

NORTH DAKOTA LEGISLATIVE MANAGEMENT

Minutes of the

HEALTH SERVICES COMMITTEE

Wednesday, October 30, 2013
Roughrider Room, State Capitol
Bismarck, North Dakota

Senator Judy Lee, Chairman, called the meeting to order at 9:00 a.m.

Members present: Senators Judy Lee, Howard C. Anderson, Jr., Robert Erbele, Tim Mathern; Representatives Alan Fehr, Curt Hofstad, Rick Holman, Jon Nelson, Marvin E. Nelson

Members absent: Senators Oley Larsen, Joan Heckaman; Representative Dick Anderson

Others present: See [Appendix A](#)

It was moved by Senator Mathern, seconded by Senator Erbele, and carried on a voice vote that the minutes of the July 31, 2013, meeting be approved as distributed.

DENTAL SERVICES STUDY

At the request of Chairman Lee, Dr. Leon A. Assael, Dean of the School of Dentistry, University of Minnesota, provided information ([Appendix B](#)) regarding the education, certification, and licensure of advanced dental therapists in Minnesota. Dr. Assael said dental therapy is not new, and dental therapists have practiced in New Zealand and the United Kingdom for decades. He said existing comprehensive program accreditation processes include standards on admission policies and procedures, curriculum, clinic, administration, preparation for practice, student assessment and examination, evaluation procedures and outcomes, research, and articulation pathways (team integration experience). He said in the United Kingdom, where the General Dental Council regulates all dental professionals including dental therapists, there are processes in place to determine whether dental therapy programs are meeting training requirements and to monitor programs suspected of not meeting requirements. He said the dental therapy program at the School of Dentistry, University of Minnesota, is in its fifth year, and through December 2013, the program will have graduated 27 dental therapists in three classes. He said dental therapy students are fully integrated into the existing accredited dental and dental hygiene education program, and for the courses relevant to dental therapy practice, much of the coursework and clinical education is done with Doctor of Dental Surgery (DDS) students. He said the Board of Dentistry of Minnesota has accredited the program. He said in addition to the program at the School of Dentistry, the Minnesota State Colleges and Universities System sponsors a program at Metropolitan State University. He said the federal Centers for Medicare and Medicaid Services (CMS) has demonstrated interest in the dental therapy model by awarding a \$45 million state innovation model grant to the Minnesota Department of Health and the Minnesota Department of Human Services. He said the goal of the innovation model is to expand the use of innovative provider types within primary care practices, and the grant will support the integration of new providers, such as dental therapists, into clinical practices. He said dentists who employ dental therapists can expand their practices by offering care to patients with high disease rates, but low reimbursement, while concentrating on more complex procedures. He said Minnesota's dental therapists are employed in private practice, group practice, nonprofit community clinics, and federally qualified health centers (FQHCs). He said they are employed in urban and rural areas, and feedback from employers has been positive.

In response to a question from Representative Fehr, Dr. Assael said a dental therapists may educate patients, perform oral examinations and preventative procedures, drill and repair early stages of tooth decay, and assist in other procedures.

In response to a question from Senator Anderson, Dr. Assael said although a dentist may not be physically present, a dentist should always be involved in the care of the patient. Dentists should confirm the diagnosis and the treatment plan and be present for the critical portion of the treatment. He said technology has made it possible to be involved without being physically present.

At the request of Chairman Lee, Dr. Mary Williard, Dental Health Aide Therapist Training Director, Alaska Native Tribal Health Consortium, provided information ([Appendix C](#)) regarding the education, certification, and licensure of midlevel dental service providers; how midlevel providers are utilized in Alaska, including services provided to Native American populations; and *Recommended Standards For Dental Therapy Education Programs in the United States*. Dr. Williard presented the results of a 2010 study funded by the W.K. Kellogg Foundation, the Rasmuson Foundation, and the Bethel Community Service Foundation which confirmed that dental therapists are filling a vital need in Alaska, expanding the services of dentists, and allowing those in remote areas to receive care. She said the evaluation suggests alternative workforce models like dental therapists can be part of the solution as they expand the outreach of the dental team, provide treatment and alleviate pain for vulnerable families and children who have not had regular access to care, and often return to practice in the underserved communities where they grew up. She said in Alaska, dental therapists have been providing preventative and basic dental care in remote tribal villages since 2005. She said applicants to the two-year program must have a high school diploma or general education development (GED) and be sponsored by a tribal health organization that guarantees employment upon graduation. She said after graduation and completion of a 400-hour externship under direct supervision of a dentist, dental therapists are certified to provide a limited scope of dental services under general supervision of a dentist. She said dental therapists' scope of practice includes a specific set of services, including cleanings, fillings, and simple extractions. She said the supervising dentist determines the services each dental therapist can provide while working remotely based on their demonstrated skills and community needs. She said although the training period for dental therapists in Alaska is shorter than Minnesota, the therapists in Alaska have a broader scope of practice and may practice outside of the office of a practicing dentist. She said there are 25 certified dental therapists working in over 80 villages in Alaska to provide care to over 30,000 individuals who previously had limited or no access to dental care. She said because dental therapists allow dentists to do more complex treatments, dentists may feel more rewarded when they can practice to the extent of their licensure. She said because dental therapists are chosen from the communities they will serve, they are culturally more accepted. She said a 2010 study found that 95 percent of patients were satisfied or very satisfied with care received from dental therapists. She said the value of a dental therapist is not in replicating what a dentist does, but rather to provide limited services with an education and prevention program in the community. She cautioned against making dental therapy education requirements too onerous. She said additional time and cost could act as a barrier to minority students considering dental therapy careers.

In response to a question from Senator Mathern, Dr. Williard said there was initially opposition to the dental therapy program; however, because the program is within the federal tribal health system, an Alaska Attorney General opinion determined the tribal program was not subject to state regulations related to dental practice. She said while opposition has diminished, dental therapists are not used in nontribal programs in the state. She said expanded services and positive outcomes, with no impact on dental practices, have led to acceptance, and she anticipates regulatory changes will eventually allow for dental therapists in practices outside of tribal programs.

In response to a question from Senator Lee, Dr. Williard said dental therapists only provide care within the tribal health system. She said they may treat nonnative patients only if there is no access to a dental service provider and there is a compact agreement with the Indian Health Service (IHS) to treat nonnative patients.

