NORTH DAKOTA LEGISLATIVE MANAGEMENT

Minutes of the

HEALTH SERVICES COMMITTEE

Wednesday, July 30, 2014
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., Joan Heckaman, Oley Larsen, Tim Mathern; Representatives Dick Anderson, Alan Fehr, Curt Hofstad, Rick Holman, Jon Nelson

Members absent: Senator Robert Erbele; Representative Marvin E. Nelson

Others present: Todd Porter, State Representative, Mandan
Senator Dave Oehlke, member of the Legislative Management, was also in attendance.
See Appendix A for additional persons present.

It was moved by Senator Mathern, seconded by Representative Fehr, and carried on a voice vote that the minutes of the April 24, 2014, meeting be approved as distributed.

DENTAL SERVICES STUDY

At the request of Chairman Lee, Ms. Julie Schwab, Director, Medical Services Division, Department of Human Services, provided information (Appendix B) regarding Medicaid dental service providers by geographical area of the state, areas of the state lacking Medicaid service providers, the effect of the state's medical assistance payment rates on dentists accepting Medicaid recipients, billing and reimbursement for services provided by dental therapists and expanded function dental assistants and dental hygienists, the effect of Medicaid Expansion on the dental coverage of certain Medicaid participants, options to improve access to dental services in the state--especially in rural areas, and whether the use of incentives for dental service providers to locate in underserved areas in the state may improve access. Ms. Schwab presented two maps identifying the number of children (ages 0 to 20 years) and adults enrolled in Medicaid in each county as of November 2013. She said 40 counties had a dentist that provided a service to 1 to 49 children enrolled in Medicaid, 26 counties had a dentist that provided a service to 50 to 99 children enrolled in Medicaid, and 18 counties had a dentist that provided service to 100 or more children enrolled in Medicaid. She provided a summary of Medicaid dental rates effective July 1, 2014, for North Dakota, Montana, South Dakota, Minnesota, and Wyoming. She said from state fiscal year 2007 to 2013, the usage rate for children has increased 24.6 percent and the adult usage rate increased 1.4 percent. She said North Dakota Medicaid reimburses dental hygienists and dental assistants that are under the supervision of a dentist for the application of fluoride varnish. However, she said, the Department of Human Services (DHS) does not currently enroll or directly reimburse dental therapists, expanded function dental assistants, or dental hygienists.

Ms. Schwab said the current Medicaid Expansion covers dental services for recipients 19 and 20 years old. She said certain individuals who have had dental coverage under traditional Medicaid will not have coverage with the Medicaid Expansion. She said when implementing the Medicaid Expansion, DHS selected the Sanford Health Plan which was consistent with the benchmark selected for the federal Marketplace. She said the Sanford Health Plan does not include dental coverage.

Ms. Schwab said DHS developed the nonprofit clinic dental access project to support the recruitment of additional dentists to serve in nonprofit clinics. She said a nonprofit dental clinic, by proposing Medicaid and children's health insurance program (CHIP) access and outreach plans, can qualify for funding for a part-time dentist (up to $10,000 per year, for a maximum of $30,000 for three years) or a full-time dentist (maximum of $60,000).

At the request of Chairman Lee, Ms. Kimberlie Yineman, Director, Oral Health Program, Family Health Division, State Department of Health, provided information (Appendix C) regarding the potential for local public health units to support the provision of dental services, especially in rural areas of the state, and reintroduction of basic dental health prevention services in schools, including the estimated cost and resources available to provide the services.

Ms. Yineman said the majority of local public health unit nurses are applying fluoride varnish, and regional public health units, authorized in North Dakota Century Code Section 23-35-01, provide an opportunity to expand dental services in local public health units. She said public health regional networks are an efficient and effective model for delivering public health services.

Ms. Yineman said federal funding to support school-based fluoride varnish and dental sealant prevention service programs was not reinstated in 2013. However, she said, the State Department of Health (DOH) has recently received notification that federal funding may become available to reestablish school-based dental health prevention service programs for the next three years. She said current school participation criteria requires that 50 percent or more of the student population qualify for the free and reduced-fee school lunch program. She said in years two and three of the grant, DOH anticipates expanding the school-based dental health prevention service programs to schools with 45 percent or more of their student population participating in the free and reduced-fee school lunch program. She said funding to maintain staffing and operating expenses for school-based dental health prevention service programs that target high-risk and underserved students/schools would cost approximately $450,000 annually.

In response to a question from Senator Heckaman, Ms. Yineman said all of the children in a qualifying school receive services whether or not they qualify for free and reduced-fee lunches.

Senator Mathern suggested the committee receive information regarding the estimated cost to provide school-based dental health prevention services to all children in the state and to only those that qualify for free and reduced-fee lunches. He said billing for services provided to insured children would allow the state to provide services in all schools at a lower incremental cost.

In response to a question from Chairman Lee, Ms. Jodi Hulm, Administrator, Children's Health Insurance Program, Department of Human Services, said the new contract for CHIP effective July 2013 includes fluoride varnish services provided by physicians. She said a child is allowed two fluoride applications per year.

In response to a question from Representative J. Nelson, Ms. Yineman said DOH estimates 50 schools in the state have 50 percent or more of their children eligible for free and reduced-fee lunches and approximately 100 schools with 45 percent or more of their children eligible for free and reduced-fee lunches.

Representative J. Nelson suggested the committee receive information regarding the number of schools anticipated to qualify for school-based dental health prevention services in each year of the proposed program.

