NORTH DAKOTA LEGISLATIVE MANAGEMENT

Minutes of the

HEALTH SERVICES COMMITTEE

Wednesday, April 13, 2016
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., Tyler Axness, Joan Heckaman, Dave Oehlke, John M. Warner; Representatives Alan Fehr, Gail Mooney, Gary Paur, Todd Porter, Karen M. Rohr, Jay Seibel

Members absent: Representatives Rich S. Becker, Dwight Kiefert, Marie Strinden

Others present: Senator Rich Wardner, Dickinson, member of the Legislative Management
See Appendix A for additional persons present.

It was moved by Representative Seibel, seconded by Representative Rohr, and carried on a voice vote that the minutes of the January 7, 2016, meeting be approved as distributed.

DENTAL SERVICES STUDY

Chairman Lee welcomed Dr. Louis W. Sullivan, Former Secretary, United States Department of Health and Human Services. Dr. Sullivan provided information (Appendix B) regarding access to oral health care and dental health workforce issues. He said oral health is an integral part of overall health and poor oral health increases risk for diabetes, heart disease, and poor birth outcomes. He said over the past 20 years, the number of dental health professional shortage areas in the country has grown from nearly 800 in 1993 to more than 4,900 in 2014. He said dental caries disproportionately impact low-income and rural populations. He said North Dakota has one of the highest Medicaid reimbursement rates nationwide (62 percent in 2013), but only 8 percent of the dental practices billing Medicaid in 2013 provided care to a majority (52 percent) of the Medicaid enrollees accessing dental services. He said the dentist-to-population ratio is approximately 54 per 100,000 in North Dakota, and as of 2013, 67 percent of all the licensed North Dakota dentists worked in the four largest counties--Burleigh, Cass, Grand Forks, and Ward. He said 12 counties had no dentist, 9 counties had 1 dentist, and 9 counties had 2 dentists. He said if oral health needs are to be met, new models of care must be considered and one proven model is the dental therapist model. He said similar to nurse practitioners and physician assistants in medicine, dental therapists are professionally trained, mid-level dental providers who can improve access to dental care. He said dental therapists support the work of a dentist and can work in different locations, using telehealth technology, while under a dentist's supervision. He said by adopting and implementing standards for dental therapy education, the Commission on Dental Accreditation (CODA) has ensured that the quality and scope of educational training for dental therapists will be consistent from one state to another. He said mid-level dental providers have been in place in other countries for up to 90 years and in New Zealand, a school-based delivery system using dental therapists has been in place since 1921. He said dental therapists should be seen as an asset to a dental practice, bringing increased revenue and freeing up dentists to focus on more complex procedures. He said the dental system, as it is, is not working and must be improved. He said the mid-level dental providers will improve the dental team.

In response to a question from Senator Anderson, Dr. Sullivan said he anticipates mid-level dental providers will eventually be accepted just as physician's assistants and nurse practitioners were eventually accepted in the medical field. Dr. Sullivan said when dentists see the opportunity to increase access to care and revenue, they will be convinced.

In response to a question from Representative Paur, Dr. Sullivan said he is not aware of an increase in adverse incidents for individuals treated by mid-level dental providers. Dr. Sullivan said the scope of practice of a mid-level provider is limited and programs are monitored.

In response to a question from Representative Rohr, Dr. Sullivan said prescriptions are provided under the supervision of the dentist.

Dr. Sherin Tooks, Director, Commission on Dental Accreditation, provided information (Appendix C) regarding CODA resources, dental therapy program accreditation standards, the process used to approve and implement the standards, and the dental therapy timeline and implementation. She said CODA is recognized as the national programmatic accrediting agency for dental and dental-related educational programs and accredits programs, but not individuals or institutions in which the programs reside. She said CODA has not taken a position on the merits of dental therapy and the scope of practice of the dental therapist is within the purview of each state. She said accreditation standards may be used by regulatory agencies to define scopes of practice. She said draft dental therapy standards were written in 2013 and circulated for comment for 1 year. She said the standards were revised in 2014 and circulated an additional year. She said after the standards were adopted, an implementation process was developed in 2015. She said in February 2016 CODA adopted the process of accreditation for dental therapy education programs and began accepting applications for accreditation of dental therapy programs. She said the CODA application process includes application review and an on-site accreditation evaluation visit. She said dental therapy accreditation standards consider institutional effectiveness; educational program; faculty and staff; educational support services; and health, safety, and patient care provisions. She said dental therapy accreditation standards provide for advanced standing and allow for career laddering.

In response to a question from Senator Warner, Dr. Tooks said the first draft of the dental therapy accreditation standards included a baccalaureate degree; however, CODA determined the degree should be determined by the institution. Dr. Tooks said CODA requires a 3 academic year (August through May) or equivalent, full-time, postsecondary program. She said the institution determines what degree will be awarded upon completion.

In response to a question from Senator Warner, Dr. Tooks said the opportunity exists for career laddering from a dental therapy degree to dental school. Dr. Tooks said the degree to which dental hygienists and dental therapists are able to receive advanced standing in dental school will depend on their level of training and the advance standing policies and procedures of the dental program. She said the dental school would need to adopt appropriate mechanisms to ensure dental therapy candidates entering dental school with advanced standing satisfy the same level of competency as students receiving the full dental school experience.

In response to a question from Chairman Lee, Dr. Tooks said peer review is outside of the scope of CODA. Dr. Tooks said CODA is limited to assessing educational programs. She said licensing and practice oversight is the responsibility of states and their professional licensing boards.