In response to a question from Representative Holman, Dr. Williard said after formal training, dental therapists work with a supervising dentist for a minimum of 400 hours or three months, whichever is longer. She said the supervising dentist decides when the externship is complete and the therapist is prepared to be certified. She said once certified, dental therapists can work under general supervision, meaning they need not be in the same facility as the dentist. She said dental therapists are recertified every two years which allows the supervising dentist to work with the therapists to improve their skills. She said the dental therapists must work under the direct supervision of a supervising dentist for at least 80 hours to be recertified.

In response to a question from Representative M. Nelson, Dr. Williard said the Alaska State Dental Practice Act was changed to expand the scope of practice for dental hygienists. She said changes allow dental hygienists to work under collaborative practice agreements with dentists in public health settings and nursing homes. She said hygienists may also now perform restorative procedures after the dentist prepares the tooth. She said she is not aware of a dental hygienist who has successfully arranged for a practice under the expanded scope.

In response to a question from Representative J. Nelson, Dr. Williard said the educational program in Alaska does not exist within a dental school but contracts with the University of Washington for curriculum development and other assistance.

In response to a question from Senator Lee, Dr. Williard said three cohorts of students were trained in New Zealand prior to partnering with the University of Washington.

At the request of Chairman Lee, Ms. Peggy Metzger, Chief Executive Officer, People's Center Health Services, Minnesota, provided information ([Appendix D](#)) regarding the role of midlevel dental service providers at FQHCs. She said the People's Center Health Services (clinic) is a FQHC and operates under rules set forth by the Health Resources and Services Administration (HRSA). She said HRSA requires FQHCs provide access to oral health services through partnerships, affiliations, or through direct services. She said the clinic purchased an established dental practice in October 2010 that was fully equipped, staffed, and had a patient base that included Medicaid patients. She said in 2012 a shortage of dentists prompted the dental practice to hire a dental therapist who in the first year saw over 1,000 patients, of which 64 percent were Medicaid patients. She said the dental therapist generated net patient revenue sufficient to cover the cost of her salary, including benefits, operations, and overhead. She said the dental therapist is able to perform routine procedures, allowing the dentist to spend time on more complex procedures. She said a second dental therapist was added in 2013.

In response to a question from Representative J. Nelson, Ms. Metzger said the FQHC model is an option for rural areas, especially where a dentist may be selling the practice.

In response to a question from Representative Fehr, Ms. Metzger said FQHCs must apply for federal malpractice coverage each year, which must be updated when a new scope of service is added. She said in Minnesota, dental therapists are licensed and required to participate in continuing education to retain licensure. She said dental therapists may also test for an advanced dental therapist license. She said claims for services are approved by the dentist and filed with the appropriate payer under the dentist's name. She said clinic is reimbursed through the state's third-party payer system.

At the request of Chairman Lee, Ms. Julie Stitzel, Manager, the Pew Center on the States Children's Dental Campaign, The Pew Charitable Trusts, provided information ([Appendix E](#)) regarding national and state workforce data related to access to oral health services. Ms. Stitzel said according to the American Dental Association's Health Policy Resources Center, the number of dental emergency room visits in the United States increased from 1.1 million in 2000 to 2.1 million in 2010. She said emergency room visits for preventable dental conditions are a burden on state budgets. In addition, most emergency rooms do not have a dentist, resulting in the patient leaving with prescriptions to treat symptoms but not the underlying dental problem. She said North Dakota has had successes in community water fluoridation, providing sealants to low-income children, and providing adult dental benefits to the Medicaid-insured. She said problems still exist with respect to access to care, especially for Medicaid-eligible children; rural residents; low-income adults; the elderly, especially those in nursing homes; and Native Americans. She said a 2012 study revealed rural counties with high numbers of Medicaid-eligible children that do not have a dentist to serve their oral health needs. She said although there is a surplus of licensed dental hygienists in the state, the oral health workforce is concentrated in the major cities. She said in 2011 the Institute of Medicine recommended states amend their dental practice Acts to use dental auxiliaries to the full extent of their training and that state deploy additional types of dental service providers, such as dental therapists, to address the growing access problem. She said Minnesota and Alaska have implemented this strategy, and California is considering expanding the scope of practice for dental assistants and dental hygienists while using technology to connect them with a supervising dentist. She said midlevel providers allow dentists to serve more Medicaid patients while increasing profits.

In response to a question from Representative J. Nelson, Ms. Stitzel said the Pew Center does not endorse a model but rather supports states' recommendations and provides technical assistance to help translate recommendations into policy. She said the Pew Center does not pay for services but provides access to other states' and national information.

In response to a question from Senator Mathern, Ms. Stitzel said a Minnesota clinic serves schools at approximately 20 locations. She said advanced dental therapists go directly to the schools to provide the services.

Mr. Scott J. Davis, Executive Director, Indian Affairs Commission, provided information ([Appendix F](#)) regarding dental service systems on Indian reservations. He said a complex and lengthy federal credentialing process makes it difficult to recruit dentists within the IHS system. He said access to dentists and dental services on the reservations has been limited for decades as dentists come and go on the reservations making it difficult to create a

patient-dentist relationship. He said in 2012 stakeholders organized the first Dakota Oral Care Workshop in Bismarck to discuss oral health issues on reservations and create pathways to improve oral health on reservations. He included a copy of the Dakota Oral Care Workshop Final Report in his testimony.

In response to a question from Senator Lee, Mr. Davis said he is exploring whether the federal government would honor a compact between the state and the tribe to allow a dental professional licensed by the state to provide services on the reservation. He said he is also exploring the possibility of a waiver available through the United States Department of Health and Human Services that would allow licensed professionals to serve on the reservation.

In response to a question from Senator Mathern, Mr. Davis said the goal is to bring dental services to the reservation. He said transportation is a barrier to accessing dental services outside of the reservation. He said expanding service hours has helped to bring dentists from out of state who serve for a week at a time and then return home.

In response to a question from Senator Anderson, Mr. Davis said a consortium, such as Alaska's, might work on North Dakota's reservations.

In response to a question from Representative J. Nelson, Mr. Davis said he supports the model proposed by the North Dakota Dental Association and has been working with the association to remove barriers so dentists wanting to work on the reservation are able to do so.