Ms. Mary Amundson, Assistant Professor, Department of Family and Community Medicine, University of North Dakota School of Medicine and Health Sciences, provided information (Appendix D) regarding dental loan repayment program limits on the number of dentists funded per facility during the biennium; the potential for expanding the dental loan repayment program, including cost and eligible candidates; options to improve access to dental services in the state--especially in rural areas; and whether the use of incentives for dental service providers to locate in underserved areas in the state may improve access. At the request of Chairman Lee, Ms. Amundson provided a copy of her testimony (Appendix E) presented to the Health Care Reform Review Committee in July 2014 relating to loan repayment programs offered to qualified health professionals in the state. She said DOH administers three dental loan repayment programs--the state loan repayment program, the public health and nonprofit dental loan repayment program, and the federal/state loan repayment program. She said the two state dental loan repayment programs cause confusion among applicants and communities. She said award amounts, service commitments, service location, funding match requirements, and limitations on prior work experience in the state vary between the dental loan repayment programs and other medical loan repayment programs. She said combining the dental loan repayment programs into one program is feasible. She said the National Health Service Corps (NHSC) program has a set of policies that apply to all disciplines participating in the program and may provide a model for how the program could be structured. She suggested removing the requirement that the applicant may not have practiced dentistry full time in the state during the last three years to allow dentists to move from urban to rural areas of the state. She said establishing or upgrading a practice is challenging and suggested the committee consider resuming the new practice grant program and allowing funds not utilized for new practice grants to be converted to dental loan repayment awards. She said if the dental loan repayment programs were expanded, each additional state loan repayment program slot approved in the first year of the biennium would cost $40,000 and each slot approved in the second year of the biennium would cost $20,000. She said the state loan repayment program provides up to $80,000, so each slot would cost an additional $40,000 in the subsequent biennium. She said dentists have expressed concern regarding payment delays and suggested the committee consider making payments six months after the participant's start date and allowing lump sum payments issued 90 days after the contract start date as provided in the NHSC program. She also suggested the committee consider an option for the participant to apply for award continuations in addition to the new awards.

Chairman Lee suggested the committee receive a chart summarizing all of the dental loan repayment programs, including those under Medicaid. Representative J. Nelson suggested the chart include the funding source for each program.

In response to a question from Representative J. Nelson, Ms. Arvy Smith, Deputy State Health Officer, State Department of Health, said for the 2013-15 biennium, dental loan repayment programs receive funding from the general fund and the community health trust fund.

In response to a question from Chairman Lee, Ms. Amundson said qualified candidates are available to fill additional slots if additional funding was made available for the dental loan repayment programs.

At the request of Chairman Lee, Ms. Rita Sommers, Executive Director, State Board of Dental Examiners, provided information (Appendix F) regarding the potential for establishing dental residencies in the state and any related costs, availability of liability insurance for dental therapists and expanded function dental assistants and dental hygienists, and an update of the expanded function dental assistant and dental hygienist language approved by the State Board of Dental Examiners. Ms. Sommers said the board has not studied the potential for establishing dental residencies, but other states have designed a resident license based on the type of residency program made available. She said the board has recently renoticed rules related to the expanded function dental assistant and dental hygienist and the comment period ends August 6, 2014.

In response to a question from Chairman Lee, Ms. Sommers said the board has not been contacted regarding any potential residency program in the state. She said information available indicates residencies have been successful in other states.

In response to a question from Senator Mathern, Ms. Sommers said under the new rules, dental hygienists are allowed, once trained and permitted by the board, to assist with anesthesia under the direct supervision of an oral and maxillofacial surgeon. In addition, she said, both dental assistants and dental hygienists would be allowed to perform certain restorative functions.

At the request of Chairman Lee, Mr. Scott J. Davis, Executive Director, Indian Affairs Commission, provided information regarding dental services on reservations and possible collaboration with the federal Indian Health Service for dental health services on the reservation. Mr. Davis said his office has met with the North Dakota Dental Association and the American Dental Association regarding a potential partnership. He said credentialing is an obstacle to recruiting dentists from surrounding communities to provide services on the reservation.

At the request of Chairman Lee, Dr. Brent Holman, Executive Director, North Dakota Dental Association, provided information (Appendix G) regarding a case management pilot project, including costs and anticipated resources. Dr. Holman said case management is an effective way to reduce barriers to care for Medicaid and other high-risk patients. He said the pilot project would provide an opportunity to prove case management is a cost-effective service that has the potential to reduce dental costs significantly, improve oral health, and decrease tooth decay. He said the association anticipates partnering with the North Dakota oral health program to implement and administer the five-year pilot project. He said outcome measures will be developed for future years to measure the impact of the pilot. He said service codes exist for fluoride varnish and sealants, but the pilot program would need a legislative directive to DHS to develop oral health assessment and case management service codes which will allow for Medicaid reimbursement. He said state support would be needed for matching grants to implement the model.

In response to a question from Chairman Lee, Dr. Holman said either a dental assistant or dental hygienist would provide case management services.

Chairman Lee suggested stakeholders collaborate and bring recommendations for changes to the dental loan repayment programs to the committee.