In response to a question from Representative Rohr, Dr. Tooks said the consequence of noncompliance depends on the deficiency. Dr. Tooks said if the deficiency is severe, CODA may withhold accreditation; however, a deficiency that is less severe could allow for accreditation, with followup monitoring and review. She said programs are allowed to become compliant with close monitoring and reporting requirements. She said CODA accreditation is not a requirement for student financial aid.

In response to a question from Chairman Lee, Dr. Tooks said to maintain accreditation, programs must submit an annual report for review, including information regarding admission rates, graduation rates, program changes, and curriculum data collection. Dr. Tooks said CODA also has a program change policy which requires CODA be notified of certain program changes.

Ms. Kimberlie Yineman, Oral Health Program Director, State Department of Health, and Vice President, North Dakota Oral Health Coalition, provided information (Appendix D) regarding the efforts of the North Dakota Collaborative Practice Task Force. She said the task force reviewed, discussed, and agreed upon key elements of a collaborative practice by reviewing current state supervision laws. She said task force members solicited input from individuals who had prior experience with collaborative practice from an implementation and policy perspective. She said the task force agreed collaborative practice agreements should maintain and improve current quality standards of care and safety, increase access to care with the best interests of the patient in mind, and link patients to a dental home. She said in December 2015 the North Dakota Collaborative Practice Task Force concluded existing North Dakota Century Code (NDCC) Sections 43-20-03, 43-20-01, 43-28-18, and North Dakota Administrative Code (NDAC) Section 20-04-01-01, as they related to collaborative practice and supervision, should remain. She said the task force agreed that existing language in NDAC describes a collaborative practice model that works best for the state. She said NDAC Chapter 20-01-02 defines general supervision to mean the dentist has authorized the procedures and they are carried out in accordance with the dentist's diagnosis, if necessary, and treatment plan. She said the dentist is not required to be in the treatment facility and limitations are contained in NDCC Section 43-20-03. She said NDAC currently allows a dental hygienist to provide services without a dentist present under general supervision. She said this allows a dental hygienist to provide outreach services in public settings, such as schools or nursing homes, under a standing order from a dentist. She said the North Dakota Collaborative Practice Task Force summary report was provided to the State Board of Dental Examiners for their consideration.

Dr. Omar Chahal, President, North Dakota Dental Association, provided information (Appendix E) regarding an update on the outcomes of the North Dakota Dental Association's Medicaid outreach; efforts to encourage dentists to cover call hours at hospitals; and collaboration with the Indian Affairs Commission, Indian Health Service (IHS), and the State Board of Dental Examiners to streamline credentialing for dental providers on reservations and regarding the recognition of state licensing by tribes and IHS. He said the North Dakota Dental Association initiatives regarding Medicaid include the "Take Five More" program which challenged dentists to see five more Medicaid patients in a week, a month, or a year. He said 75 dentists have responded to date. He said the North Dakota Dental Association is also helping dental offices navigate the administrative changes related to the Department of Human Services' Medicaid management information system upgrade deployed last October. He said dentists from across the state formed a Medicaid advisory committee last summer to meet with the Department of Human Services quarterly and discuss provider issues and solutions. He said barriers to dental care for Medicaid recipients include limited availability of dental providers, low reimbursement rates, administrative burden for providers, lack of understanding by beneficiaries about dental benefits, missed dental appointments, transportation, cultural attitudes, language competency, fear, and lack of knowledge about the importance of oral health. He said removing barriers will require the collaboration of all stakeholders, including the dental community, state government, public health entities, and patients.

Dr. Chahal said Family HealthCare Dental Services in Fargo has an agreement with Sanford Emergency Center to serve any dental pain patients within the next day. He said the Red River Valley Dental Access Project in Fargo serves as a backup to this coverage with a weekly walk-in clinic for free humanitarian relief of dental pain provided by 45 volunteer dentists. He said Dr. Katie Stewart has initiated a process to set up a similar system in Bismarck. He said a meeting was held with Sanford Health physicians to discuss possible solutions to reduce the number of dental emergency room visits and how to refer patients to a local dentist. He said Bismarck area dentists discussed the prospect of piloting a local emergency room diversion plan and the recruitment of volunteers. He said the group plans to meet with the dental director of the nonprofit organization Bridging the Dental Gap to gauge the level of commitment to a diversion program similar to Family HealthCare in Fargo and present a proposal to Sanford Health.

Dr. Chahal said credentialing of IHS dental professionals has been identified as a barrier to providing an adequate dental workforce for not only IHS dentists that are assigned to the Great Plains Area, but also to local dentists that wish to volunteer or contract their services with a tribe. He said working with the Great Plains Area IHS in Aberdeen, South Dakota, the the North Dakota Dental Association developed a memorandum of understanding with that office to outsource their credentialing process with the goal of accelerating the process and making it less of a barrier in recruiting workforce. He said this project also included a service to match dental professionals with not only IHS clinic opportunities but also with needs that other nonprofit dental clinics might have in the state. He said current administrative challenges within the Great Plains Area IHS have delayed implementation of the credentialing project. He provided a map showing the distribution of the potential volunteers and potential sites. He said 67 dentists, 8 dental assistants, and 7 hygienists responded to the volunteer or contracted services survey. He said the Great Plains Area IHS officials in Aberdeen, South Dakota, confirmed that if a dentist or dental hygienist is working in an IHS clinic, they only need to be licensed in good standing in any state. He said they do not need a license from the state where the IHS clinic is located. He said dentists, hygienists, or assistants working in a tribally contracted Pub. L. 93-638 clinic, not affiliated with IHS, must comply with state licensure requirements. He said dental assistants can be hired by IHS clinics without any certification or registration.