Dr. Murray Greer, President, North Dakota Dental Association, provided information ([Appendix G](#)) regarding the distribution of dentists in the state and the appropriate number of dentists in a population. He said the state does not have a shortage of dentists but rather a misdistribution of dentists around the state. He said the ratio of dentists to population in the state is approximately one dentist per 1,750 residents. He said this ratio compares favorably with South Dakota (1:1,890) and Iowa (1:1,825) but not with Minnesota (1:1,630). He said nationally the ratio is one dentist per 1,612 residents. He said the growing economy has brought more dentists to the state to practice and the number of licenses issued by the State Board of Dental Examiners has steadily increased. He provided a map ([Appendix H](#)) identifying the location of dental offices throughout the state. He said the map does not include the number of dentists and said some dentists operate satellite clinics to bring dental services closer to patients. He said, with few exceptions, the delivery of dental care is available to nearly all North Dakota residents within 25 miles or less of their home. He said the dental loan repayment programs that help place dentists in rural areas of the state and encourage dentists to work in safety net clinics have been successful. He said continuing to fund these programs and expanding safety net clinics will continue to improve access to dental care. He said to improve access to the Medicaid population, provider reimbursement must improve. He said Medicaid fees for dental services are approximately 61.6 percent of commercial fees in North Dakota. In addition, he said, a community dental health coordinator could assist Medicaid patients to access services. He said expanding the duties of dental assistants and hygienists to improve the efficiency of dentists is being considered by the State Board of Dental Examiners. In addition to his testimony, he provided information regarding the number of dentists and population by county in the state, including those counties without a dentist, the age distribution of professionally active dentists nationally and in the state, and the percentage of dentists indicating they have the capacity to serve more patients.

In response to a question from Senator Lee, Dr. Greer said a model being explored by the North Dakota Dental Association would include an expanded function dental hygienist or assistant that would act as a community dental health coordinator to assist with education and prevention of dental disease. He said the coordinator would be another member of the dental team and employed by a dentist or a clinic.

In response to a question from Representative Hofstad, Dr. Greer said an expanded function dental hygienist or assistant could complete some tasks, freeing the dentist to complete more complex procedures and making the dental practice more efficient.

In response to a question from Representative Holman, Dr. Greer said the State Board of Dental Examiners is currently reviewing the additional training necessary to allow hygienists and assistants to expand their scope of practice.

In response to a question from Senator Anderson, Dr. Greer said the State Board of Dental Examiners is exploring appropriate supervision guidelines for expanded function hygienists and assistants.

Senator Lee said the University of North Dakota School of Medicine and Health Sciences has prepared a report regarding the health care workforce in the state entitled *2010 Snapshot of North Dakota's Health Care Workforce*. She suggested the committee receive information regarding a review of dental service providers in the state contained in the report.

Dr. Brent Holman, Pediatric Dentist, Fargo, provided information ([Appendix I](#)) regarding dental access in North Dakota. He suggested the committee consider the differences between Alaska and North Dakota when reviewing the midlevel provider model in Alaska. He said based on a July 2013 Kaiser Family Foundation study, North Dakota needs only seven dentists to remove a health professional shortage area designation, and the rate of increase in the number of new dentists licensed in the state is among the highest in the nation. He said in August 2012 a National Center for Health Statistics Data Brief reported that 14.2 percent of children nationally had untreated caries, while 3.1 percent of parents reported an inability to get care for their children. He said lack of access to care may not be the reason some patients do not access care. He said the use of expanded function dental assistants has been thoroughly evaluated and is accepted practice in over 20 states and federal programs. He said developing practice models similar to the expanded function dental assistant model could address workforce needs in a more efficient and cost-effective manner using resources unique to North Dakota. He said Medicaid reform and case management could also increase the number of Medicaid patients dentists are willing to serve. In addition, he said, increasing Medicaid reimbursement to the 75th percentile would have a positive effect on the number of dentists willing to accept Medicaid patients.

Dr. Robert Lauff, Dentist, Mayville, State Board of Dental Examiners, said his practice includes a large number of Medicaid patients, and his No. 1 concern is reimbursement. He said satellite clinics are not always profitable because many of the individuals living in rural locations choose to travel for health care, shopping, and other purposes, including dental care, leaving few residents served by the rural satellite clinic. He said the dental therapist program at the University of Minnesota is not a nationally accredited program, and the board supports an expanded function dental assistant and dental hygienist program rather than the dental therapist midlevel provider program. He said the board has been exploring expanded function hygienists and assistants and believes they can help alleviate some of the access issues.

Senator Lee suggested the State Board of Dental Examiners continue to update the committee on its actions relating to expanded function dental assistants and dental hygienists.

Ms. Patricia Patron, CEO, Family HealthCare, Fargo, said the clinic has grown from two dental chairs to seven dental chairs and has benefited from the loan repayment programs. She said dentists remain with the clinic for an average of three years.

Senator Lee suggested the committee receive information regarding whether the dental loan repayment programs are meeting the needs of the state.

Ms. Marsha Krumm, Immediate Past President, North Dakota Dental Assistants Association, submitted written testimony ([Appendix J](#)) regarding expanded function dental auxiliaries. She said 18 states allow expanded function dental auxiliaries to perform restorative functions. She said benefits of an expanded function dental auxiliary program include:

- Expanded function dental auxiliary programs have been successful in other states;
- Existing curriculum and assessment tools would result in a shorter and more cost-effective implementation; and
- Supervision of the expanded function dental auxiliaries would mean less risk to patients.

Ms. Kim Mertz, Director, Family Health Division, State Department of Health, provided information ([Appendix K](#)) regarding dental programs available through State Department of Health programs and oral health needs assessment documents prepared by the department as part of the federal grant process and the status of Centers for Disease Control and Prevention (CDC) grant funding related to oral health. She said programs supported by

the department include a donated dental services program, Smiles for Life fluoride varnish program, a school-based fluoride varnish and sealant program, and a mobile dental care program.

Ms. Mertz said the donated dental services program is supported by a \$50,000 general fund appropriation for the 2013-15 biennium. She said the program provides dental care, through a network of 141 volunteer dentists and 29 dental laboratories, to disabled, elderly, or medically compromised individuals who cannot afford treatment. She said 671 individuals have received over \$2 million in donated dental therapies since the program's inception in 2000.