At the request of Chairman Lee, Dr. Michael Helgeson, Chief Executive Officer, Apple Tree Dental, provided information (Appendix H) regarding options to improve access to dental services in the state--especially in rural areas. Dr. Helgeson said Apple Tree Dental would collaborate with the private dental community, dental professional organizations, community health centers, legislators, and government stakeholders, including the North Dakota oral health program, to expand private, public, and nonprofit capacity for community-based collaborative practice. He said the Apple Tree Dental nonprofit model is experienced in dental public health, data collection, cloud-based electronic health records, and telehealth. He said Apple Tree Dental partners with educators to provide student rotations for dental assistants, dental hygienists, dental therapists, dentists, and

nurses. He said case management is synonymous with care coordination. He said Apple Tree Dental could collaborate with dentists and community health centers to provide care coordination. He said Apple Tree Dental could provide training, management expertise, and software.

In response to Chairman Lee's earlier question regarding dental residencies, Dr. Helgeson said approximately 20 percent of dentists seek a one- or two-year residency. He said a dental school is not necessary to establish dental residencies; however, residencies require a sponsor. He said dental residents would be ideal additions to community health centers, hospitals, or other nonprofit providers.

Ms. Dana Schmit, President, North Dakota Dental Hygienists' Association, provided summary findings (Appendix I) of a survey of the state's dental hygienists regarding new workforce models. She said an online survey of 770 registered dental hygienists resulted in 214 responses, of which 60 percent were members of the North Dakota Dental Hygienists' Association (NDDHA). She said 70 percent of respondents were in favor of the dental therapist model and 64 percent indicated they would not change the scope of practice proposed to the 2013 Legislative Assembly for the dental therapist. She said 94 percent agree or strongly agree that a registered dental hygienist license should be required to become a dental therapist. She said based on the survey results, the association believes the dental therapist model is a viable option for improving access to care in the state.

Mr. Tyler Winter, President, North Dakota Dental Assistants Association, provided information regarding the expanded function dental auxiliary (EFDA), including written testimony (Appendix J) in favor of the EFDA from the American Dental Assistants Association and the Dental Assisting National Board, Inc. He said benefits of the EFDA model include:

- A history of success in other states;
- Existing curriculum and assessments available in other states will result in quicker and less costly implementation; and
- EFDAs will work under the direct supervision of a dentist.

AUTOPSY STUDY

At the request of Chairman Lee, Dr. Mary Ann Sens, Chair, Department of Pathology, University of North Dakota School of Medicine and Health Sciences, provided information (Appendix K) (via video) regarding models and systems for medicolegal death investigation, including advantages and disadvantages of each, relative to the needs of North Dakota and funding and resources for delivery and establishment of statewide standards and expectations for achieving national standards for death investigation. She said the two autopsy facilities currently serving the state are within two hours of over 95 percent of the state's population.

Dr. Sens provided information regarding funding models, state compared to county death investigation systems, and cost components. She said the state already has significant infrastructure and components in place and is prepared to improve the coordination and effectiveness of the system. She said the goal should be to have a medicolegal death investigation system in the state that fully meets all national standards. She provided the following goals and objectives for the committee's consideration:

1. Control or ownership of forensic facility in Grand Forks.
2. Education and training of investigators and first responders.
3. Develop a strategy to meet imaging/radiology needs within the forensic system.
4. Plan for national accreditation of all forensic facilities in North Dakota.
5. Design and implement a plan for training and distribution of qualified and certified medicolegal death investigators for all regions of North Dakota.

Dr. Sarah Meyers, Assistant Professor, Department of Pathology, University of North Dakota School of Medicine and Health Sciences, provided information regarding possible funding models. She suggested the per capita model would be appropriate for smaller counties because budgets may influence autopsy decisions in the "fee-for-service" model. She said cases should be investigated based on the merit of the case, not funding available. She recommended a hybrid death investigation system that is a combination of state and county resources and responsibilities.

At the request of Chairman Lee, Mr. Kirby Kruger, Section Chief, Medical Services Section, State Department of Health, provided information (Appendix L) regarding an update on the efforts of the State Forensic Examiner's office to collaborate with counties to improve the medicolegal death investigation system in the state, the work of

stakeholders to develop recommendations for a system approach to death investigation and recommendations for the framework of a regional death investigation system, and estimated costs and funding available for the establishment and implementation of statewide standards for death investigation. He said a task force consisting of various agencies and organizations has identified the following recommendations for improvement:

- Maintain a manageable workload at the State Forensic Examiner's office in Bismarck. The group recommends DOH receive continued funding to maintain the contractual agreement between DOH and the School of Medicine and Health Sciences for forensic autopsy services.
- Provide authority to the State Forensic Examiner to review nonnatural deaths and amend the cause and manner of death if necessary. He said DOH is reviewing whether this could be accomplished through a change to the North Dakota Administrative Code.
- Develop a system to prompt health care providers to consult with the local coroner in all deaths that are not natural deaths. He said DOH is developing a component in its electronic death certificate system for this.
- Allow copies of toxicology reports generated by the State Crime Laboratory to be sent to the State Forensic Examiner. He said this can be implemented by the State Crime Laboratory.
- Increase the number of people in the state trained in death scene investigation and increase and improve the knowledge and skills of coroners, death investigators, and others who may conduct death investigations or assist in death investigations, including a mechanism to offset travel costs for the training of coroners. He estimates the cost of this initiative would require an appropriation of $29,375. In addition, he said, scholarships to assist in travel costs for five county coroners per year to attend the training provided by the Hennepin County Coroner in Minnesota on death investigations would require an additional appropriation of $10,000.
- Develop the capacity of the State Crime Laboratory to produce quantitative toxicology results. He said currently, the laboratory can provide only qualitative results.
- Allow the State Forensic Examiner and School of Medicine and Health Sciences Department of Pathology to review death records electronically and allow these entities to send the electronic record to other medical providers for further review or correction. He said the Division of Vital Records, State Department of Health, anticipates working with the Information Technology Department (ITD) to make the necessary modifications. He said the modifications are estimated to cost between $10,000 and $20,000. He said authority for the State Forensic Examiner could be accomplished with a rule change.
- Develop a mass fatality response plan for the state.