Ms. Rita Sommers, Executive Director, State Board of Dental Examiners, provided information (Appendix F) regarding collaboration with the North Dakota Dental Association, IHS, and the Indian Affairs Commission to streamline credentialing for dental providers on reservations and regarding the recognition of state licensing by tribes and IHS. She said the credentialing of dentists, dental hygienists, and dental assistants practicing anywhere in the state, except on or within military installations or IHS facilities on reservations, is the responsibility of the State Board of Dental Examiners. She said dental professionals seeking employment in IHS dental clinics are credentialed through the regional IHS office in Aberdeen, South Dakota, and may be licensed in any state. She said dental professionals serving in IHS and military dental clinics are not governed by North Dakota law, but must comply with federal guidelines with regard to scope of practice. She provided a list of dental professionals employed in IHS clinics in the state, including whether or not they are licensed in North Dakota.

In response to a question from Representative Paur, Ms. Sommers said the tribes and IHS could recognize any licensure they choose, including a licensed dental therapist.

Ms. Marsha Krumm, President, North Dakota Dental Assistants Association, provided information (Appendix G) regarding expanded function dental assistant language approved by the State Board of Dental Examiners, including information regarding how the changes will improve access to dental services for underserved populations and in rural areas of the state and continuing education requirements for dental assistants and related costs. She said the

State Board of Dental Examiners approved an expansion of the duties of registered dental assistants in April 2015. She said NDAC Chapter 20-01-01 was amended to define the extent of the expanded duties and to clarify the definition of contiguous and direct supervision. She said a registered dental assistant must apply for and receive a permit from the State Board of Dental Examiners to perform the expanded duties. She said there is currently no program in the state that would enable a registered dental assistant to meet the training and education requirements necessary to perform the expanded functions. She said North Dakota State College of Science in Wahpeton, and Northwest Technical College in Bemidji, Minnesota, are each developing the necessary curricula at their respective campuses. She said the closest program is at the University of Minnesota School of Dentistry. She said the 80-hour program is delivered in three phases and costs $2,895. She said training for dental assistants interested in supporting anesthesia is available through the American Association of Oral and Maxillofacial Surgeons' Dental Anesthesia Assistant National Certification Examination.

Ms. Krumm said the expanded function dental auxiliary is critical to improving access to care for underserved populations. She said 71 percent of dental assistants and 18 percent of dental hygienists utilize their restorative function permit in Minnesota. She said the most cited reasons for nonutilization is a lack of delegation by the dentist or the individual's primary focus is dental hygiene. She said when dentists are willing to delegate certain restorative functions, productivity and efficiency increase and practices serve more patients, generating higher gross billings and net incomes. She said the expanded functions result in a 67 percent increase in access to care. She said in addition to the increased productivity and efficiency, when the level of delegation is high, the practicing dentist's stress is reduced. She said research also indicates expanded functions increase access to screening, preventative services, and parent and caregiver education, improving oral health outcomes for underserved populations and increasing the percentage of Medicaid-enrolled children receiving preventative, diagnostic, and treatment dental services.

Ms. Judy Bernat, President, North Dakota Dental Hygienists' Association, provided information (Appendix H) regarding expanded function dental hygienist language approved by the State Board of Dental Examiners, including information regarding how the changes will improve access to dental services for underserved populations and in rural areas of the state, and continuing education requirements for dental hygienists and related costs. She said the recently expanded scope of practice for registered dental hygienists includes expanded restorative functions. She said dental assistants and registered dental hygienists are allowed to perform a very limited range of reversible clinical procedures under the direct supervision of a licensed dentist, including the placement and adjustment of a limited classification of restorative materials once a dentist has removed the dental disease or otherwise prepared the teeth and the adaptation and cementation of stainless steel crowns. She said other states utilizing the restorative function auxiliaries have demonstrated increased office production while maintaining high quality of care. She said the credentialing of restorative expanded functions addresses a small component of the access issue by increasing office efficiencies in services already provided. She said while the expanded functions auxiliary credentialing has been advocated by the the North Dakota Dental Association as a means to address the access to care issues within the state, in an informal survey at the North Dakota Dental Hygienists' Association's spring meeting indicated none of the dental hygienists in attendance had been approached by their employing dentist or office manager regarding the education or utilization of these expanded functions.

Ms. Bernat said the State Board of Dental Examiners requires passing the Western Regional Examining Board's (WREB) restorative functions examination or other board-approved test to verify competency. She said there are 10 WREB restorative functions examinations scheduled in 2016--8 of these are either in the state of Washington or Oregon, 1 is in Alaska, and 1 is in Idaho. She said the cost is $440 plus a school use fee for the examination, not including the cost of transportation, lodging, and meals. She said the candidates must supply all restorative armamentarium for the placement, carving, and finishing of one class II amalgam and one class II composite restoration. She said candidates are tested and must prove competency on a restoration that they are not able to perform in North Dakota. She said registered dental hygienists welcome the opportunity to expand their scope of practice and to work to the fullest extent professional licensure allows; however, in the case of restorative functions auxiliaries, the accepted language, along with the educational and testing requirements are a barrier to care. She said because the expanded services are limited to placement of the restoration under the direct supervision of a dentist, if there is no dentist in the area, the service can not be provided. She said with nearly one-half of the dentists reportedly planning to retire within the next 15 years, the struggle to find supervision will compound access-to-care issues. She said states such as Washington and Oregon have had restorative functions auxiliaries for decades, but are also struggling with access-to-care issues. She said these states are reviewing the dental hygiene-based mid-level provider model available in Minnesota. She said the North Dakota Dental Hygienists' Association suggests the committee consider a proposal for a mid-level oral health practitioner to allow for the full scope of care, including tooth preparation and placement of the restoration.