Ms. Mertz said since legislation was approved in 2007 allowing medical providers to apply fluoride varnish upon the completion of an approved curriculum, local public health units, clinics, and Head Start programs have been applying fluoride varnish to children's teeth. She said legislation was approved in 2009 authorizing general supervision of licensed dental hygienists for procedures authorized in advance by a dentist. She said in 2011 four public health hygienists employed by the department and funded through an HRSA grant began applying fluoride varnish and dental sealants to children in prekindergarten through sixth grade and in some schools grades 7 through 12. She said since 2011, the program has served approximately 1,700 students per year. However, she said, loss of the HRSA grant has resulted in a significant reduction in the number of students served. She said, as a result of the loss of the federal grant, the department has also discontinued certain collaborative projects, including some support of the Ronald McDonald Care Mobile and Bridging the Dental Gap. She said the department has been awarded a five-year CDC State Oral Disease Prevention Program grant, but the annual funding is less than previous CDC funding levels. She said due to the reduced funding, the department has modified staff roles and responsibilities and made reductions in prevention efforts, oral health epidemiology, and administrative assistant support. She included in her testimony copies of the needs assessments required for both the HRSA and CDC grants. She also provided a copy of the State Department of Health publication [Oral Health in North Dakota - Burden of Disease and Plan for the Future 2012-2017](#) (on file in the Legislative Council office).

In response to a question from Representative Holman, Ms. Mertz said a focus of the DentaQuest Foundation grant is medical and dental care collaboration.

In response to a question from Representative M. Nelson, Ms. Mertz said Medicaid reimburses for fluoride varnish at the local public health units, and the department is working with third-party payers to provide reimbursement for fluoride varnish provided at schools.

In response to a question from Representative M. Nelson, Ms. Jodi Hulm, Children's Health Insurance Program and Health Tracks Administrator, Medical Services Division, Department of Human Services, said as a result of the Medicaid expansion effective January 1, 2014, 19-year-old and 20-year-old individuals will begin receiving the pediatric dental benefit. She said sealants are a covered service under Medicaid.

Senator Lee suggested the committee receive additional information regarding billing, reimbursement, and liability insurance for dental therapists and expanded function dental assistants and dental hygienists.

Senator Mathern suggested the committee receive information regarding the expanded function dental assistant and dental hygienist language under consideration by the State Board of Dental Examiners.

Senator Mathern suggested the committee receive information from a representative of IHS regarding dental services on reservations.

Representative Holman suggested the committee receive information from the State Department of Health regarding which gaps on the map distributed by the North Dakota Dental Association might be filled with services provided by other medical service providers.

Representative J. Nelson suggested the committee receive information regarding how local public health units can support the provision of dental services.

Representative M. Nelson suggested the committee receive information from the North Dakota State College of Science regarding an overview of its dental program and potential for expansion.

COMPREHENSIVE STATEWIDE TOBACCO PREVENTION AND CONTROL STUDY

At the request of Chairman Lee, Ms. Krista Fremming, Director, Tobacco Prevention and Control Program, State Department of Health, provided information ([Appendix L](#)) regarding recent tobacco prevention and control newspaper campaigns; trends in smokeless tobacco, electronic cigarettes, and other smoking alternatives; a breakdown of 2013-15 biennium funding by focus areas outlined in the CDC's *Best Practices for Comprehensive Tobacco Control Programs*; cessation programs; and how the comprehensive statewide tobacco prevention and control programs provided by the State Department of Health address tobacco use by the Native American population on the Indian reservations. She said the department provides funding for several cessation programs, including NDQuits, NDPERS Tobacco Cessation Program, City-County Employee Cessation Program, and the Baby & Me - Tobacco Free Program. She said fewer individuals watch television in the summer, so the department spent \$467,607 on a newspaper and billboard campaign from mid-June through July 2013 to boost enrollments in the department's cessation programs, which are traditionally the lowest during the summer. She said enrollment in the NDQuits program increased 47 percent from June 2013 to July 2013. She said cessation programs served 3,521 individuals during fiscal year 2013 at a total cost of \$1,543,614. She said data from fiscal year 2013 indicates 31.2 percent of participants in the NDQuits program were abstinent from tobacco for 30 days or more at the time of the followup survey seven months after enrollment.

Ms. Fremming said based on the Behavioral Risk Factor Surveillance Survey (BRFSS), adult smokeless tobacco use changed little from 2011 (7.2 percent) to 2012 (7.3 percent). She said although--based on a North Dakota Youth Risk Behavior Survey--overall youth tobacco use in the state has decreased, the use of smokeless tobacco and e-cigarettes appears to have risen.

Ms. Fremming said the department provides funding and technical assistance to each tribe to implement tobacco prevention and control initiatives on each of the reservations. She said each reservation has a tribal tobacco prevention coordinator who is an enrolled member of the tribe. She said the primary objectives of tribal tobacco prevention and control programs are to:

- Evaluate readiness and implement tobacco taxes on reservations.
- Implement tobacco-free policies in public buildings, on school campuses, and in tribal housing.
- Engage health care personnel and tribal health stakeholders to manage chronic diseases adversely affected by tobacco use.
- Collaborate with the Northern Plains Tribal Tobacco Technical Assistance Center to educate community health representatives using culturally specific materials on motivational interviewing to assess tobacco use with their clients.
- Educate youth and the public on the dangers of commercial tobacco use.
- Educate reservation citizens on the dangers of secondhand smoke.
- Actively participate in the Intertribal Tobacco Abuse Coalition to coordinate statewide efforts to provide more effective tobacco prevention services and develop appropriate resources.
- Actively partner with tribal tobacco prevention coordinators funded by the Department of Human Services to more effectively deliver prevention services.

Ms. Fremming provided the following detail of the department's \$5,544,251 budget for tobacco prevention and control programs:

- State and community interventions - \$942,522.
- Health communications - \$0.
- Cessation - \$3,880,976.
- Surveillance and evaluation - \$388,098.
- Administration and management - \$332,655.

In response to a question from Senator Mathern, Ms. Fremming said the department provides grants to local public health units and partners with medical providers and insurers to promote cessation programs. She said the North Dakota Center for Tobacco Prevention and Control Policy provides funding for tobacco prevention and control employees at the local public health units.

In response to a question from Representative J. Nelson, Ms. Karalee Harper, Director, Chronic Disease Division, State Department of Health, said the State Department of Health has been providing tobacco prevention and control grants to tribes since 2002. She said the tribes are required to report outcomes.

Ms. Fremming said tribal tobacco prevention coordinators are compiling a list of accomplishments on the reservations. Senator Lee suggested the department provide the information regarding tobacco prevention and control outcomes on the reservations at a future meeting.

