized. She suggested a regional public health network require more than one public health unit.

Ms. Kelly Nagel, Public Health Liaison, State Department of Health, commented on the bill draft. Her comments related to the definition of a regional public health network and references to the various types of local public health units in the bill draft. She said the six core public health activities are a national standard for public health, and the 10 essential services are how local public health units accomplish these core activities. She said the reference to the six core public health activities was suggested by the stakeholders to make the language less prescriptive. She said the core public health activities are general so that specific activities may be identified for each community, included in the annual plan, and approved by the State Health Officer.

STUDY OF THE FEASIBILITY OF PLACING THE FORT BERTHOLD RESERVATION IN A SINGLE PUBLIC HEALTH UNIT

Commander Arne Sorenson, United States Public Health Service and Director of Diabetes Prevention Program, Mandan, Hidatsa, and Arikara Nation, provided information (Appendix C) regarding a proposed funding model for a local public health unit that includes the entire Fort Berthold Reservation and an update on the status of the proposed governance of a local public health unit by the Mandan, Hidatsa, and Arikara (MHA) Nation Health Authority. He said the MHA Nation continues to support a small tribe model for tribal public health delivery. He said the MHA Nation Health Authority Board was created to address governing body requirements of the health care systems on the reservation. He said changes to the MHA Nation Health Authority Board could be made to accommodate the appointment of a subcommittee of the board that, with the addition of ex officio appointments from the State Department of Health, could oversee the addition of the public health unit functions and required reporting. He said the MHA Nation is able to provide some of the same health care services that are provided by other public health units, including health promotion, communicable disease, school health, and noncertified nursing home visits. He said the principles of success for the integration of primary care and public health activities include a common goal of improving population health and community involvement in defining and addressing the needs of the community. He said the MHA Nation is prepared to collaborate with the state of North Dakota for the integration of primary and public health care activities. He said the cost could be shared based on population, and an annual review would allow for improvements.

In response to a question from Senator Lee, Commander Sorenson said the MHA Nation hopes to establish a federally qualified health center (FQHC). He said a planning grant for an FQHC provides an opportunity to merge primary care and public health services.

In response to a question from Senator Lee, Commander Sorenson said in addition to chronic disease care, medical facility officials are supportive of the medical home concept for chronic disease management.

In response to a question from Senator Lee, Commander Sorenson said telemedicine may provide some solutions to the geographical barriers to including the entire Fort Berthold Reservation in one local public health unit.

In response to a question from Senator Lee, Commander Sorenson said the tribe has made significant investments to improve services, including its investment in the current facility. He said he anticipates the tribe will continue to invest in services on the reservation.

Senator Mathern said any plan for an additional public health unit that includes the entire Fort Berthold Reservation would need to address the effects of the new unit on the public health units currently serving this population.

Senator Lee suggested the public health units serving the reservation be invited to comment to the committee on providing services on the reservation.

Mr. Johnson said delivery of services from a federally qualified health center would require collaboration with Health Resources and Services Administration (HRSA). He said for stakeholders, such as HRSA and Indian Health Services (IHS), collaboration may be difficult. He said for a plan to work, there must be collaboration from the tribe, HRSA, IHS, and local public health units serving the reservation.

In response to a question from Senator Warner, Mr. Johnson said in addition to remedial care, FQHC objectives include public health activities.

In response to a question from Senator Warner, Dr. John Baird, Special Populations Section Chief, State Department of Health, said an FQHC is federally funded, but it is meant to be a community facility with users making up over 50 percent of the FQHC board.

In addition to the federal funding, he said, funding is also received through Medicaid and various other reimbursements. He said the FQHC provides primary care and also serves to educate the public. He said FQHCs are heavily regulated by HRSA, and they must provide services to underserved populations in designated shortage areas. He said there are currently four FQHCs in the state.

Senator Mathern said the tribe in Coeur d'Alene, Idaho, is responsible for its health center, but everyone is served. He said the health center benefits from a broader base of payers.