In response to a question from Chairman Lee, Ms. Bernat said the expanded restorative functions recently approved by the State Board of Dental Examiners must be done under direct supervision with the dentist onsite,

therefore, an expanded function auxiliary could not provide restorative functions at a school without a dentist present.

Ms. Andrea Olson, Executive Director, Community Action Partnership of North Dakota, provided information (Appendix I) regarding dental health care needs identified in a needs assessment survey conducted as part of a community services block grant program. She said the Community Action Partnership of North Dakota consists of 7 community action agencies across the state, serving all 53 counties. She said programs include Head Start, the Weatherization Assistance Program, Sportsmen Against Hunger, and Volunteer Tax Assistance. She said community action agencies are primarily funded by community services block grant funding, allocated through a funding formula based on poverty, through the Department of Commerce. She said last year the Community Action Partnership of North Dakota, along with the Department of Commerce, conducted a needs assessment that solicited information related to low-income issues such as employment support, emergency services, child and family development, and any other miscellaneous needs identified in communities. She said dental service was the second highest miscellaneous need identified statewide. She said expanding the scope of practice of dental hygienists would benefit low-income populations and would prevent them from seeking expensive emergency care.

Mr. Ken Kompelien, Dean, Arts, Science and Business Division, North Dakota State College of Science, said the North Dakota State College of Science is in the process of developing an online and hybrid version of the dental assisting program and is collaborating with Williston State College and Bismarck State College to bring the dental assisting program to the central and western parts of the state. He said some of the dental assisting courses have been developed and are being delivered in an online format and others are in the process of being developed.

In response to a question from Chairman Lee, Mr. Kompelien said the North Dakota State College of Science continues to discuss the college's role in providing the education for expanded function auxiliaries and mid-level dental providers with the dental community and is willing to serve the needs of the state in those areas.

DEATH INVESTIGATION AND FORENSIC PATHOLOGY CENTER STUDY

Mr. Kirby Kruger, Medical Services Section Chief, State Department of Health, provided information (Appendix J) regarding the availability of cold storage for decedents across the state; an update on the stakeholder group established by the State Department of Health, including information regarding the development of a system approach to death investigation, a regional death investigation system framework, and statewide standards for death investigation; responsibilities of the State Forensic Examiner; and ways to improve statewide standards for death investigation and to develop a system approach to death investigation and a regional death investigation system framework. He said the State Department of Health and the University of North Dakota School of Medicine and Health Sciences (UNDSMHS) Department of Pathology facilities can store up to 10 and 30 decedents, respectively. He said in addition to storage available at the State Department of Health and the UNDSMHS Department of Pathology facilities, 18 facilities reported functioning cold storage for up to 94 decedents for a total capacity of 134 decedents. He said the stakeholder group feels education for county coroners and local and state law enforcement is important. He said the group also believes county coroner functions should be more standardized. He said the stakeholder group reviewed progress made on updates to the electronic vital events records system. He said the updates will ensure non-natural deaths are referred to a coroner. He said a subgroup of the stakeholder group is also reviewing hospital policies with regard to the retention of patient's blood samples.

Ms. Connie Kadrmas, Deputy Coroner, Stark County and Billings County, provided information (Appendix K) regarding the responsibilities of local coroners and ways to improve statewide standards for death investigation and to develop a system approach to death investigation and a regional death investigation system framework. She said the coroner meets law enforcement at the scene, determines which agencies are involved, receives an initial verbal report, and assists as needed. She said the coroner reviews evidence, discusses possible organ procurement, ensures death notification, investigates witnesses, maintains scene safety, pronounces time of death, develops diagrams to reconstruct the scene, provides proper equipment, identifies the number of fatalities, maintains dignity of the deceased, safeguards personal property, determines whether the scene matches the injuries, and if the case should be evaluated by the medical examiner. She said the State Forensic Examiner provides guidance on which cases should be forwarded for autopsy. She said the examination of the deceased includes obtaining a toxicology kit, identifying features, estimating the time of death, determining the manner of death, collecting and identifying evidence on the body, and identifying physical characteristics and traumatic injuries. She said the coroner also obtains the medical and social history of the deceased. She provided copies of death investigation forms, a *Report of Coroner's Investigation* form, a death certificate, a *Request for Examination/Autopsy* form, and the United States Department of Health and Human Services *Sudden Unexplained Infant Death Investigation Reporting Form*. She said coroners may also counsel family members or others at the scene.

In response to a question from Senator Anderson, Ms. Kadrmas said when there are multiple fatalities, victims may be identified initially by clothing. Dr. William Massello, III, State Forensic Examiner, said the medical examiner relies on scars, tattoos, dental records, x-ray comparisons, fingerprints, and in some cases, DNA analysis to identify the body.