In response to a question from Senator Mathern, Mr. Kruger said DOH would coordinate the implementation of the task force's recommendations.

In response to a question from Senator Oehlke, Dr. Meyers said pathologists are qualified, with very rare exceptions, to handle any type of death investigation. In addition, she said, pathologists can specialize in a variety of areas.

At the request of Chairman Lee, Mr. Terry Traynor, Assistant Director, North Dakota Association of Counties, provided information (Appendix M) regarding a summary of county costs incurred for social services programs. Mr. Traynor said the North Dakota Association of Counties is supportive of the recommendations of the task force. He said the association compiled information provided by the Tax Commissioner, DHS, and county auditors to prepare summaries of fiscal year 2013 social service expenditures and reimbursements and calendar year 2014 county-dedicated mills and general fund allocations for social services programs. He said county social service costs increased $6.1 million--or 14 percent--from fiscal year 2012 to fiscal year 2013. He said net county social service costs for state fiscal year 2013 totaled $50.5 million. He said calendar year 2014 county budgets include approximately $57 million in local revenue for social services. He said increases in wages related to the Hay Group study and increased health insurance rates and retirement contributions contributed to the increase in 2014 budgeted social service costs. In addition, he said, many larger counties have included new full-time equivalent (FTE) employees in their budgets in anticipation of the administrative impact of expanded Medicaid.

In response to a question from Chairman Lee, Mr. Traynor said the DOH contract with the School of Medicine and Health Sciences for conducting autopsies has resulted in transportation cost-savings for counties. He said counties support continuing the arrangement.

In response to a question from Representative J. Nelson, Mr. Traynor said counties have always supported state funding for social services. He said it is a cost counties cannot control.

Dr. John Baird, Coroner, Cass County, said he agrees with the recommendations of the task force.

Senator Oehlke expressed concern regarding funding for additional testing. He said unnecessary testing will add cost and result in autopsy delays.

In response to a question from Representative Holman, Ms. Smith said DOH is in the process of developing its 2015-17 budget. She said funding for quantitative analysis should be appropriated to the Attorney General and the State Crime Laboratory. She said DOH currently contracts with an out-of-state firm for quantitative analysis. She said if funding for quantitative analysis is included in the Attorney General's budget, there could be a reduction in the DOH budget related to contracts for these services.

In response to a question from Chairman Lee, Ms. Janelle Portscheller, Forensic Scientist, State Crime Laboratory, Attorney General's office, said the toxicology section does not currently have methods for quantitative analysis.

Chairman Lee suggested the committee receive information from the State Crime Laboratory regarding the estimated cost of providing quantitative analysis and whether the Attorney General's office supports the recommendations of the task force.

Senator Anderson suggested the committee receive information from DOH regarding the cost of contracting for the quantitative analysis services.

Dr. Meyers said all autopsies will include a toxicology screening test or qualitative analysis. She said if a drug appears, then a quantitative analysis is performed. She said the medical school contracts with an outside laboratory for both types of analyses.

It was moved by Senator Mathern, seconded by Senator Anderson, and carried on a voice vote that the Legislative Council staff prepare a bill draft to implement the recommendations of the task force.

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 N) regarding a report on an assessment completed by DOH and the Tobacco Prevention and Control Executive Committee of programs in both agencies, including funding sources for the programs, service providers, areas and populations served, and effectiveness of the programs on improving the health and policy environment in the state; how the comprehensive statewide tobacco prevention and control programs provided by the Tobacco Prevention and Control Executive Committee and programs provided by DOH address tobacco use among youth, the number of youth tobacco users statewide, and changes in the number of youth tobacco users; and efforts to collaborate with tribal tobacco prevention and control programs and recommendations for additional opportunities to collaborate. Ms. Fremming provided assessments of the DOH tobacco prevention and control programs during fiscal year 2009 and fiscal year 2014. She said outcomes included in the assessments for both years indicate a reduction in smoking among pregnant women from 17 percent in 2009 to 15.1 percent in 2014.

Ms. Fremming said DOH granted funding to local public health units as part of the community health grant program until fiscal year 2010. She said as part of the school component of the grant program, local public health units supported smoke-free and tobacco-free school policies, tobacco prevention curricula, and staffing, either at the local public health unit or the schools, to advance these activities. She said the Tobacco Prevention and Control Executive Committee began administering local public health unit grants in fiscal year 2010. She said currently, the department focuses on addressing youth tobacco use in Native American communities by providing grant funds to each of the reservations to implement tribal tobacco prevention and control programs. She said smoking rates among American Indian youth were reduced from 43.9 percent in 2009 to 29.4 percent in 2014. She said based on the youth risk behavior survey, statewide youth (grades 9 to 12) cigarette use declined from 22.4 percent in 2009 to 19 percent in 2014 and smokeless tobacco use declined from 15.3 percent in 2009 to 13.8 percent in 2014. However, she said, youth who report ever trying e-cigarettes increased from 4.5 percent in 2011 to 13.4 percent in 2013.

Ms. Fremming said collaboration with tribal tobacco prevention and control programs includes implementing more smoke-free public place policies, engaging tribal health programs with cessation assistance, developing tribal-specific media products, and engaging tribal communities, including tribal councils from each reservation. She said DOH will participate in tribal tobacco strategic planning facilitated by the Indian Affairs Commission.