Senator Mathern suggested stakeholders collaborate with the Legislative Council to prepare a bill draft including the concepts provided by the representatives of the Fort Berthold Reservation. Senator Lee expressed concern that the public health units serving the Fort Berthold Reservation have not yet been part of the discussion and may not be prepared to work on a bill draft. Dr. Baird said he would facilitate discussion with the stakeholders. Senator Lee asked Dr. Baird to work with stakeholders to formulate a plan that could be presented to the committee and potentially incorporated into a bill draft.

OTHER COMMITTEE RESPONSIBILITIES

At the request of Chairman Lee, the Legislative Council staff presented a memorandum entitled *Smoking Rates and Related Trends in Tobacco Prevention and Control Spending, Cigarette Tax Rates, and Smoke-Free Environment Laws*. The Legislative Council staff said cigarette use is measured based on data from the Centers for Disease Control and Prevention (CDC) behavioral risk factor surveillance survey. The Legislative Council staff provided information regarding adult cigarette use in each state and the District of Columbia from 2000 to 2010. Overall adult cigarette use in North Dakota declined from 23.2 percent in 2000 to 17.4 percent in 2010. The 5.8 percent reduction in adult cigarette use from 2000 to 2010 in the state ranked North Dakota 18th among the 50 states and the District of Columbia.

The Legislative Council staff selected for comparative analysis the five states that had the most significant decreases in adult cigarette use from 2000 to 2010, the five states that had the least change or an increase in adult cigarette use during the same period, and other states based on proximity to North Dakota or other factors, including similarities in population and smoking rate reductions. The Legislative Council staff said tobacco prevention and control spending and policies vary widely from state to state, and these differences make comparisons between the states difficult. Other factors not considered in these comparisons may also affect cigarette use by adults in these states.

The Legislative Council staff said of the five states that had the most significant decrease in adult cigarette use from 2000 to 2010, three--New Hampshire, Nevada, and Rhode Island--decreased funding for tobacco prevention and control from 2003 to 2010, while two--Iowa and Connecticut--increased funding. Of the five states that had the least change or an increase in adult cigarette use, three--Louisiana, Montana, and Oklahoma--increased funding, Mississippi decreased funding, and West Virginia had minimal funding changes over the eight-year period. From 2003 through 2009, funding for tobacco prevention and control in North Dakota ranged from $3.4 million to $4.5 million annually, while the adult smoking rate decreased from 20.5 percent to 18.6 percent during the same period. Funding for tobacco prevention and control in North Dakota increased to $9.4 million in 2010, and the smoking rate decreased to 17.4 percent. In 2010 only North Dakota fully funded the CDC best practices for comprehensive tobacco control, and Alaska had the next highest level of funding, which funded 87 percent of CDC best practices for comprehensive tobacco control. States funding the lowest level of CDC best practices for comprehensive tobacco control in 2010 were Missouri (3 percent) and New Hampshire (5 percent).

The Legislative Council staff provided a summary of cigarette tax rates compared to adult cigarette use for selected states from 2000 through 2010. The Legislative Council staff said in 2000 cigarette tax rates charged by states ranged from $.025 per package in Virginia to $1.11 per package in New York. In 2010 state cigarette tax rates ranged from $.17 per package in Missouri to $4.35 per package in New York. Of the five states that had the most significant decrease in adult cigarette use from 2000 to 2010, three--New Hampshire, Rhode Island, and Connecticut--increased cigarette tax rates several times over the 10-year period. Of the five states that had the least change or an increase in adult cigarette use, four--Louisiana, Mississippi, Oklahoma, and West Virginia--increased cigarette tax rates once, while Montana increased its cigarette tax rate twice over the 10-year period. In North Dakota the cigarette tax rate remains unchanged from 2000 at $.44 per package, while in South Dakota the cigarette tax rate was increased twice over the 10-year period and is currently $1.53 per package. Minnesota has increased its cigarette tax annually since 2005 and currently charges $1.586 per package.