In response to a question from Representative Seibel, Ms. Kadrmas said if hospitals were more informed of federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy rules, the release of a decedent's medical records to the medical examiner would be more efficient.

Dr. Joshua Wynne, Dean, University of North Dakota School of Medicine and Health Sciences, provided information regarding an update on the UNDSMHS advisory council's collaboration with the State Department of Health and the UNDSMHS Department of Pathology on ways to improve death investigation in the state, especially with regard to how autopsy services relate to population health. He said the committee has requested the advisory council undertake a death investigation and forensic pathology study with regard to statewide services, polices, and needs. He said the advisory council has agreed to conduct the study and will hold a planning meeting in May. He said a subcommittee would gather data, survey stakeholders, and summarize the subcommittees findings. He said the advisory council would schedule a public meeting in September to review the findings of the subcommittee and solicit testimony from stakeholders and the public. He said the advisory council would analyze all of the data and testimony and prepare a report with the findings of its study and any recommendations no later than October 31, 2016. He said appropriate portions of the report could be incorporated into the fourth biennial report on health issues of the state which is prepared jointly by UNDSMHS and the advisory council and distributed to legislators and other stakeholders prior to the legislative session. He said the advisory council is willing to conduct the study, but requests the Health Services Committee provide guidance with regard to its expectations and timing. He said, assuming the scope of the requested study is in alignment with the expectations and the proposed plan of the advisory council, no additional funding would be required.

Chairman Lee said representatives of the State Department of Health and the UNDSMHS Department of Pathology have shared with the committee the need for improvements in death investigation and autopsy services, especially in the rural areas of the state. She said the issues to be reviewed and studied by the committee are more than the committee has time to address in the remaining months of the interim. She said although the committee may not make a recommendation with regard to the study, the information gathered during the advisory council's study may be valuable during the legislative session.

In response to a question from Representative Fehr, Dr. Wynne said the majority of the advisory council is not under the control of UNDSMHS and he does not perceive a conflict of interest.

In response to a question from Representative Paur, Dr. Wynne said that while the advisory council is willing to assist the committee, the council does not have the insight or the expertise to frame the question. Dr. Wynne said there are experts who could help the committee define the questions to be asked of the advisory council.

Dr. Mary Ann Sens, Chair, Department of Pathology, University of North Dakota School of Medicine and Health Sciences, provided information regarding questions that could be addressed by the UNDSMHS advisory council's death investigation study; a review of the department's recommendations relating to the development of a system approach to death investigation, a regional death investigation system framework, and statewide standards for death investigation; and framework for a peer-review committee. She said the presentation by Ms. Kadrmas revealed how medical care of the deceased intersects with emergency response and future health planning. She said a workgroup has been formed to evaluate the need for a statewide reporting and review system for drug abuse. She said there is a need for specialized education. She said the Ebola outbreak emphasized the need for a statewide plan for highly contagious and deadly diseases. She said the advisory council may approach the health care workforce aspect of death investigation by reviewing the health care resources of the state, how they would meet the needs of the state under various circumstances, and how they could be improved. She said the state has invested in a death investigation system and there is an enormous amount of data available in the system.

Dr. Sens said education is very important and, in addition to a low-cost course available online, the State Forensic Examiner has been working with first responders, law enforcement, and coroners in communities across the state.

Chairman Lee suggested the advisory council study could address ways to:

- Improve education;
- Provide consistency statewide in autopsy services and the circumstances under which autopsies are performed;

- Use data obtained from death investigation to identify trends and improve population health and safety; and
- Develop a plan for mass fatality and pandemic situations.

In response to a question from Senator Warner, Dr. Sens said there is an increasing number of national organizations that collect data. She said North Dakota is one of a few states that do not participate in the Centers for Disease Control and Prevention's death reporting system. She said federal funding is available to participate in this standardized reporting system. She said it may be time to review the possibility of participating in these national reporting systems. Mr. Kruger said the federal grant currently offered by the Centers for Disease Control and Prevention is competitive and the department must evaluate whether or not the state will meet the criteria to be competitive before undertaking the application process.

In response to a question from Senator Anderson, Mr. Kruger said the stakeholder group has identified some things the department can improve, including education and coordination with coroners.

In response to a question from Senator Anderson, Mr. Kruger said the department is exchanging data with the UNDSMHS Department of Pathology regarding deaths that have occurred in each of the counties. Mr. Kruger said certain infectious diseases are required to be reported, but overdose data may not be captured consistently.

In response to a question from Senator Oehlke, Mr. Kruger said the state has a plan for a mass fatality incident and will exercise the plan in the fall. Mr. Kruger said the state and federal government would be available to assist the county. Dr. Sens said the State Forensic Examiner is authorized by statute to take charge of the deceased, but the advisory council may able to review the current plans and offer input. Dr. Massello said the State Department of Health and the State Forensic Examiner are well prepared with regard to equipment and manpower to handle a large disaster. He said the exercise in September 2016 will identify any weaknesses.

In response to a question from Senator Wardner, Mr. Kruger said, if identified, the death certificate would include information regarding drug overdose deaths. Dr. Sens said the death certificate is very specific with regard to all of the drugs found in the body; however, drugs are missed in those deaths that are not recognized and investigated.

In response to a question from Senator Anderson, Mr. Kruger said HIPAA permits the sharing of medical data for death investigation. Dr. Massello said state statute also supports providing the medical data for death investigation.