Chairman Lee said more coordination is needed regarding populations served by DOH and the Tobacco Prevention and Control Executive Committee. She suggested the committee receive information from each agency regarding the source of tobacco prevention and control funding, including details of the program's funding by source, populations served, populations that are being reached, and how collaboration between DOH and the Tobacco Prevention and Control Executive Committee could provide services to populations not currently being served.

In response to a question from Representative J. Nelson, Ms. Fremming said a memorandum of understanding between DOH and the Tobacco Prevention and Control Executive Committee regarding the comprehensive tobacco prevention and control program has expired. She said DOH and the Tobacco Prevention and Control Executive Committee have not yet agreed on a replacement memorandum. She said DOH provided a copy of a replacement memorandum of understanding with recommendations for changes to the Tobacco Prevention and Control Executive Committee in November 2013, but they have not yet finalized the agreement.

At the request of Chairman Lee, Dr. Eric Johnson, Member, Tobacco Prevention and Control Executive Committee, provided information (Appendix O) regarding a report on an assessment completed by DOH and the Tobacco Prevention and Control Executive Committee of programs in both agencies, including funding sources for the programs, service providers, areas and populations served by the programs, and effectiveness of the programs on improving the health and policy environment in the state; how the comprehensive statewide tobacco prevention and control programs provided by the Tobacco Prevention and Control Executive Committee and programs provided by DOH address tobacco use among youth, the number of youth tobacco users statewide, and changes in the number of youth tobacco users; and efforts to collaborate with tribal tobacco prevention and control programs and recommendations for additional opportunities to collaborate. Dr. Johnson provided a summary of integrated programs, including funding, service providers supported by the Tobacco Prevention and Control Executive Committee, and areas and populations served for each program. He said from 2009 to 2014, the Tobacco Prevention and Control Executive Committee has provided local policy grants to local public health units totaling $13.7 million, special initiative grants totaling $2 million, and special initiative contracts totaling $3.4 million. He provided information regarding changes in various policy and cessation focus areas from 2009 to 2014, including populations served. He said overall tobacco use rates for youth (ages 14 to 17) declined from 30.6 percent in 2009 to 25.7 percent in 2014.

In response to a question from Chairman Lee, Dr. Johnson said the Tobacco Prevention and Control Executive Committee continues to collect both current and long-term data, including the effects of advertising on the state's quitline, smoking rates, and information regarding smoking-related diseases.

In response to a question from Senator Mathern, Dr. Johnson said primary prevention is population-based and prevention measures are customized to reach various populations. He said education and mass media campaigns focus on preventing individuals from using tobacco. He said secondary prevention efforts include mitigating the effects of tobacco and providing cessation assistance to individuals using tobacco. He said the state's quitline has an average success rate of 30 percent.

In response to a question from Senator Mathern, Dr. Johnson said the Tobacco Prevention and Control Executive Committee's mission is more narrow by law because it is required to follow Centers for Disease Control and Prevention's *Best Practices for Comprehensive Tobacco Control Programs*. He said best practices are supported by scientific evidence and are the most cost-effective. He said although the Tobacco Prevention and Control Executive Committee is pursuing best practices, promising practices should not be ignored. He said DOH is pursuing promising practices, which may have merit, but do not yet have supporting scientific evidence.

Representative J. Nelson expressed concern that since the comprehensive tobacco prevention and control program was adopted, some health care programs are no longer supported by the community health trust fund because they are not considered best practices.

In response to a question from Representative J. Nelson, Dr. Johnson said some of the programs administered by DOH are considered best practices. He said the community health trust fund is ideal for those programs that are considered promising practices.

In response to a question from Representative J. Nelson, Dr. Johnson said the state's overall tobacco prevention and control grade is low due to the state's low tobacco tax. He said education programs work, but increasing the price is far more effective at preventing and reducing youth tobacco use. He said nationwide, raising the tobacco tax by one dollar reduces youth smoking by 10 percent. He said increasing the tobacco tax has also been shown to reduce tobacco use in lower socioeconomic populations.

Representative J. Nelson suggested removing the requirement that 80 percent of the revenue in the community health trust fund be used for tobacco prevention and control. In addition, he suggested increasing the tobacco tax and depositing the revenue in the community health trust fund to be used for other health-related programs.

Senator Mathern suggested that, if the state increases the state tobacco tax, the Tobacco Prevention and Control Executive Committee work with the tribes to implement a tobacco tax on the reservations. He said the tribes could use tobacco tax revenue for health care programs on the reservations.

Mr. Jerry Jurena, President, North Dakota Hospital Association, said the association is supportive of measures to improve the health of youth in the state.

Mr. Brad Hawk, Indian Health Systems Administrator, Indian Affairs Commission, provided information (Appendix P) regarding a strategic plan to coordinate the tobacco prevention efforts on reservations, the proposed tribal tobacco tax, and efforts among the tribal leaders to reach a consensus regarding smoke-free casinos. He said tribal tobacco prevention programs continue to address tobacco use on each reservation by encouraging smoke-free policies; engaging tribal health programs in cessation assistance; developing media products; and engaging tribal communities, including tribal councils. He said a tobacco user's fee (tobacco tax) of five cents per pack of cigarettes has been approved by the Turtle Mountain Band of Chippewa Indians Tribal Council. He said funds from the tax will be used to provide health care-related assistance on the reservation, including travel assistance for medical appointments. He said raising the tobacco tax would have a more profound effect on lower-income populations which exist in greater numbers on reservations, and the increase would likely reduce smoking rates, especially among Native American youth. He said a stakeholder group from each North Dakota reservation is working with the tribal casinos to implement smoke-free policies. He said some issues have developed between the tribes and the Tobacco Prevention and Control Executive Committee, but the commission continues to partner with agencies and organizations to reduce tobacco use on reservations. He said the commission discussed the development of a strategic plan with the tribes and DOH and determined a strategic plan is not needed at this time. He said because tribal tobacco prevention agencies are not fully staffed, it is likely a strategic plan could not be implemented.