The Legislative Council staff provided a summary of smoke-free environment laws by state as of December 31, 2009. The Legislative Council staff said 21 states and the District of Columbia had smoke-free environment laws enacted for worksites, restaurants, and bars. Nineteen states had no smoke-free environment laws, and the remaining 10 states had laws providing partial coverage. Of the five states that had the most significant decrease in adult cigarette use from 2000 to 2010, two--Rhode Island and Iowa--covered worksites, restaurants, and bars in their smoke-free indoor air laws. Nevada covered worksites and restaurants, New Hampshire

covered just restaurants, and Connecticut had no smoke-free indoor air coverage. Of the five states that had the least change or an increase in adult cigarette use, three--Mississippi, Oklahoma, and West Virginia--had no laws for smoke-free indoor air. Montana covered worksites, restaurants, and bars in their smoke-free indoor air laws; Louisiana covered worksites and restaurants; South Dakota smoke-free indoor air laws covered worksites and restaurants; and Minnesota smoke-free indoor air laws covered worksites, restaurants, and bars. North Dakota prohibits smoking in all enclosed areas of public places and places of employment but provides exemptions for other areas, including bars. In addition, local governments may enact more stringent tobacco control laws.

In response to a question from Senator Lee, Dr. Jon Rice, Tobacco Prevention and Control Advisory Committee, said the CDC behavioral risk factor surveillance survey is an annual telephone survey.

Representative Weisz asked the Legislative Council staff to e-mail to the committee a summary of each selected state's percentage of the CDC best practices funding level for comprehensive tobacco control.

Representative Weisz said it appears high cigarette tax rates are most common among states with the largest decrease in smoking rates.

Dr. Rice said tobacco prevention and control spending policies vary by state. He said policies include more than just funding, tax rates, and smoke-free laws. He said the use of funding for CDC best practices is not identified in the information provided. He said programs take years to show results but raising the cigarette tax typically yields quick results.

Ms. Kim Mertz, Director, Division of Family Health, State Department of Health, provided a report (Appendix D) regarding the department's inventory of material relating to abortions and outlining the department's practice of gathering the inventory items pursuant to Section 15 of 2011 House Bill No. 1297. She said the department has received feedback from all stakeholders on the second draft of a publication that combines the materials related to the characteristics of the unborn child, the support obligations of the father, and the various methods of abortion and their effects. She said a third draft will be distributed for final review by the stakeholders within the next few weeks. She said the department is also updating a publication to inform women of public and private agencies to assist them through pregnancy, and she anticipates both publications will be distributed together. She said the publications will also be available on the department's website. She said the Division of Vital Records is responsible for the abortion compliance report and the abortion data report. She said the Red River Women's Clinic in Fargo has filed a lawsuit objecting to provisions of 2011 House Bill No. 1297 relating to information requested on the data and compliance reports. She said the clinic continues to submit reports but does not include the information that is the subject of the lawsuit. She said a hearing on the lawsuit is scheduled in late April 2012.

Representative Karls asked the State Department of Health to e-mail information regarding where the lawsuit will be heard to the Legislative Council staff so the information may be sent to the committee.

In response to a question from Senator Lee, Ms. Mertz said partners can be asked to link their websites to the electronic versions of the publications on the State Department of Health website.

Mr. Jerry Jurena, board member, Health Council, provided information (Appendix E) regarding the findings of its review of current health care bed recommendations and whether changes should be made to better serve the population of the state. He said the Legislative Assembly in 2011 House Bill No. 1040 directed the Health Council to review current health care bed limits and determine if changes were necessary to better serve the people of North Dakota. He said average monthly nursing facility recipients decreased from 3,589 in 2004 to 3,120 in 2011 and average monthly basic care recipients increased from 468 in 2004 to 513 in 2011. He said to date in 2012 the monthly recipients for nursing facilities average 3,078, and for basic care the average is 566. He said appropriations for nursing facilities have increased 81.7 percent over the last 15 years, while home and community-based services (HCBS) increased by 215.7 percent over the same period. He said while both are increasing, growth in the utilization of HCBS has outpaced growth in the use of nursing facilities. He said the number of average monthly HCBS recipients has increased from 1,707 in 2004 to 2,371 in 2011. He provided information regarding the number of nursing home beds, swing beds, and basic care beds by region in the state during 2010 and the current number of assisted living units by region. He said in 2010 North Dakota had 57.10 nursing home beds and 16.49 basic care beds per 1,000 of population over age 65 (15.53 basic care beds per 1,000 of population over age 65 if special care facilities are excluded). He said the current targets of 60 nursing facility beds per 1,000 population aged 65 and above and 15 basic care beds per 1,000 of population aged 65 and above were adopted in January 1994. Based on the information received, he said, the Health Council recommends:

- Continuing the moratorium on nursing facility and basic care beds in the state;
- Reducing the target for nursing facility beds in the state from 60 to 55 nursing facility beds per 1,000 population aged 65 and above;
- Continuing the target for basic care facility beds at 15 basic care beds per 1,000 of population over age 65; and
- The Legislative Assembly reconsider provisions that allow for new and additional basic care beds.

