**2026 JOINT POLICY**

**SB 2401**

# 2026 JOINT STANDING COMMITTEE MINUTES

**Policy Committee**
Pioneer Room, State Capitol

SB 2401
1/21/26

| |
|---|
| Relating to physician continuing education requirements; to provide a statement of legislative intent; and to provide an effective date. |

10:49 a.m. Co-Chairman Lee called the meeting to order.

Members Present: Co-Chairman Senator Lee, Co-Chairman Ruby, Senators Boschee, Clemens, Cory, Gerhardt, Hogan, Kessel, Myrdal, Powers, Roers, Rummel, Van Oosting, Walen, Weston, Representatives Beltz, Davis, Dobervich, Dressler, Frelich, Heinert, Jonas, Klemin, Novak, Porter, Rohr, Vollmer, Weisz.

**Discussion Topics:**

- Per-capita funding
- Out of State coverage
- Frontier Counties
- Physician Education
- Tribal Liaisons

10:49 a.m. Emily Obrien, Deputy Commissioner of the North Dakota Department of Health and Human Services testified in favor and presented testimony #45434.

11:00 a.m. Dirk Wilke, Executive Director of Public Health for North Dakota Health and Human Services, testified in neutral.

11:06 a.m. Courtney Peterson, Deputy CEO for North Dakota Health and Human Services testified in neutral.

11:17 a.m. Krista Fremming, Assistant Director of Medical Services at North Dakota Department of Health Services testified in neutral.

11:46 a.m. Courtney Peterson Executive Director of North Dakota Medical Association answered committee questions.

**Additional written testimony:**

Donna Aukland submitted testimony in neutral #45434.

*Andrew Ficek, Committee Clerk*

# Rural Health Transformation Program

## Joint Policy and Appropriations Committees

## January 21, 2026

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# ND HHS North Star

- HEALTHIEST CITIZENS ON THE PLANET
- MODEL OF EFFICIENCY AND EFFECTIVENESS
- HEALTHIEST, HIGHEST PERFORMING TEAM

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# North Dakota Rural Health Transformation Program (RHTP) Award

**Year 1: Federal Fiscal Year 2026**

**Award Amount: $198.9MM**

- Year 1 Award received on December 29, 2025.
- Future Awards determined by the Centers for Medicare and Medicaid Services (CMS) based on a state's progress in successful implementation.

**LINKS:**

ND Rural Health Transformation Website

Sign up for RHTP Announcements Here!