Representative Paur suggested Mr. Kruger coordinate with the stakeholders and work with the advisory council to develop a list of items to be reviewed by the advisory council.

The Legislative Budget Analyst and Auditor said the committee should receive the approval of the Chairman of the Legislative Management to request the assistance of an outside entity such as the advisory council. He said the motion should be to request the Legislative Management Chairman ask the advisory council to assist with the study.

Chairman Lee suggested the stakeholders provide input with regard to the items reviewed by the advisory council. She said the recommendations should move the current system forward in a way that provides data and procedures that are appropriate for today's needs.

In response to a question from Chairman Lee, Mr. Kruger said the stakeholder group has met several times over the course of the last few years and has reviewed several issues. Mr. Kruger said, in his opinion, most of what the stakeholder group has identified can be addressed by education. He said the department could review the minutes of the stakeholder group's meetings and condense the items discussed into a summary to be provided to the advisory council or he could convene the stakeholder group to develop a list of pointed questions to be addressed by the advisory council.

Chairman Lee said near-death experiences as a result of drug overdose are not reported. She said there should be a system in place so that complete data can be available for overall population health.

Chairman Lee suggested the stakeholder group share its information with the advisory council. She suggested the advisory council review the information with a plan for a system that would enhance population health and make recommendations, if appropriate.

Dr. Wynne suggested the advisory council convene in May and invite the stakeholder group to present its information. He said the group could summarize and sort the issues with regard to administrative, legislative, or educational. He said the advisory council could provide feedback, or perhaps short-term and long-term direction.

Ms. Arvy Smith, Deputy State Health Officer, State Department of Health, said the department has access to data including drug overdose data which is different than the autopsy data. She said the department collects ambulance run data and can receive hospital discharge data for a fee. She said it takes resources to pay for and manage the data.

It was moved by Senator Anderson, seconded by Senator Heckaman, and carried on a voice vote that the committee request the Chairman of the Legislative Management to request the University of North Dakota School of Medicine and Health Sciences advisory council review options to improve the gathering and use of data from death certificates to enhance the population health of the state and report its findings and recommendations to the Health Services Committee.

Senator Anderson said the stakeholder group is addressing death investigation and coroner education.

In response to a question from Senator Warner, Mr. Kruger said all childhood fatalities are reviewed but he is not aware of any comprehensive review of adult deaths that would identify as those resulting from a drug overdose.

Chairman Lee requested the Legislative Council staff review whether there are any statutory requirements to report drug overdoses, fatal or otherwise.

OTHER COMMITTEE RESPONSIBILITIES

Dr. Patricia Moulton, Executive Director, North Dakota Center for Nursing, provided information (Appendix L) regarding the nursing workforce in the state, including information regarding nursing education, supply, and demand. She said there are 16 nursing education programs in the state, including preparation for licensed practical nurses (LPN), registered nurses (RN), advanced practice nurses and other graduate education programs. She said 1,803 individuals applied for 990 practical nurse and registered nurse program admission slots during the 2013-14 academic year. She said in 2014 North Dakota had more LPNs and RNs per 1,000 people than the national average; however, these professionals are not evenly distributed throughout the state with the greatest concentration being in the major cities and in the eastern portion of the state. She provided information regarding the number of nurses in the state by county. She said in 2015, North Dakota had 706 nurse practitioners compared to 407 in 2010; 321 certified registered nurse anesthetists compared to 286 in 2012; 55 clinical nurse specialists, with the greatest number of clinical nurse specialists located in Cass County; 17 certified nurse midwives, with the greatest number of certified nurse midwives located in Cass and Ward Counties. She said assuming retirement at age 67, an estimated 27.9 percent of LPNs, 21.1 percent of RNs, and 25.4 percent of advanced practice nurses will retire by 2026. She said from July 1, 2014, to June 30, 2015, according to Job Service North Dakota, there was an average of 111.8 LPN jobs available per month. She said there was an average of 511 RN jobs and 60.2 nurse practitioner jobs available per month during the same period. She provided information regarding statewide average salaries for LPNs, RNs, nurse practitioners, nurse anesthetists, and nurse midwives. She said while there are regional differences in salary, statewide LPN, RN, and nurse practitioner salaries have been below the national average for the last 5 years.

Chairman Lee said a unified nursing school application would allow individuals, not accepted into their first choice nursing program, to be considered by another program with available slots.

Dr. Wynne provided information regarding how the University of North Dakota and the North Dakota State University can collaborate to increase the health care workforce. He said he is collaborating with Dr. Charles D. Peterson, Dean, College of Health Professions, North Dakota State University, to assess health care workforce needs in the state. He said UNDSMHS is currently implementing a health care workforce initiative to address many of the health care workforce challenges in the state. He said the health care workforce initiative has focused on those health care professions trained at UNDSMHS; however, the health care workforce includes other important health care providers, including nurses, pharmacists, advanced practice providers, addiction counselors, and others. He said the North Dakota Hospital Association has organized a task force to study some of the health care professional workforce issues. He said the task force will develop a more coordinated and comprehensive statewide plan for health care workforce that will complement the health care workforce initiative, especially with regard to nurses, including advanced practice providers, and behavioral health professionals. He said the initial focus will be short term and will include those initiatives task force members can implement. He said the task force will report on measures implemented.