In response to a question from Senator Lee, Mr. Jurena said written testimony (Appendix F) provided to the committee by Ms. Shelly Peterson, President, North Dakota Long Term Care Association, indicated there are currently over 500 nursing facility beds and 255 basic care beds open in the state. Mr. Jurena said instead of providing new beds, there should be a transfer or some other mechanism to utilize the beds that are currently open.

Mr. Howard C. Anderson, board member, Health Council, said current exceptions to the basic care bed moratorium cause the number of beds per 1,000 of population over age 65 to increase and make the target number of beds more difficult to reach. He said the Health Council is recommending a review of the criteria for exceptions to the moratorium.

After the luncheon recess, in response to a question from Senator Mathern, Mr. Anderson said the Health Council's recommendations for nursing facility and basic care bed levels are not set in statute, rather they are recommendations for consideration by the Health Services Committee.

The Legislative Budget Analyst and Auditor said the current statutory provisions establishing moratoriums on the expansion of nursing facility and basic care beds are set to expire on July 31, 2013. He said if the Health Services Committee wishes to extend the moratoriums, the committee may request a bill draft to change the expiration dates.

In response to a question from Senator Lee, Mr. Wade Peterson, Administrator, Medcenter One Mandan Living Center, and board member, Health Council, said the Health Council subcommittee responsible for the recommendations included representation from assisted living, basic care, skilled nursing, and home health care.

It was moved by Senator Mathern, seconded by Senator Warner, and carried on a roll call vote that the Health Services Committee accept the recommendations of the Health Council relating to the recommended target numbers of nursing facility and basic care beds in the state. Senators Lee, Mathern, Uglem, and Warner and Representatives Karls, Kilichowski, Pietsch, Rohr, Sanford, and Weisz voted "aye." No negative votes were cast.

Senator Mathern suggested the Legislative Council staff draft a bill to extend the current moratoriums on the expansion of nursing facility and basic care beds through July 31, 2015. Senator Lee asked the Legislative Council staff to prepare the bill draft.

Mr. Anderson, Chairman, Health Care Data Committee, Health Council, provided information (Appendix G) regarding the status of potential legislative changes related to the Health Care Data Committee. He said the Health Care Data Committee has asked the State Department of Health to consider legislative changes to the mission of the Health Care Data Committee. He provided marked-up copies of North Dakota Century Code Chapter 23-01.1 relating to the Health Care Data Committee. He said changes to the statute include changing the name of the committee and its focus to concentrate on the collection of data that can be used by practitioners. He said the State Department of Health could be a repository for data and a resource for the new public health program at the state's research universities. He said research results could be used in resource allocation decisions.

In response to a question from Senator Warner, Mr. Anderson said varying data sets collected in various federal programs present a data collection challenge. He said information is difficult to compare from one program to another. He said the State Department of Health has been asked to identify resources required for the collection of the data.

In response to a question from Senator Lee, Mr. Anderson said most of the data is already being collected but is not consolidated. He said there may also be opportunities for the collection of new data if hospital discharge data were made available.