Ms. Jeanne Prom, Executive Director, North Dakota Center for Tobacco Prevention and Control Policy, provided information ([Appendix M](#)) regarding the number of tobacco users and tobacco prevention and control spending in the state; demographics and changes in the number of adult tobacco users statewide; and how the comprehensive statewide tobacco prevention and control programs provided by the Tobacco Prevention and Control Executive Committee address tobacco use by the Native American population on the Indian reservations. She said an independent review of the center's comprehensive tobacco prevention and control plan is required each biennium to ensure the plan is consistent with the CDC's *Best Practices for Comprehensive Tobacco Control Programs*. She said the results of the review are to be reported to the Governor and the State Health Officer on or before September 1 of each odd-numbered year. She said a copy of the report is available on the center's website. She said based on 142,795 estimated tobacco users in the state and average annual expenditures of \$8.6 million during the 2011-13 biennium, tobacco prevention and control expenditures averaged \$60.38 per tobacco user in the state. She said based on average annual tobacco prevention and control expenditures budgeted for the 2013-15 biennium of \$10.7 million and an estimated 192,105 tobacco users in the state, tobacco prevention and control expenditures are anticipated to total \$55.59 per tobacco user in the state during the 2013-15 biennium. She said expenditures during the 2013-15 biennium are estimated to total \$14.57 per capita statewide, \$2.43 less than the CDC recommendation, adjusted for estimated inflation, of \$17 per capita. She said the tobacco industry is estimated to have spent \$40 per capita for marketing in the state during the 2009-11 biennium.

Ms. Prom provided information regarding annual health care costs directly caused by smoking and annual smoking-related productivity losses in the state. She said annual health care costs directly related to smoking in the state total \$247 million, of which \$47 million is paid through Medicaid. She said annual productivity losses in the state related to smoking total \$192 million.

Ms. Prom provided information regarding tobacco use in the state by race. She said tobacco use among adults in the state was 27.1 percent in 2011 and 26.2 percent in 2012. She said tobacco use among white adults in the state was 25.3 percent in 2011 and 24.5 percent in 2012, while tobacco use among American Indians was 59.7 percent in 2011 and 56.1 percent in 2012. She said while American Indians comprised 5.2 percent of the state's adult population in 2012, they represented 11.2 percent of the state's adult tobacco users.

Ms. Barbara Andrist, Community Programs Manager, North Dakota Center for Tobacco Prevention and Control Policy, submitted testimony ([Appendix N](#)) on behalf of Ms. Javayne Oyloe, Executive Officer, Upper Missouri District Health Unit. She said in 2009 the State Department of Health distributed the CDC grant funds to the local public health units, and the center provided funding from the tobacco prevention and control trust fund. She said in 2011 the department discontinued CDC funding for the local public health units but continued to provide CDC funding to the tribes for tobacco prevention. She said the center has provided additional funding to offset the reduction in funding from the department. She said the health unit received \$225,000 from the center for fiscal year 2014.

Ms. Andrist also submitted testimony ([Appendix O](#)) on behalf of Ms. Barbara Frydenlund, Administrator/Director of Nursing, Rolette County Public Health District. She said 75 percent of the population of Rolette County is American Indian. She said the Rolette County Public Health District has not been invited to participate in State Department of Health-coordinated tobacco prevention meetings, and the collaboration that exists is organized at the local level. She provided examples of collaboration between the Rolette County Public Health District and the Turtle Mountain Tobacco Prevention Program. She said there is a need for increased collaboration between programs of the State Department of Health and the center.

Senator Lee suggested the committee receive information from local public health units serving reservations regarding tobacco prevention and control activity on the reservations and efforts to collaborate with tribal programs, the State Department of Health, and the center.

COMMUNITY PARAMEDIC STUDY

At the request of Chairman Lee, Mr. Tim Wiedrich, Section Chief, Emergency Preparedness and Response Section, State Department of Health, provided information ([Appendix P](#)) regarding community paramedic programs operating in other states, including the benefits and challenges experienced by states implementing community paramedic programs and the status of the community paramedic and community health care worker pilot program. Mr. Wiedrich said using community paramedics to deliver basic primary care appears to offer opportunities to reduce emergency room visits and improve health outcomes for underserved patients. He said rural and urban models are emerging. He said a pilot program in Fort Worth, Texas, resulted in a 58 percent decrease in ambulance calls and emergency room visits for enrolled patients and an estimated \$10 million in savings on health care expenditures. He said challenges include sustainable funding streams, defining scope of education, and providing oversight. He said the Minnesota Legislature established funding sources for its program through Medicaid. He said the state received final CMS approval to make community paramedic programs eligible for fee reimbursement in February 2012. He said covered services include health assessments, immunizations, chronic disease monitoring and education, collection of laboratory specimens, medication compliance checks, hospital discharge followup care, and minor medical procedures approved by a medical director. He said CMS recently provided \$9 million in grants to study the health care savings generated by implementing community paramedic programs.

Mr. Wiedrich said the North Dakota Emergency Medical Services Advisory Committee formed a Community Paramedic Subcommittee. He said the subcommittee and staff from the Division of Emergency Medical Services and Trauma are reviewing available draft curricula to identify possible enhancements. He said the first community paramedic training program is tentatively planned for July 2014. He said staff has identified training issues to be resolved, and success will depend on the support and participation of ambulance services with higher volumes and active primary care providers. He said staff is also developing evaluation metrics to assist in the evaluation of the success of the pilot project and the program.

In response to a question from Senator Lee, Mr. Wiedrich said the administrative rule process allows for the establishment of standards for certification and licensure. He said administrative rules exist for all types of emergency medical service providers in the system as it currently exists. He said if implemented, the community paramedic program would be incorporated into the rules.

In response to a question from Senator Lee, Mr. Wiedrich said community paramedics would not be independent agents providing services in the community but rather part of a team of primary care providers in the community.

In response to a question from Senator Anderson, Mr. Wiedrich said the department is encouraged by CMS approval of the Minnesota legislation, but to be successful, the program will need third-party payer reimbursement as well.

Mr. Sherm Syverson, Executive Director, F-M Ambulance Service, appeared in support of the community paramedic initiative and to provide information ([Appendix Q](#)) regarding frequent use of emergency medical services by a relatively small number of individuals. He said from January through October 2013, 10 individuals accounted for 293 emergency medical service calls and transports to emergency rooms, accounting for a combined billing total of nearly \$200,000. He said health issues resulting in these emergency medical service calls and transports include mental health-related issues (50 percent), diabetes complications (20 percent), seizures (20 percent), and substance abuse (10 percent). He said in addition to ambulance services, high-frequency users of emergency medical services also burden state and local law enforcement, fire departments, behavioral health professionals, and emergency departments. He said issues to be addressed by the community paramedic study include scope of practice, duplication of services, and reimbursement.