Ms. Jane Myers, Diabetes Program Director, State Department of Health, provided information (Appendix M) regarding an update on a report by the Department of Human Services, State Department of Health, Indian Affairs Commission, and Public Employees Retirement System on their collaboration 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. She said agency representatives shared information and

examined data on the prevalence of diabetes and its financial impact. She said the committee reviewed the status and benefits of current diabetes-related programs, funding, and collaborative efforts among agencies. She said the committee identified action plans and recommendations to improve health outcomes in the state related to diabetes. She said the draft report of *Diabetes in North Dakota 2016* is currently being reviewed and will be submitted to the Legislative Council by the June 1, 2016, deadline. She said type 2 diabetes can be prevented with behavior changes at the individual level and at the population level. She said agencies must collaborate to enact and support policies that make the healthy choice the default choice. She said those living with diabetes need policies that support the proper care and management of the disease in order to prevent costly complications and to improve the quality of life. She said 49,000 adults in the state have diabetes and 202,000 have prediabetes. She provided a summary of current efforts to address diabetes in the state including programs provided through the State Department of Health, Department of Human Services, and the Public Employees Retirement System. She said the report contains a number of goals and strategies to reduce diabetes in the state, including:

- Improve access to the diabetes prevention program by increasing the number of sites where the program can be administered, personal awareness of prediabetes risk factors and self referral to the program, medical provider referral to the program, and training opportunities for lifestyle coaches;
- Improve the quality of life for those with diabetes by promoting the use of accredited diabetes self-management education programs and offering continuing education for heath professionals; and
- Leverage chronic disease initiatives through partnerships and coalition building by promoting collaboration among state agencies and with those working to prevent chronic diseases in the community.

Ms. Karol K. Riedman, Former Chief Audit Executive, Office of Internal Audit, State Department of Health, provided information (Appendix N) regarding a report (Appendix O) on the department's health professional assistance program study. She said 2015 House Bill No. 1036, approved by the Legislative Assembly, required the State Department of Health to study health professional assistance programs and report to the Legislative Management. She said the study was to include the identification of state programs to assist health professionals, consideration of whether elements of the identified state programs could be standardized, evaluation of funding and usage of the identified state programs, evaluation of the effectiveness of these identified programs and how these programs could be revised to be more effective, and consideration of whether there are gaps or duplication in programs designed to assist health professionals. She said after House Bill No. 1036 was approved, existing loan repayment programs were revised and combined into the two new loan repayment programs--the dentists loan repayment program, which combined three prior dental programs, and the health care professional student loan repayment program, which replaced two prior programs. She said the health care professional student loan repayment program assists physicians and mid-level practitioners, as well as behavioral health practitioners. She said the new programs assist health care professionals by repaying student loans of licensed, practicing professionals who provide health care to underserved areas or populations. She said the study identified four additional state programs relating to health professional financial assistance:

- Department of Commerce workforce development program, which awards a grant to provide a program encouraging youth to consider health professions;
- Bank of North Dakota addiction counselor internship loan program;
- Professional student exchange program, which subsidizes out-of-state tuition for professional programs not available in North Dakota; and
- Department of Human Services nonprofit clinic dental access project, which grants funds to a nonprofit clinic for the purpose of assisting in the repayment of dental providers' student loans.

Ms. Riedman said the study evaluated whether the dentists loan repayment program and the health care professional student loan repayment program could be standardized. She said while the programs are similar, differences include the amount and timing of award payments, the description of priority and preference in applicant criteria, community match requirements, years of service obligations, and penalties for failing to fulfill the contract. She said if criteria were standardized, the two programs could be simplified and combined into a single state loan repayment program, which would save administrative time and costs, and provide continuity between assistance programs. She said the two programs were funded at a similar level during the 2015-17 biennium--$720,000 for the dentists loan repayment program and $698,800 for the health care professional student loan repayment program. She said because nearly all of the loan repayment positions are filled each year, the programs have been successful in bringing health care and dental professionals to underserved communities. She said since 1993, 89.5 percent of program participants fulfilled their contracts. She said the percent of program participants remaining in underserved communities after their contract has been fulfilled varies by provider and length of time since the end of the contract. She said for those whose contract ended 5 or less years ago, the retention rate was 76.5 percent for physicians, 60 percent for mid-level providers, and 58.3 percent for dentists. She said for those

whose contract ended more than 5 years ago, the retention rate was 45 percent for physicians, 92.3 percent for mid-level providers, and 47.4 percent for dentists. She said overall, 61.6 percent of participants have remained in an underserved area.

Ms. Riedman said the loan repayment programs would be more effective if additional funding were made available to increase the number of positions in underserved communities. She said increased communication, encouragement, and support to providers and their families would encourage more providers to continue to practice in underserved areas. She said the only gap noted in the study was that some health care professions are not eligible for the loan repayment program. She said there is interest in including optometry, pharmacy, chiropractic, and registered nursing programs to the health care professionals receiving loan repayment benefits. She said other states in the region include nursing instructors; dental hygienists; marriage and family therapists; heath care social workers; medical and laboratory technicians; physical, occupational, speech, and respiratory therapists; dieticians; and paramedics in their assistance programs. She said except for the Department of Human Services' nonprofit dental access grants project that is somewhat similar to the State Department of Health's dentist loan repayment program, the study did not identify any other duplications between state programs. She said the State Department of Health suggests combining the dentists loan repayment program and the health care professional student loan repayment program into a single loan repayment program, standardizing program terms, and expanding the program to include other health care professions.