STUDY OF THE FUTURE OF HEALTH CARE DELIVERY IN THE STATE AND THE ABILITY OF THE UNIVERSITY OF NORTH DAKOTA SCHOOL OF MEDICINE AND HEALTH SCIENCES TO MEET THE HEALTH CARE NEEDS OF THE STATE

Ms. JoAnne Hoesel, Director, Division of Mental Health and Substance Abuse Services, Department of Human Services, provided information (Appendix H) regarding the funding sources for mental health services, including information regarding mental health parity and services for adults and children. She said primary funding sources for public mental health services are the general fund, Medicaid, the community mental health block grant, and third-party insurance. She said the federal Mental Health Parity and Addiction Equity Act of 2008 does not require group health plans to cover mental health and substance use disorder benefits. She said the Act requires group health insurance plans covering more than 50 insured employees and offering coverage for mental illness and substance use disorders to provide those benefits in a way that is no more restrictive than all other medical and surgical procedures covered by the plan. She said group health plans can manage the use and cost of the benefits they provide by determining the medical necessity criteria, the scope of coverage, and when prior authorization for treatment is required. However, she said, large group plans are required to provide medical necessity and managed care criteria used to make decisions and, if benefits are denied, the reasons for denial. She provided information regarding federal interim final regulations effective in April 2010 relating to financial restrictions and quantitative treatment limits in six classifications of benefits defined in the interim final rule. Under parity law and the interim final rules, she said, financial restrictions and quantitative treatment limits on mental health and substance use disorder benefits may not be more restrictive than

those that apply to at least two-thirds of medical/surgical benefits in the same classification. She said classifications include inpatient/in-network, inpatient/out-of-network, outpatient/in-network, outpatient/out-of-network, emergency care, and prescription drugs.

Dr. Andy McLean, Medical Director, Department of Human Services, provided information (Appendix I) regarding issues affecting the recruitment and retention of psychiatrists in the state. He said the State Hospital has four general adult psychiatrists (full or part time), one consulting child psychiatrist, and is currently recruiting two additional psychiatrists. He said there are also 17 psychiatrists at the regional human service centers, for a total of 21 psychiatrists in the Department of Human Services. He said the majority of the regional human service center psychiatrists were either trained, did their residency, or both, at the School of Medicine. He said the department maximizes its resources by using advanced practice registered nurses, sharing positions between institutions and regional human service centers, and using telepsychiatry. He said the State Hospital and regional human service centers serve as training sites for the School of Medicine. He said the Southeast Human Service Center is an American Psychological Association accredited training site for Ph.D. level psychologists, and many other behavioral health care and addiction treatment interns rotate through the department's sites. He said the department has been successful in recruiting providers through their training programs. He said the department has recruited from within the department for open positions, and telepsychiatry has helped fill gaps. He said approval of the State Hospital as a National Health Service Corps loan forgiveness site and increased exposure of psychiatry residents to other parts of the state would likely improve recruitment and retention of psychiatrists. He said telepsychiatry, flexible staffing, collaboration with advanced practice registered nurses, and collaboration with primary care, particularly in underserved areas, such as FQHCs, have helped meet the need for psychiatric service among more vulnerable populations.

In response to a question from Senator Warner, Dr. McLean said the School of Medicine psychiatry residency program is in Fargo. He said the salaries for approximately half of the psychiatrists in the state range from $150,000 to $275,000. He said private sector psychiatrist salaries are typically higher than public sector, but salaries are comparable between the eastern and western parts of the state. He said regionally the Upper Midwest and West have the highest salaries in the nation for psychiatrists, and a graduate of a residency program could start at a salary exceeding $250,000 per year.

In response to a question from Senator Mathern, Dr. McLean said there are different accreditations and licensures available for advanced practice registered nurses (RN). He said clinical nurse specialist (CNS) is an RN in psychotropic practice. He said a family practice nurse practitioner (FNP) or another nurse practitioner could receive accreditation or additional training for prescribing in psychiatry. He said the additional training could take up to 18 months depending on the level of previous training.

In response to a question from Senator Warner, Dr. McLean said a number of psychiatrists have child and adolescent certification, but the state's residency program does not include an adolescent fellowship.

In response to a question from Senator Lee, Mr. Alex Schweitzer, Cabinet Lead for Institutions and Regional Human Service Centers, Department of Human Services, said the department has found it most difficult to recruit professionals to the rural areas of the state. He said the department is working with the State Board of Psychologist Examiners regarding the credentialing of behavior analysts.