In response to a question from Senator Anderson, Mr. Syverson said the current reimbursement model encourages transport because it is the only way the ambulance service is able to bill. He said many of the frequent callers do not qualify for home health care; but if a community paramedic could visit on a regular basis, some calls could be avoided.

In response to a question from Senator Mathern, Mr. Syverson said as the community paramedic becomes familiar with the patient, the community paramedic can refer the patient to appropriate services.

Senator Lee suggested the committee continue to receive information from State Department of Health regarding the proposed certification and licensure of community paramedics, including services to be provided by the community paramedics.

Senator Lee suggested the committee receive information regarding the community paramedic program in Colorado.

AUTOPSY FUNDING STUDY

At the request of Chairman Lee, the Legislative Council staff presented a memorandum entitled [Autopsy Funding Study - Background Memorandum](#) relating to the committee's study of the funding provided by the state for autopsies and state and county responsibilities for the cost of autopsies, including the feasibility and desirability of counties sharing in the cost of autopsies performed by the State Department of Health and the School of Medicine.

The Legislative Council staff said the 1995 Legislative Assembly created a new section to North Dakota Century Code Chapter 23-01 allowing the State Department of Health to perform autopsies and to employ a State Forensic Examiner to conduct investigations into cause of death. Chapter 11-19.1 requires, under most circumstances, each organized county to have a county coroner. The coroner, the coroner's medical deputy, the sheriff, or the state's attorney may direct an autopsy be performed. Section 11-19.1-11 provides the State Forensic Examiner or the State Forensic Examiner's authorized pathologist must perform the autopsy at a facility approved by the State Forensic Examiner. Except for the cost of an autopsy, investigation, or inquiry that results from the death of a patient or resident of the State Hospital or any other state residential facility or an inmate of a state penal institution and for the cost of an autopsy performed by the State Forensic Examiner or the State Forensic Examiner's designee, all costs with respect to the autopsy, the transporting of the body, and the costs of the investigation or inquiry are the responsibility of the county.

The Legislative Council staff said information provided as part of the State Department of Health budget request for the 2013-15 biennium indicates that since 2004 the number of autopsies performed by the State Forensic Examiner has increased 64.8 percent--from 196 autopsies to 323 autopsies per year. In addition, the number of consultations increased 48 percent--from 83 consultations in 2010 to 123 consultations in 2011. The department noted accreditation standards indicate one forensic examiner should perform 225 autopsies to 250 autopsies per year. The number of forensic autopsies performed by the department exceeded the number of autopsies recommended by the National Association of Medical Examiners in 2011. The department's 2013-15 budget request to the Governor proposed two options for addressing the increase in the number of autopsies performed by the State Forensic Examiner. One option was to contract with the School of Medicine to conduct medical examiner services for counties in the eastern part of North Dakota at an estimated cost of \$640,000, and the other option was to add a pathologist (one full-time equivalent (FTE) position) and support services to the State Forensic Examiner's office at the department, including two autopsy assistants and laboratory testing at an estimated cost of \$624,145.

The Legislative Council staff said the executive budget recommendation for the State Department of Health in Senate Bill No. 2004 provided \$640,000 from the general fund for professional services to contract with the School of Medicine to perform autopsies in the eastern part of the state. The Legislative Assembly reduced the funding to provide a total of \$480,000 of one-time funding from the general fund and added a section to the bill to provide for a study of autopsy funding and state and county responsibilities for the cost of autopsies. In addition, the Legislative Assembly provided \$1,360,585 to continue funding for existing forensic examiner staff (three FTE positions) for a total of \$1,840,585 from the general fund for autopsy services during the 2013-15 biennium.

The Legislative Council staff presented the following proposed study plan for the committee's consideration:

1. Gather and review information regarding the regions in which autopsies are originating, the demographics of those autopsied, regional gaps in autopsy services, the cost of an autopsy, and state and local funding provided for autopsy services during the 2013-15 biennium.

2. Gather and review information regarding state and county responsibilities for the cost of autopsies and the impact on counties and autopsy services of changes in the responsibility for the cost of autopsies, including the feasibility and desirability of counties sharing in the cost of autopsies.
3. Gather and review information regarding the School of Medicine's willingness to perform autopsies in the eastern part of the state and advantages to contracting with the School of Medicine for autopsy services.
4. Develop committee recommendations and prepare any legislation necessary to implement the committee recommendations.
5. Prepare a final report for submission to the Legislative Management.

Senator Mathern said autopsy funding is just one of several state and county funding issues considered by the Legislative Assembly. He suggested the study include a review of state and county funding responsibilities and the committee receive regular updates regarding changes to state and county funding responsibilities under consideration by other interim committees.

Mr. Kirby Kruger, Section Chief, Medical Services Section, State Department of Health, provided information ([Appendix R](#)) regarding the regions in which autopsies are originating, the demographics of those autopsied, regional gaps in autopsy services, the cost of an autopsy, and state and county responsibilities for the cost. He said the number of forensic autopsies performed in North Dakota has been steadily increasing. He said a total of 240 forensic autopsies were performed in North Dakota in 2004, and in 2012, 434 autopsies were performed--an 80.8 percent increase over nine years. He said of the \$480,000 provided from the general fund to the State Department of Health, \$459,000 has been obligated to the Department of Pathology at the School of Medicine to conduct autopsies in eastern North Dakota. He said during fiscal year 2014, the School of Medicine will perform autopsies for 13 eastern counties, and during fiscal year 2015, an additional 8 counties will send bodies to the School of Medicine for autopsies.

Mr. Kruger provided information regarding the number of autopsies performed by county in each emergency preparedness region of the state from 2004 through 2012. He said in 2012 the most autopsies were performed in the west central region (83 autopsies), including 55 autopsies in Burleigh County. He said among counties, Cass County performed the most with 58 autopsies. He said the fewest autopsies were performed in the southwest region (20 autopsies). He said while more forensic autopsies are performed on older adults aged 30 to 59, the number of autopsies among adults aged 20 to 29 has been increasing in the past two years.