CMS Award Notice

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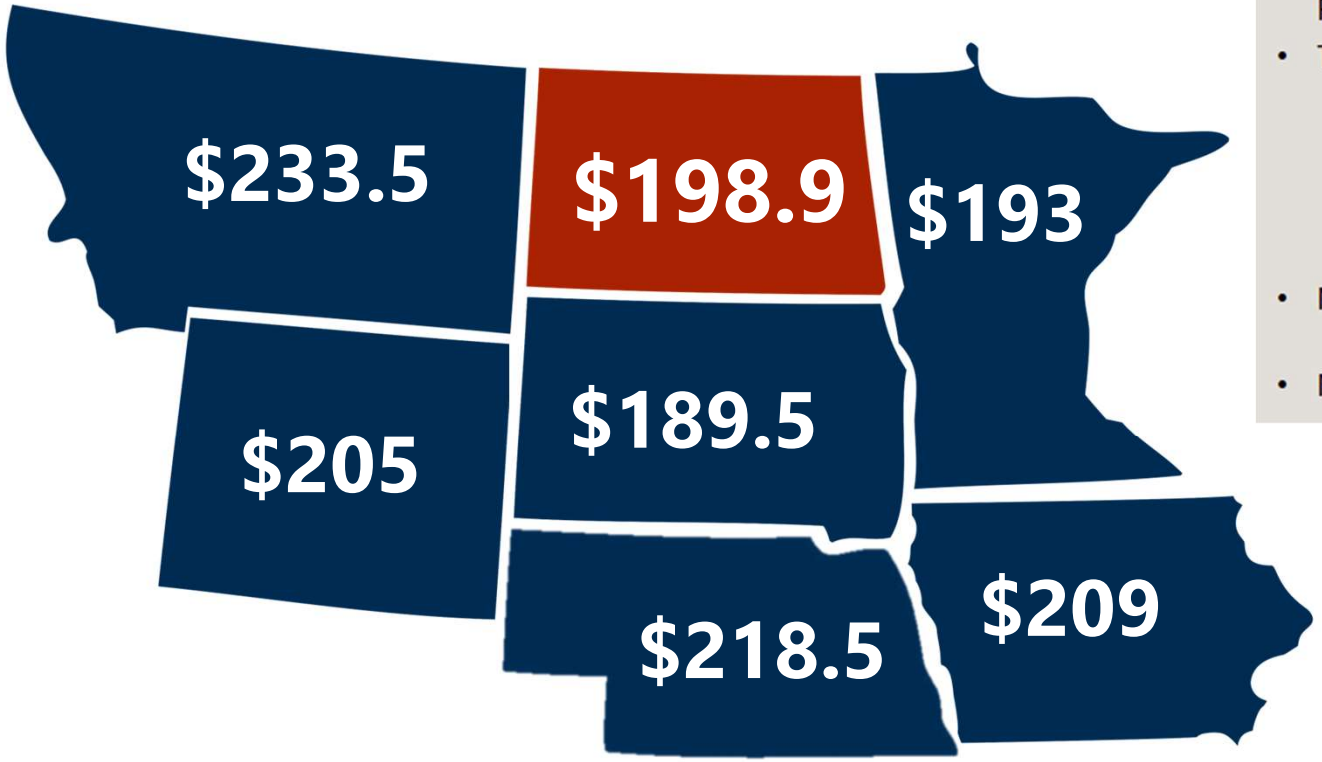
# How does North Dakota's award compare?

**in millions**




## National Context

- All 50 states awarded RHTP funds.
- Top Awards:
  - Texas | $281.3 Million
  - Alaska | $272.2 Million
  - California | $233.6 Million
  - Montana | $233.5 Million
  - Oklahoma | $223.5 Million
- Minimum Award Amount:
  - New Jersey | $147.3 Million
- North Dakota's Year 1 Award ranks 29 out of 50.