In response to a question from Senator Mathern, Mr. Hawk said turnover in tribal leadership would make a tobacco tax sharing agreement with the state difficult to implement and manage.

Senator Anderson suggested the committee receive information from the Tax Commissioner regarding taxable and nontaxable tobacco products sold in the state.

Mr. Davis said the Tax Commissioner may have information available regarding tobacco sales on each reservation.

COMMUNITY PARAMEDIC STUDY

At the request of Chairman Lee, Mr. Tom Nehring, Director, Emergency Medical Services and Trauma Division, State Department of Health, provided information (Appendix Q) regarding community paramedicine and the educational requirements of community paramedics. Mr. Nehring said community paramedicine does not increase the scope of paramedic practice and does not replace current health care providers. He said medically trained emergency medical services (EMS) personnel receive additional training to operate in other environments and address disease issues. He said paramedicine currently exists in 17 states and 40 states are anticipated to have some form of community paramedicine in the next two years. He said the urban model could decrease unnecessary ambulance calls and emergency room visits and the rural model could fill gaps in the current health care delivery system. He said DOH anticipates 200 to 400 hours of additional training will be required and services could be provided for patients with chronic diseases, workplace and home wellness, home visits, and occupational health. He said training is currently available in Minnesota, but DOH anticipates training in the state could be provided by the state's higher education institutions. He said DOH will eventually need to establish the community paramedic as a licensed professional to be eligible to receive third-party payment for services.

In response to a question from Representative Fehr, Mr. Nehring said community paramedics will play an important role in behavioral health care, resulting in more cost-effective access to behavioral health services.

Mr. Kenneth Reed, Community Paramedic Coordinator, Emergency Medical Services and Trauma Division, State Department of Health, provided information (Appendix R) regarding an update on the community paramedic pilot project, including proposed licensure and reimbursement. He said pilot project oversight and coordination has been assigned to the Community Paramedic Subcommittee of the EMS Advisory Council. He said proposals to participate in the pilot project, including impact, utilization, effectiveness, delivery systems, and required funding,

were solicited from licensed ambulance services. He said the advisory council has reviewed and approved proposals from Heart of America Medical Center in Rugby, F-M Ambulance in Fargo, Southwest Health Systems in Bowman, and Billings County EMS in Belfield/Medora/Beach. He said the four project sites approved have a combined eight paramedics that have completed training and are in clinical rotations and another five paramedics that will begin training in August. He said pending proposals include the Carrington Health Center/Ambulance and Essentia Health in Fargo. He said DOH has approached third-party payers, including Blue Cross Blue Shield of North Dakota and DHS, regarding reimbursement. He said DOH continues to review administrative rule changes necessary to recognize the licensure of community paramedics, develop program evaluation metrics, and establish criteria for including other licensed EMS providers.

In response to a question from Representative Fehr, Mr. Reed said DOH currently licenses all levels of EMS providers. He said the community paramedic licensure would be an extension of the existing paramedic license for those individuals completing additional training.

In response to a question from Representative Holman, Mr. Reed said benefits of the community paramedic program will vary by community. He said each community paramedic program is established to meet the unique needs of the community.

In response to a question from Representative Hofstad, Mr. Reed said community paramedics in Minnesota receive fee-for-service reimbursement from Medicaid. He said services provided by community paramedics to Medicare patients are currently not billable on a fee-for-service reimbursement basis.

Ms. Karen Tescher, Assistant Director, Long-Term Care Continuum, Medical Services Division, Department of Human Services, provided information (Appendix S) regarding the potential relationship between community paramedics and home and community-based services (HCBS) providers. She said to provide HCBS, community paramedics would enroll as qualified service providers (QSPs) with DHS. She said QSPs are reimbursed for personal care services and can also enroll to provide adult day care, adult foster care, adult residential, chore, emergency response system, environmental modification, specialized equipment/supply, supported employment, transitional care, home-delivered meals, family home care, family personal care, HCBS case management, extended personal care, nonmedical transportation, respite, and attendant care services. She said community paramedics could be a partial solution to the shortage of QSPs in rural areas, and reimbursement for HCBS could provide an additional revenue source for the community paramedic.

Mr. Sherman Syverson, Executive Director, F-M Ambulance Service, Fargo, provided information (Appendix T) regarding services it could provide and the effect of the community paramedic program on ambulance calls. He said the Fargo pilot project is supported by Sanford Health, Fargo-Cass Public Health, Southeast Human Service Center, and F-M Ambulance. He said in Fargo, five paramedics have completed a portion of community paramedic training and are participating in targeted clinical internships in behavioral health, social work, case management, emergency medicine, medical detox, chronic illness management, and public health. He said limited deployment of the community paramedics is anticipated to begin in September 2014.

In response to a question from Chairman Lee, Mr. Nehring said the community paramedic designation will not require a change in the scope of practice of the paramedic. He said an administrative rules change will be proposed to establish the community paramedic licensure. He said if the rule change is approved, the licensure will be recognized by DOH.