In response to a question from Senator Lee, Mr. Sheldon Wolf, Director, Health Information Technology, Information Technology Department, updated the committee on the health information exchange program. Mr. Wolf said a contract with Axolotl is in place to assist health care providers and health plans to efficiently and securely exchange health information. He said testing is occurring on the first phase of the project which is the direct phase and includes securely sending information from one provider to another. To date, he said, 14 providers have signed up, and approximately 118 providers are needed to receive approval from the federal government to continue to the second phase of the project. He said the second phase is the query process.

In response to a question from Senator Mathern, Mr. Wolf said he is not concerned about the low number of providers signed up because the process is just beginning.

Mr. Wolf provided information (Appendix J) regarding laws that prevent health information technology from being used as a registry resulting in the selling of personal information. He said there are federal laws that generally prohibit a health information exchange (HIE), such as the North Dakota Health Information Network (NDHIN), from selling any individually identifiable health information the exchange stores or transmits. He included in his testimony a copy of a letter drafted by Mr. Michael J. Mullen, Special Assistant Attorney General for the Information Technology Department, regarding the prohibition on the sale of protected health information. Mr. Wolf said federal regulations and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) generally provide if the disclosure of individually identifiable health information is not permitted under the HIPAA privacy rule, the disclosure is prohibited. He said the Health Information Technology for Economic and Clinical Health (HITECH) Act provides the HIPAA privacy rule applies to not only covered entities but also business associates. He said NDHIN must be treated as a

business associate of the health care providers, and health plans for whom the network transmits health information and business associates must ensure that any subcontractors that create or receive protected health information on behalf of the business associate agree to the same restrictions and conditions that apply to the business associate. He said there is an exception for the disclosure of protected health information for public health purposes. In addition, he said, providers participating in the NDHIN are required to comply with the network's policies which expressly prohibit the sale of health information without the authorization of the individual to whom the information pertains.

Dr. Jim Mitchell, Chair, Department of Clinical Neuroscience, University of North Dakota School of Medicine and Health Sciences, Grand Forks, provided information (Appendix K) regarding programs to expand the number of psychiatric service providers in the state. He said a psychiatry residency is four years. Since its inception in 1981, he said, the state's program has graduated 82 residents, of which 31, or 38 percent, are practicing in North Dakota. He said the program began with three residency slots but was expanded to four slots several years ago.

In response to a question from Senator Lee, Dr. Mitchell said the residents accepted in the program are a mixture of students from different medical schools, including the School of Medicine.

In response to a question from Senator Mathern, Dr. Mitchell said all of the psychiatry residency slots are filled.

Dr. McLean, Clinical Professor of Clinical Neuroscience, University of North Dakota School of Medicine and Health Sciences, Grand Forks, provided information regarding programs to expand the number of psychiatric service providers in the state. He said nationally 4 percent of all practicing physicians are psychiatrists, and data over the last four years indicates School of Medicine students are choosing psychiatry at a rate of 4.4 percent. He said a 2007 national study indicated 5.3 percent of practicing physicians in the state were psychiatrists and ranked North Dakota No. 14 overall, with 77 practicing psychiatrists or 12.1 per 100,000 of population. He said by mid-year, 85 psychiatrists will be actively practicing in the state or 12.4 per 100,000 of population. He said a rate of 13 psychiatrists per 100,000 of population is often considered reasonable. He said training statistics confirm most residents practice within 100 miles of their residency and two of the four upper class residents have signed contracts to stay in the state. He said there is also an elective rotation in telepsychiatry.

In response to a question from Senator Mathern, Dr. McLean said the School of Medicine has a very good training relationship with the public sector, and the majority of residents that stay in the state are in public psychiatry. He said developing relationships during clerkships and loan forgiveness through the National Health Service Corps encourage residents to remain in the state.

Dr. Joshua Wynne, Dean, University of North Dakota School of Medicine and Health Sciences, Grand Forks, provided information (Appendix L) regarding a space utilization study of the School of Medicine. He said the State Board of Higher Education has endorsed a plan to increase class sizes to meet the health care provider needs of the state. He said with the increased class sizes come a need for added facilities to accommodate the additional students and faculty. He said when the Legislative Assembly in 2011 did not support the needed capital construction, the School of Medicine modified the health care workforce plan to limit the increase to as many new students as could be housed in the existing facilities. He said the modified plan called for approximately half of the student numbers identified in the original plan. He said the Legislative Assembly in 2011 approved the modified plan and provided for studies of the ability of the School of Medicine to meet the health care needs of the state and of facility needs at the School of Medicine. He said JLG Architects engaged the national design firm of Perkins+Will to assist with the project.