Mr. Kruger said during the 2011-13 biennium, 764 autopsies were performed by the State Department of Health. He said actual expenditures for the 2011-13 biennium were \$1,395,243, and the cost per autopsy for the biennium was \$1,826. He said when excluding fixed costs related to the building bond payment, the cost decreases to \$1,605 per autopsy. He said as required in Section 11-19.1-18, counties are responsible for the cost of transporting the body to the morgue in Bismarck and other costs associated with the investigation or inquiry into the death, but the state pays all of the costs to conduct the autopsy, which consists of staff, medical supplies, and laboratory testing.

Dr. Mary Ann Sens, Chair, Department of Pathology, University of North Dakota School of Medicine and Health Sciences, provided information ([Appendix S](#)) regarding the impact of medicolegal death investigation (MLDI), national perspective and population-based standards, structure and expenses of the Grand Forks facility, and potential general models for consideration. She said medicolegal death investigation provides a service to families and benefits law enforcement and public health. She said although the role of forensic death investigation is often associated with criminal justice, a greater role is played in public and population health. She said the sharing of knowledge and education benefits practitioners, clients, regulators, and future generations. She said certification and accreditation are fundamental to the public health system. She suggested those who provide death investigation and forensic pathology services be certified. She said there are currently no accredited facilities for forensic autopsies in the state. She said the School of Medicine is endeavoring to become accredited.

Dr. Sens provided information regarding the national metrics for services. She said if judicial and public health missions of the medicolegal death investigation system are met in a manner which accomplishes full accreditation of the system, the metric of number of autopsies needed per population base is constant at one autopsy per 1,000 of population. She said the metric for personnel is 38 staff, including six forensic pathologists, per 1,000 autopsies or one million in population. She said cost differences in state- and county-based systems are negligible, and both

systems are experiencing baseline medicolegal death investigation system costs of \$3.75 to \$4.00 per capita annually.

Dr. Sens said the forensic pathology program at the School of Medicine began as an effort to maintain clinical skills and share conical experiences with students. She said it became clear there was an unmet need for autopsy and forensic services in the region. She said the forensic pathology program at the School of Medicine allowed for the transition and recruitment of a new State Forensic Examiner when the State Forensic Examiner resigned in fiscal year 2007.

Dr. Sens provided information regarding a pure state model versus a pure county model of death investigation and forensic pathology. She said North Dakota is currently a hybrid of the two with some responsibilities at the county level and others at the state level. She said in a pure state model, all responsibility for the entire system falls to the state. She said this model is generally used in geographically small states, such as New England states, although some larger states--Maryland and New Mexico--operate under this model. She said there is generally a single, centrally located office, and all personnel involved in death investigation are from the state office. She provided the following advantages and disadvantages of the pure state model:

Advantages:

- Specialization of services, more physicians, more staff, more specialized equipment possible such as CT scanners, MRIs, neuropathologists, pediatric pathologists, etc.
- Counties do not provide services or financial support.
- Generally most economical for small geographic states.
- Clear delineation and required independence from judicial and law enforcement branches.

Disadvantages:

- Border and geographic issues.
- Reduced county and local accountability.
- Tends not to follow medical referral lines, difficulties with records, trauma reporting, etc.
- May have significant transportation expenses and access issues.
- May not be responsive to local issues and needs.

Dr. Sens said in the pure county model, the state pays nothing for forensic and death investigation services. She said most states have some performance standards but with variable means to enforce them. She said this model is effective for populous counties, ideally the population must exceed one million people. She provided the following advantages and disadvantages of the pure county model:

Advantages:

- Most responsive to local constituents (family, law enforcement, hospitals, trauma committees, etc.).
- Flexible model with staffing and cases.
- Follows natural medical referral lines already in existence.

Disadvantages:

- Fragmentation within an area and a state possible. Significant differences in services and quality within a state.
- Often large discrepancies in services and investigations across county lines.
- Limited coordination of public health and other data to the state.
- Generally more difficult to ensure quality assurance and control initiatives.
- May not have independence from law enforcement or judicial systems.
- Not possible for small and rural counties.

Dr. Sens said the plan for medicolegal death investigation services in the state should be responsive to needs of primary and secondary stakeholders. She suggested the committee consider the following:

- Assess current and optimal provision of medicolegal death investigation services in the state, including death investigation, autopsy performance, and death certification;
- Identify current and unmet needs, obstacles, and practices within the medicolegal death investigation system in North Dakota;
- Identify costs associated with medicolegal death investigation and construct framework for state, county, and health systems and family responsibilities in financing;
- Assess other models and systems for medicolegal death investigation, including advantages and disadvantages of each, relative to the needs of North Dakota;
- Identify any necessary statutory changes for the implementation or improvement of medicolegal death investigation in North Dakota and draft appropriate legislation and appropriation requests with emphasis on accountability, cost-effective use of resources, equity, transparency, and sustainability; and
- Identify funding and resources for delivery and establish statewide standards and expectations for achieving national standards for death investigation.

In response to a question from Senator Mathern, Dr. Sens said anytime the number of autopsies falls below one autopsy per 1,000 of population, there is a risk that drug deaths, homicides, and undiagnosed diseases may not be detected. She said there are situations where autopsies are not done due to cost or transportation issues.

Senator Lee suggested the study plan include the suggestions of Dr. Sens.

Senator Mathern suggested the study plan consider information regarding other state and county funding responsibilities.

Senator Anderson suggested the committee receive information from the North Dakota Association of Counties regarding autopsy costs incurred by the counties, including the cost of transportation.

It was moved by Senator Mathern, seconded by Senator Erbele, and carried on a voice vote that the committee proceed with this study as follows:

1. **Gather and review information regarding the regions in which autopsies are originating, the demographics of those autopsied, regional gaps in autopsy services, the cost of an autopsy, and state and local funding provided for autopsy services during the 2013-15 biennium.**
2. **Assess current and optimal provision of medicolegal death investigation services in the state, including death investigation, autopsy performance, and death certification.**
3. **Identify current and unmet needs, obstacles, and practices within the medicolegal death investigation system in North Dakota.**
4. **Assess other models and systems for medicolegal death investigation, including advantages and disadvantages of each, relative to the needs of North Dakota.**
5. **Gather and review information regarding state, county, and family responsibilities for the cost of autopsies, including transportation, and the impact on counties and autopsy services of changes in the responsibility for the cost of autopsies, including the feasibility and desirability of counties sharing in the cost of autopsies.**
6. **Review state and county funding responsibilities and receive regular updates regarding changes to state and county funding responsibilities under consideration by other interim committees.**
7. **Identify funding and resources for delivery and establish statewide standards and expectations for achieving national standards for death investigation.**
8. **Gather and review information regarding the School of Medicine's willingness to perform autopsies in the eastern part of the state and advantages to contracting with the School of Medicine for autopsy services.**

9. **Develop committee recommendations and prepare any legislation necessary to implement the committee recommendations.**
10. **Prepare a final report for submission to the Legislative Management.**

OTHER COMMITTEE RESPONSIBILITIES

At the request of Chairman Lee, the Legislative Council staff presented information ([Appendix T](#)) regarding legislation considered during the 2013 legislative session relating to the repayment of tuition assistance provided through professional student exchange programs (PSEPs) if the participant does not return to the state to practice.