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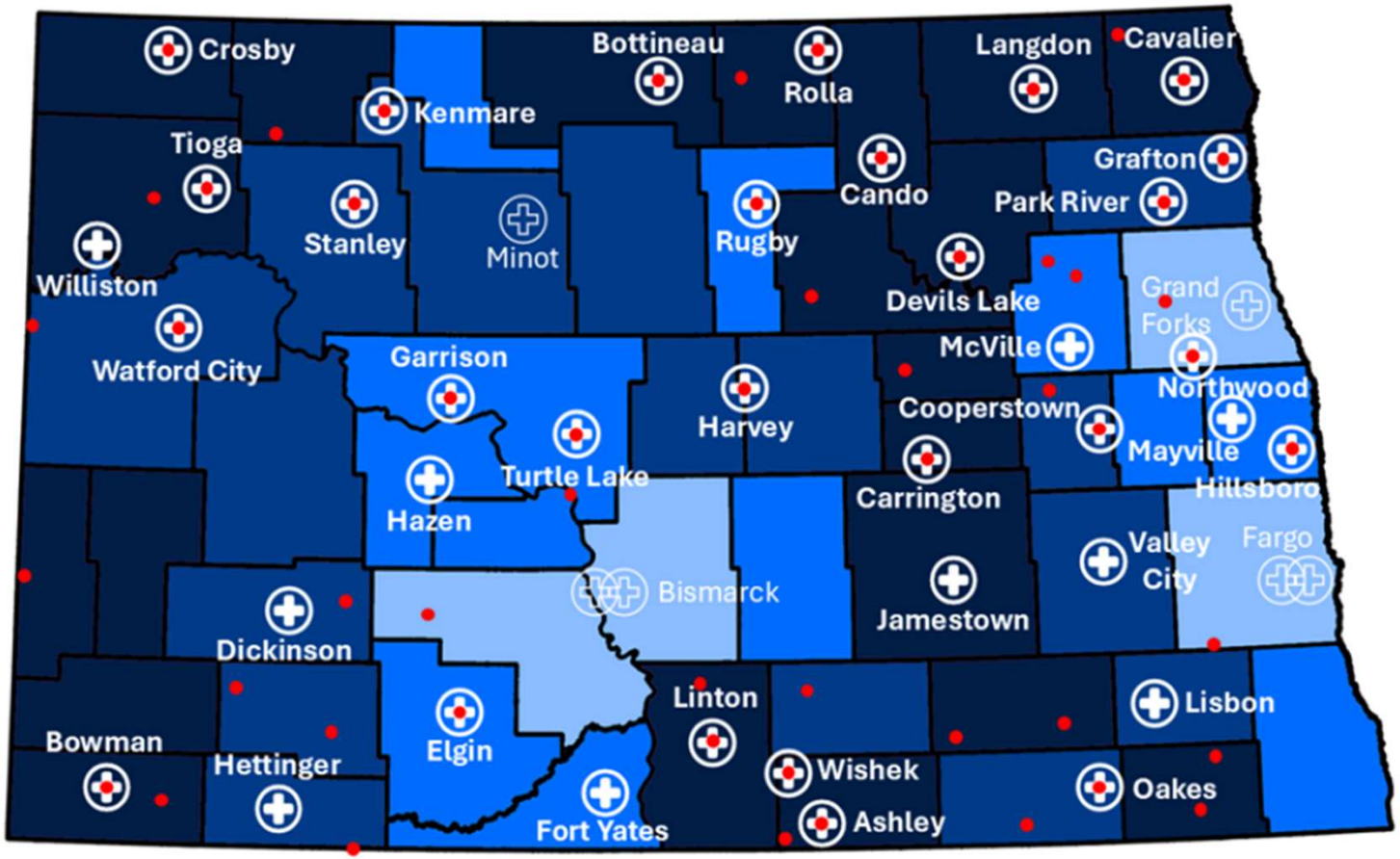
# Critical Access Hospitals & Rural Health Clinics




- Partially Rural
- Entirely Rural
- Partially Frontier
- Entirely Frontier
- Critical Access Hospital
- Urban Referral Center
- Rural Health Clinic

Center for Rural Health
University of North Dakota
School of Medicine & Health Sciences