Mr. Dave Molmen, Chair, University of North Dakota, School of Medicine and Health Sciences Advisory Council, provided information regarding the recommendations of the advisory council relating to the health care workforce initiative and the School of Medicine 2013-15 biennium budget. Mr. Molmen said the School of Medicine and the advisory council prepared a comprehensive workforce plan to address the shortage of health care professionals in the state. He said the plan includes training more physicians and health care professionals, retaining professionals, and reducing the burden of disease. He said the original workforce plan included increasing each year the medical school class by 16 students, the health sciences classes by 30 students, and the residency program by 17 residents. He said the initial phase of the workforce plan was approved by the Legislative Assembly in 2011 and included an increase of 8 students at the medical school, 15 students in the health sciences classes, and 9 residency slots. He said the second phase includes the studies, which allow the workforce projections to be reevaluated and for an examination of facility needs. He said the final build phase would begin in 2013 to allow for the full implementation of the class size increases. He said a second edition of the biennial report will be published later this year and will support earlier findings regarding the increased need for health care professionals, especially in the western part of the state. He said the School of Medicine and Health Sciences Advisory Council endorses the comprehensive workforce plan and recommends its full implementation.

Mr. Jim Galloway, Principal, JLG Architects, Grand Forks, provided information regarding the history and the condition of the current School of Medicine facility.

He said JLG Architects partnered with Perkins+Will, a national firm with experience in health care education. He provided a copy of the space utilization study executive summary (Appendix M) and a copy of the full report (on file in the Legislative Council office). He said the study considered university initiatives, including enrich the student learning environment; encourage gathering; facilitate collaboration; expand the university's presence; and enhance the quality of life for the faculty, staff, and students. In addition, he said, study consideration was given to School of Medicine objectives, including collocating health sciences and medical student education, provide space for the recruitment and retention of faculty required with increased enrollment, analyze the existing building to support the missions of education research and service, verify that accreditation requirements are met, and maximize federal indirect cost return. He said in addition to professional staff, administration, faculty, staff, and students were included in focus groups for feedback on building use. He said the main building is a retired hospital constructed in 1952 and repurposed in 1988 as the School of Medicine. He said challenges of the existing facility include a small structural grid, low floor-to-floor heights, lack of natural light, age of major building systems and components, aging windows and building envelope, and limitations on technology and renovation. He said many of the classrooms, labs, patient-centered learning (PCL) environments, and lecture halls are overcrowded and recommended clearances are unobtainable. He said other departments related to health care education are located at different locations because there is not room in the current facility.

Mr. Bob Lavey, Higher Education Market Leader, Perkins+Will, provided information regarding options to accommodate the student enrollment growth associated with the health care workforce initiative at the School of Medicine. Mr. Lavey said the evolution of the medical education curriculum has left spaces, such as large lecture halls, underutilized, while others, such as the anatomy laboratory, are too small. He said the complete report includes details of the space study, including room scheduling, room use and capacity, and class size. He said there is little flexible space in the current facility and the facility is at maximum capacity. He said full implementation of the comprehensive workforce plan will increase class size 24 percent which translates into 162 students. He said there has been a shift from lecture-based education to a team-oriented structure in which students teach each other. He said there is a greater need for flexible space where students are able to work together, active learning space where simulation is possible, and space for interprofessional learning opportunities. He provided the following construction options:

- Option 1 - With an estimated cost of $38.5 million, includes an 80,103 gross square footage (GSF) addition with shared education space and the renovation of 42,311 GSF of faculty offices and education space.
- Option 2 - With an estimated cost of $68.3 million, includes a 169,390 GSF addition with shared education space and student collaboration space and the renovation of 48,332 GSF of faculty office, collaboration, and administration space.
- Option 3 - With an estimated cost of $124 million, creates a new 376,812 GSF building with shared education space, student and faculty collaboration space, faculty and administration offices, and research facilities.