Mr. Tom Nehring, Director, Division of Emergency Medical Systems, State Department of Health, provided information (Appendix P) regarding a report on the progress made toward the recommendations provided in NDCC Section 23-43-04, relating to continuous improvement of quality of care for individuals with stroke and any recommendations for future legislation. He said the North Dakota stroke system was created in 2009 to establish a comprehensive, coordinated, efficient system, along the continuum of health care for individuals suffering a stroke. He said the program is administered by the Division of Emergency Medical Systems and stroke partners, including the American Heart Association, critical access hospitals, tertiary hospitals, the North Dakota Emergency Medical Services Association, and the State Department of Health's Division of Chronic Disease. He provided a summary of responsibilities assigned to the State Department of Health in NDCC Section 23-43-04 and the department's activities related to its responsibilities and the continuous improvement of quality of care for individuals with stroke. He said there are 24 critical access hospitals and 6 tertiary hospitals in the stroke registry and others are expected to join. He said data is shared at quarterly stroke task force meetings and at regional critical access hospital quality meetings where it is used by the stroke task force to make recommendations for interventions to improve stroke care delivery in the state. He said some of the additional improvements in the stroke system include:

- All six tertiary hospitals in the state are now primary stroke centers;
- 22 of 36 critical access hospitals are designated as acute stroke ready hospitals;
- The Division of Emergency Medical Systems has contracted with the North Dakota Emergency Medical Services Association to offer stroke education to all North Dakota emergency medical services providers;
- The Division of Emergency Medical Systems collaborates with primary stroke center coordinators to provide education to critical access hospitals;
- Each emergency medical services provider will soon be required to submit detailed stroke transport plans;
- The stroke protocols will address the transport of acute stroke patients to the nearest stroke designated hospital within a specific time of onset of symptoms; and
- Last year the Division of Emergency Medical Systems created a stroke campaign, and materials from the campaign continue to be used in public education efforts across the state.

Mr. Nehring said in 2010 emergency medical services providers gave advanced notification to the destination hospital of a potential stroke patient being transported from the scene in only 56 percent of cases. He said in 2015 hospitals received advance notification 77.4 percent of the time compared to 55.9 percent nationally. He said the percentage of acute ischemic stroke patients who arrived at the hospital within 2 hours of the time the patient was last known to be without the signs and symptoms of the current stroke, and for whom intravenous thrombolytic therapy was initiated within 3 hours of the time the patient was at his or her prior baseline, increased from 30.9 percent of patients that qualified in 2010, to 80 percent of eligible patients in 2015.

In response to a question from Representative Rohr, Mr. Nehring said there has not yet been a significant improvement in mortality rates from stroke. Mr. Nehring said although some hospital designations are only 6 months old, there is improvement with regard to morbidity.

In response to a question from Representative Porter, Mr. Nehring said initially the department was not receiving hospital discharge data so it is still too early to assess patient discharge outcomes. Mr. Nehring said the information regarding morbidity and mortality is in the database and can be reported at a later date.

In response to a question from Chairman Lee, Mr. Nehring said some of the remaining 14 of the 36 critical access hospitals may never be designated as acute stroke ready hospitals, because computed tomography (CT) scans are required and some facilities may never implement the technology. Mr. Nehring said another 10 critical access hospitals may receive the designation.

Ms. June Herman, Regional Vice President of Advocacy, American Heart Association, provided information (Appendix Q) regarding continuous improvement of quality of care for individuals with stroke. She said North Dakota is a model, regionally and nationally, for its progress in establishing a system based on quality of care performance measures. She said the state's statutes are a national model and she does not believe any changes are necessary at this time. She said stakeholders continue to monitor developments including the expansion of telemedicine coverage, first responder capacity in rural areas, brain injury definition, and funding to maintain the state's investment in the stroke system.

At the request of Chairman Lee, the Legislative Council staff presented a memorandum entitled *Survey of Agency Alcohol, Drug, Tobacco, and Risk-Associated Behavior Prevention and Treatment Programs* regarding funds appropriated for prevention or treatment programs relating to risk-associated behavior, including whether programs relate to prevention, treatment, or enforcement of risk-associated behavior. The Legislative Council staff said the memorandum includes a summary of actual funding spent during the 2013-15 biennium and funding budgeted for the 2015-17 biennium for programs relating to prevention and treatment of alcohol, tobacco, and drug abuse and other kinds of risk-associated behavior which are operated by various state agencies. The Legislative Council staff said funding for programs is summarized by prevention, treatment, or enforcement. The Legislative Council staff said of the $144.7 million budgeted for the prevention and treatment of alcohol, tobacco, and drug abuse and other kinds of risk-associated behavior during the 2015-17 biennium, $44.3 million (30.6 percent) relates to prevention, $86.5 million (59.8 percent) relates to treatment, and $13.9 million (9.6 percent) relates to enforcement.

In response to a question from Senator Heckaman, the Legislative Council staff said the 2015-17 biennium budgeted amounts were reported based on agency appropriations prior to the Governor's February budget allotments.

Chairman Lee said the next committee meeting is tentatively scheduled for Wednesday, July 27, 2016.

It was moved by Representative Mooney, seconded by Representative Fehr, and carried on a voice vote that the meeting be adjourned. No further business appearing, Chairman Lee adjourned the meeting at 4:20 p.m.

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Sheila M. Sandness
Senior Fiscal Analyst

ATTACH:17