Chairman Lee suggested the committee receive information from DHS and insurance providers regarding legislation and funding required for third-party reimbursement for community paramedic services.

OTHER COMMITTEE RESPONSIBILITIES

At the request of Chairman Lee, Ms. Tera Miller, Diabetes Program Director, State Department of Health, provided information (Appendix U) regarding a report on collaboration with DHS, the Indian Affairs Commission, and the Public Employees Retirement System (PERS) to identify goals and benchmarks while also developing individual agency plans to reduce the incidence of diabetes in the state, improve diabetes care, and control complications associated with diabetes. Ms. Miller said the number of individuals in the state diagnosed with diabetes has increased more than 2.5 times over the past 16 years, and in 2007, diabetes cost the state over $400 million. She said although the agencies included in the report have individual plans, they agree a collaborative effort is necessary to reduce and manage diabetes in the state. She provided information regarding programs related to diabetes prevention and management at DOH, DHS, and PERS. She said goals and strategies to reduce diabetes in the state include:

1. Increase the availability and utilization of evidence-based lifestyle change programs, such as the National Diabetes Prevention Program, by training more Diabetes Prevention Program lifestyle coaches, providing new and existing sites with technical assistance, and working with providers to develop a referral system for these programs.
2. Increase the availability and utilization of sustainable, evidence-based diabetes and chronic disease self-management education programs, implement other health education or behavior change initiatives, work with existing diabetes and chronic disease self-management education sites to establish a better referral system, and coordinate with providers serving a high percentage of diabetes patients to offer an accredited diabetes and chronic disease self-management education program.
3. Support local communities that have prioritized programs which encourage obesity or chronic disease management and physical activity by offering community grants.
4. Support existing diabetes-related state health promotion plans, coalitions, and partnerships by offering support, information, and training to communities.
5. Improve diabetes and chronic disease surveillance systems to determine the extent and impact of diabetes on North Dakotans by identifying, collecting, storing, and analyzing relevant data.
6. Support policies that improve outcomes for persons with and at risk for diabetes by identifying successful strategies from other states and programs and applying them to North Dakota.

At the request of Chairman Lee, Ms. Lynn Priebe, Executive Director, North Dakota Veterinary Technician Association, provided information (Appendix V) regarding veterinary technicians' ability to practice at the top of their scope of practice and the potential for an expanded role for veterinary technicians--especially in the area of large food animal services. Ms. Priebe said some veterinarians allow veterinary technicians to practice to the fullest extent of the practice act, while others limit their scope. She said recent veterinarian graduates are more likely to fully utilize veterinary technicians. She provided a copy (Appendix W) of Chapter 43-29 related to veterinarians. She said the practice act identifies services that may be performed by a veterinary technician, but does not reference licensure. She said a number of veterinary clinics in the state do not employ licensed veterinary technicians, but rather employ "on-the-job trained" individuals referred to as veterinary technicians. She said licensure should be addressed before expanding the role of veterinary technicians. She said veterinary technicians are not allowed to diagnose, perform surgery, prescribe medication, or prognose. She said the National Association of Veterinary Technicians of America has developed 11 veterinary technician specialties, of which two relate to large animal and production animals. She said there are few specialized veterinary technicians in the state because certification is time-consuming and difficult to earn and maintain.

In response to a question from Senator Mathern, Ms. Priebe said the Executive Board of the Veterinary Technician Association discussed the practice act and determined changes are not necessary at this time.

Chairman Lee suggested the Veterinary Technician Association work with the Veterinarian Association to encourage clinics to use licensed veterinary technicians to the fullest extent of their scope of practice.

In response to a question from Representative J. Nelson, Ms. Priebe said establishing an education requirement for veterinary technicians may be helpful in the future, but she expressed concern regarding the willingness of veterinarians to embrace such a requirement. She said the education requirement was addressed when the practice act was drafted but was not included because many veterinarians were employing "on-the-job trained" veterinary technicians.

Representative J. Nelson suggested the committee receive information regarding the number of licensed veterinary technicians in the state compared to the number of veterinary technicians that have received on-the-job training.

Ms. Nancy Kopp, Executive Secretary, North Dakota Veterinary Medical Association, said the North Dakota Veterinary Medical Association Board has discussed licensed veterinary technicians and the association membership will also address the issue at its annual meeting in August 2014.

At the request of Chairman Lee, Mr. Robert Tweeten, Chairman, Animal Health Committee, North Dakota Stockmen's Association, provided information (Appendix X) regarding the availability of and need for large food animal veterinary services. Mr. Tweeten said shortages of food animal veterinarians are due primarily to the high cost of education, physically demanding work, long hours, and lower pay relative to small animal veterinary work. He said federal programs and the increased complexity of pharmaceuticals and biological product use requiring veterinarian supervision have expanded the role of veterinarians in food animal operations in recent years. He said

federal programs, such as the United States Department of Agriculture's Animal and Plant Health Inspection Service's animal disease traceability program, now require additional processes at every stage in the production cycle. He said shortages persist in the southwest region of the state and veterinarians engaged in daily herd maintenance are often not available for emergency service in the clinic. He said a federal program to provide support for underserved areas and the state's veterinary loan repayment program are helping to fill some of the critical needs.

In response to a question from Senator Heckaman, Mr. Tweeten said loan repayment programs are more effective than the tuition assistance programs to assist in placing veterinarians in underserved areas of the state.