In response to a question from Representative Karls, Dr. Wynne said the School of Medicine currently provides unique educational experiences for undergraduates and the incorporation of Allied Health Sciences undergraduates into the facility would not duplicate other space and educational opportunities provided elsewhere on the campus. He said efficiencies would result by bringing these students into one facility.

In response to a question from Senator Mathern, Mr. Molmen said the goal of the health care workforce plan is to close the gap between the anticipated demand and supply of health care providers in the state by gaining 210 physicians and more health care professionals over the next decade. He said each physician generates 10 jobs. Dr. Wynne said it may be possible to gain approximately half of the needed providers by increasing the retention of current graduates; however, even with the projections, retention alone will not provide the needed professionals. He said it is essential to increase class sizes and residencies and the space study has concluded these increases are not possible with the current facility. He said the plan is to provide an adequate number of health care professionals in rural and urban areas of the state.

In response to a question from Senator Lee, Mr. Galloway said alternate uses for the old building would be considered as part of a campus master plan currently under way at the University of North Dakota.

In response to a question from Representative Rohr, Dr. Wynne said the cost of additional faculty, ancillary staff, and other costs will be a separate proposal. He said the advisory council has endorsed a proposal totaling approximately $9 million per biennium to provide for these costs. He said the State Board of Higher Education has not yet acted on the proposal, but if approved, the request will be included in the School of Medicine budget request for the 2013-15 biennium.

In response to a question from Senator Mathern regarding programs to increase the number of graduates retained in psychiatry, Dr. Wynne said the School of Medicine leads the country in the number of students entering family medicine. He said predictors for retention in family medicine, especially in rural areas of the state, include a rural background and an interest in primary care both when entering and

completing medical school. He said it is possible that programs to encourage earlier exposure to psychiatry may be successful in creating an interest in the field among students entering medical school.

In response to a question from Representative Rohr, Dr. Mitchell said disincentives for medical students to enter psychiatry include length of residency training and lower pay than other specialties.

Ms. Carol K. Olson, Executive Director, Department of Human Services, said it was evident when she spoke to a group of high school students recently regarding the mental health issues experienced by those affected by flooding that there is a lack of knowledge regarding psychiatry. She said exposure to psychiatry careers in high school-aged children is important.

Dr. Wynne said the School of Medicine will consider working with the Center for Rural Health to increase its psychiatry exposure to high school students.

In response to a question from Senator Lee, Dr. Wynne said the Center for Rural Health, with the assistance of a grant from the Dakota Medical Foundation, organized a symposium on the development of rural health providers. He said discussion comments will be collated and sent to participants for review and the development of an action plan.

In response to a question from Senator Lee, Dr. Wynne said the School of Medicine has approved in principle a rural family medicine residency in Fargo. He said because the regulatory and approval process is lengthy, the School of Medicine will provide funding for the planning for a rural family medicine residency in Fargo during the 2011-13 biennium. He said the School of Medicine anticipates the request for full funding of the residency will be included in the comprehensive workforce plan to be submitted to the Legislative Assembly in 2013.

Senator Mathern suggested the committee receive a preview of the update to the comprehensive workforce plan when the second biennial report is available.

COMMITTEE DISCUSSION AND STAFF DIRECTIVES

Senator Warner suggested the Legislative Council staff provide information regarding options for including an FQHC in the definition of a public health unit in Chapter 23-35.

Senator Mathern suggested the Legislative Council staff provide information regarding the public health model at the FQHC established by the tribe in Coeur d'Alene, Idaho.

Senator Lee suggested the committee receive information regarding a summary of Western Interstate Commission for Higher Education (WICHE) students receiving tuition support to attend out-of-state schools, including cost, residency requirements, and whether they are required to return to the state to practice.

Chairman Lee asked the committee to consider conflicts for a possible meeting the week of July 23, 2012, and inform the Legislative Council staff.

No further business appearing, it was moved by Senator Mathern, seconded by Representative Karls, and carried on a voice vote that the meeting be adjourned. Chairman Lee adjourned the meeting at 3:20 p.m.

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Sheila M. Sandness
Senior Fiscal Analyst

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Allen H. Knudson
Legislative Budget Analyst and Auditor

ATTACH:13