Ms. Nancy Kopp, Executive Director, North Dakota Optometric Association, provided information ([Appendix U](#)) regarding the distribution of optometrists in the state, the appropriate number of optometrists in a population, and whether there is a shortage of optometrists in the state. She said there are 175 practicing optometrists in the state. She said the number of optometrists on the map provided to the committee is duplicative because an optometrist may practice in an urban clinic for three days to four days and then serve in a satellite location another one day to two days. She said 59 percent of the 150 members of the North Dakota Optometric Association are in private practice (100 percent ownership), 24 percent are employed by a hospital or ophthalmology clinic, and 17 percent are practicing independently but lease space and equipment from a corporate entity. She said the appropriate number of optometrists in a population will be affected by the state's aging population and the Affordable Care Act. She said there is currently no shortage of optometrists in the state, but 30 percent of the North Dakota Optometric Association membership is likely to retire in the next 10 years. In addition, she said, due to lack of housing, it has been difficult to recruit optometrists to western counties.

Ms. Laura Glatt, Vice Chancellor for Administrative Affairs, North Dakota University System, provided information ([Appendix V](#)) regarding the direct cost of educating health care professionals in the state, including physicians, pharmacists, and physical and respiratory therapists, and the estimated cost of educating dentists, optometrists, and veterinarians in the state. She said during the 2013-14 school year, the cost of educating a pharmacy student at the College of Pharmacy, North Dakota State University, is \$20,811, of which \$11,262 or 54 percent is provided from the general fund with the remainder provided by tuition and grants. She said the direct cost per student at the School of Medicine for the same year is \$82,796, of which \$56,870 or 69 percent is provided from the general fund. She said general fund support for students enrolled in other health sciences degree programs is approximately 52 percent.

Ms. Glatt said the University System office contacted dental, veterinary, and optometry programs in other states and conducted other research to determine the estimated costs of these programs. She said costs may not be comparable between schools. She said the annual direct cost of the dentistry program at the University of Minnesota is approximately \$70,000. She said the annual cost of the dentistry program at the University of Florida during the 2010-11 school year was approximately \$61,000. She said startup costs for a dental program at Lake Erie College of Dental Medicine were estimated to total \$52 million. She said utilizing existing facilities, the University of Arizona estimated a cost of \$42 million to start a school of veterinary medicine, and Midwestern University in Arizona estimated \$120 million for facilities and startup costs to begin a veterinary medicine program. She said Midwestern University of Optometry estimated \$40 million to \$50 million to start an optometry program, with annual operating costs of approximately \$5 million. She said annual operating costs at the College of Optometry, University of Houston, are approximately \$16 million.

Ms. Brenda Zastoupil, Director of Financial Aid, North Dakota University System, provided information ([Appendix W](#)) regarding the number of students applying to professional student exchange programs, including Western Interstate Commission for Higher Education (WICHE) and non-WICHE programs, and the number of students accepted. She said PSEP provides access to professional programs not offered in the state in veterinary medicine, dentistry, and optometry. She said the student pays the resident tuition rate at the professional institution, and the state--through PSEP--pays a support fee approximately equal to the difference between the resident and nonresident tuition rate at the institution. She said in addition to the state's participation in WICHE, individual contracts are available through a Minnesota/North Dakota reciprocity agreement and with Kansas State University and Iowa State University in veterinary medicine. She said since 2008, the number of applicants in the three professions available through PSEP has averaged 61 students per year. She said 37.8 percent of the applicants were in veterinary medicine, 38.6 percent were in dentistry, and 23.6 percent in optometry. She said during the 2013-14 school year, 20 new slots were funded, of which 10 were funded in veterinary medicine, 3 in optometry, and 7 in dentistry.

In response to a question from Senator Mathern, Ms. Zastoupil said funding for PSEP is appropriated by the Legislative Assembly, and the University System allocates the funding to the various professions available through the program. She said the University System does not review workforce needs as part of the funding allocation process.

In response to a question from Senator Lee, Ms. Zastoupil said during the last year, some slots were not filled, either because there were not enough applicants or because applicants were not eligible. She said the University System is reviewing the possibility of reallocating unused funding to provide additional slots in another profession.

In response to a question from Senator Lee, Ms. Kopp, North Dakota Veterinary Medical Association, said the association is conducting a workforce study, including the distribution of veterinarians in the state. She said the results of the study will be made available to the committee.

Senator Mathern suggested the committee receive information regarding national standards for the number of dentists, optometrists, or veterinarians per population.

In response to a question from Senator Anderson, Ms. Zastoupil provided information ([Appendix X](#)) regarding the funding per student provided for participants in PSEP. She said during the 2013-14 school year, PSEP is providing funding for 40 veterinary, 28 dentistry, and 26 optometry students. She said within WICHE, veterinary students receive approximately \$30,600 per student, dentistry students receive \$23,900 per student, and optometry students receive \$16,400 per student. She said non-WICHE students receive \$17,930 per student for dentistry students and from \$11,226 to \$26,059 per student for veterinary students. Senator Lee suggested the University System provide a summary of the information in an email to the committee.

In response to a question from Senator Anderson regarding the number of PSEP participants returning to the state to practice, Ms. Zastoupil said the University System is conducting a survey of the graduates of the PSEP over the last 10 years. She said the surveys are due back in November 2013 and will address where PSEP graduates are practicing and why.

COMMITTEE DISCUSSION AND STAFF DIRECTIVES

Chairman Lee said the next committee meeting date is tentatively scheduled for Wednesday, January 8, 2014.

It was moved by Representative Hofstad, seconded by Senator Erbele, and carried on a voice vote that the meeting be adjourned.

No further business appearing, Chairman Lee adjourned the meeting at 4:30 p.m.

Sheila M. Sandness
Senior Fiscal Analyst

Allen H. Knudson
Legislative Budget Analyst and Auditor

ATTACH:24