Chairman Lee suggested the committee receive information from the North Dakota Stockmen's Association and the North Dakota Veterinary Medical Association regarding recommendations to improve the state's veterinary loan repayment program and tuition assistance provided through the professional student exchange program (PSEP).

At the request of Chairman Lee, Ms. Brenda Zastoupil, Director of Financial Aid, North Dakota University System, provided information (Appendix Y) regarding reasons students commit to a job prior to graduation and recommendations, based on need, equitable contributions, and recognizing the demands of the institutions with which the North Dakota University System contracts, for changes to PSEP, including recommendations for ways to simplify the program for students and the University System. She said reasons provided by PSEP alumni in the 2013 University System survey for not returning to North Dakota included practice and job opportunities, spouse or family connections elsewhere, and personal lifestyle, including weather, community size, and quality of life. She said debt levels at graduation play a significant role in the need for establishing a viable practice. She said 71 percent of the 2014 cohort of PSEP recipients indicated they would have still applied for PSEP even if it included a repayment feature. In addition, she said, 57 percent of the new cohort indicated they planned to return to the state post graduation. She said 5 of the 11 states that participate in the Western Interstate Commission for Higher Education (WICHE) require more than one year to establish residency. She said North Dakota may wish to consider increasing the residency requirement of PSEP. However, she said, if a payback feature is implemented for those graduates of PSEP that do not return to the state, the residency requirement may not be as significant. She reviewed existing state and federal student loan forgiveness programs and how they compare to PSEP. She said PSEP provides support payments for students in programs that are not offered in the state. She said these programs are highly competitive and guaranteed slots give North Dakota residents greater access to these professional programs. She said a payback feature would allow residents to pursue these highly competitive fields of study and would continue the guaranteed slots. She said eliminating PSEP support and converting the program to a loan forgiveness program would jeopardize the slots currently reserved for North Dakota applicants. She said North Dakota is one of four WICHE states that do not require a service payback as part of PSEP. She provided the following recommendations for consideration by the University System, professional state associations, and the Legislative Assembly:

- University System - Improve the PSEP application process and communication.
- Professional state associations - Develop a reliable reporting system to determine future workforce needs and encourage professional associations to develop comprehensive mentoring and recruiting plans for students throughout their education.
- Legislative Assembly:

  Consider PSEP eligibility guidelines to lower the possibility of an out-of-state student establishing minimal residency parameters for purpose of gaining access to PSEP funding.

  Consider PSEP service payback structure options, including structure of the payback feature, appropriate work opportunities, parameters and special considerations that must be developed, repayment program provisions that are clear, concise, and not in conflict with other state or federal programs, costs of administering a payback program, administering agent, and additional programs, such as loan forgiveness, that may support opportunities in the state for returning graduates.

Ms. Zastoupil said the University System anticipates collaborating with the Bank of North Dakota to administer any service payback program. She suggested death and disability provisions be addressed in the service payback program to assist in the administration of the program.

In response to a question from Chairman Lee, Ms. Zastoupil said she would email information to the committee regarding a change in the reciprocity agreement for North Dakota students attending the University of Minnesota dentistry program.

In response to a question from Representative Fehr, Ms. Zastoupil said if PSEP were discontinued, students in the state would lose access to WICHE and contract slots. In addition, she said, students would have to borrow additional funds, increasing indebtedness upon graduation.

In response to a question from Senator Mathern, Ms. Zastoupil said there are three professions supported in PSEP, but other professions may receive support from the state in the form of scholarships.

At the request of Chairman Lee, the Legislative Council staff presented a bill draft [15.0203.01000] relating to the repayment of benefits by certain participants of PSEP.

Senator Mathern suggested the committee receive information regarding how the service payback requirement included in the bill draft compares to support for students attending the University of North Dakota School of Medicine and Health Sciences.

Senator Mathern suggested amending the bill draft to lower the possibility of an out-of-state student establishing minimal residency parameters for purpose of gaining access to PSEP funding.

Senator Heckaman suggested the committee consider the residency requirements in other WICHE states for determining eligibility for PSEP.

Senator Anderson said if the service payback requirement is approved by the Legislative Assembly, the residency of the participant accepted into PSEP is less important.

Senator Heckaman said the state has had more applicants to PSEP than slots available. She said establishing stricter residency requirements would give North Dakota students priority with regard to acceptance into the program.

Chairman Lee suggested the committee receive recommendations from the University System regarding changes to the bill draft to be considered by the committee at the next meeting.

Ms. Nancy Kopp, Executive Director, North Dakota Optometric Association, said PSEP was implemented to provide access to professional education in the areas of veterinary medicine, optometry, and dentistry because these professional opportunities do not exist in the state. She said the North Dakota Veterinary Medical Association and the North Dakota Optometric Association maintain a database of PSEP participants and recruit graduates to the state. She said both associations also provide stipends and scholarships.

Senator Anderson suggested the committee continue to receive updates from the North Dakota Dental Association regarding a case management pilot project and the State Board of Dental Examiners regarding expanded function dental assistants and dental hygienists.

It was moved by Senator Anderson, seconded by Representative Fehr, and carried on a voice vote that the Legislative Council staff prepare a bill draft to provide reimbursement for the services of community paramedics.

It was moved by Senator Larsen, seconded by Senator Mathern, and carried on a voice vote that the meeting be adjourned, subject to the call of the chair.

No further business appearing, Chairman Lee adjourned the meeting at 5:17 p.m.

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Sheila M. Sandness
Senior Fiscal Analyst

ATTACH:25