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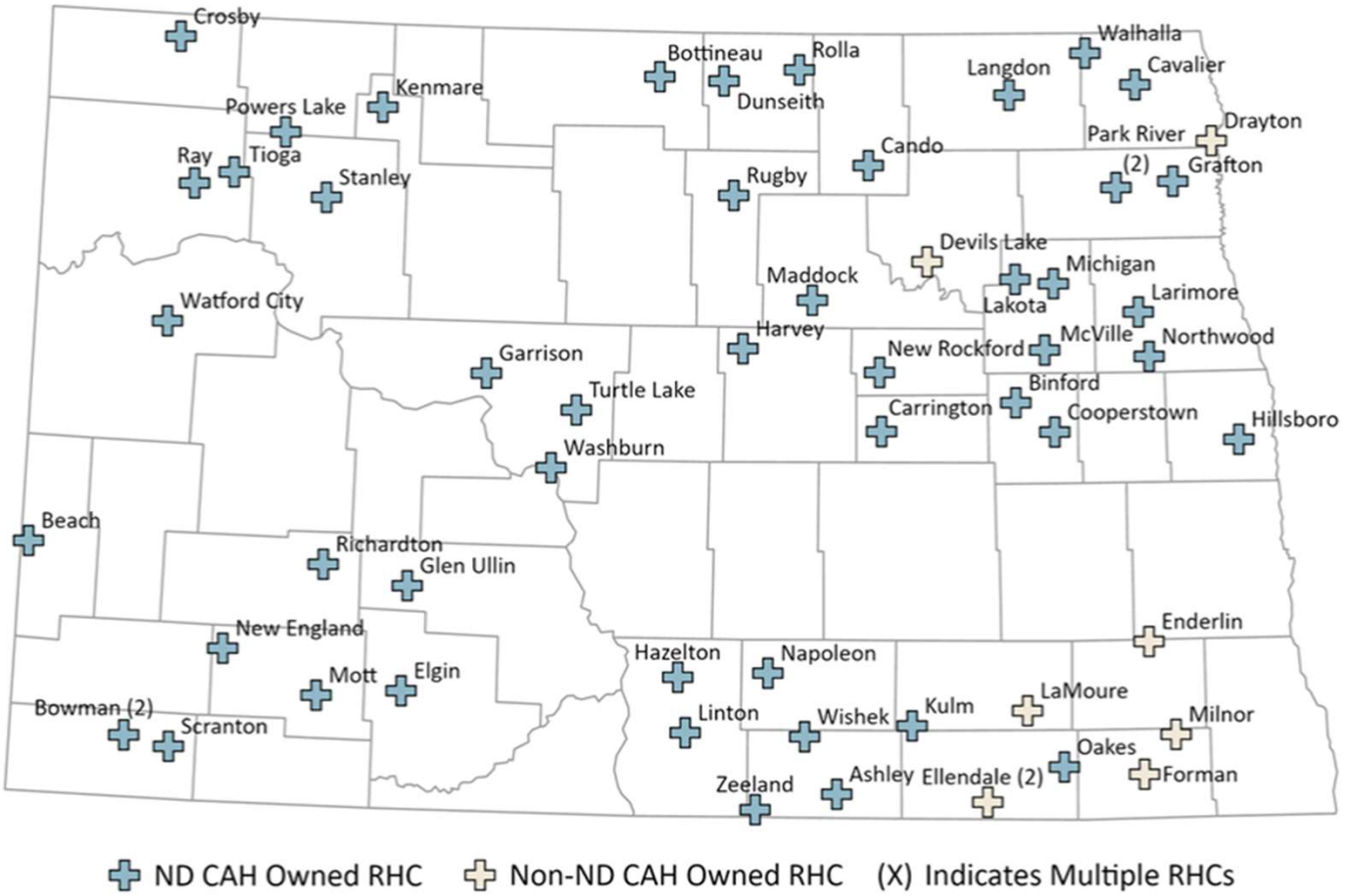
# North Dakota Rural Health Clinics, 2025




NORTH DAKOTA Rural Health Clinic NETWORK

Center for Rural Health
University of North Dakota School of Medicine & Health Sciences

*Sources: HHS.ND.gov, data.HRSA.gov, June 2025.*
*Created by the North Dakota Healthcare Workforce Group*
*June 2025*

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## Locations with North Dakota Critical Access Hospital-Owned Rural Health Clinics:

- Ashley
- Beach
- Binford
- Bottineau
- Bowman (2)
- Cando
- Carrington
- Cavalier
- Cooperstown
- Crosby
- Dunseith
- Elgin
- Garrison
- Glen Ullin
- Harvey
- Hazelton
- Hillsboro
- Kenmare
- Kulm
- Lakota
- Langdon
- Larimore
- Linton
- Maddock
- McVille
- Michigan
- Mott
- Napoleon
- New England
- New Rockford
- Northwood
- Oakes
- Park River (2)
- Powers Lake
- Ray
- Richardton
- Rolla
- Rugby
- Scranton
- Stanley
- Tioga
- Turtle Lake
- Walhalla
- Washburn
- Watford City
- Wishek
- Zeeland

## Locations with Non-North Dakota Critical Access Hospital-Owned Rural Health Clinics:

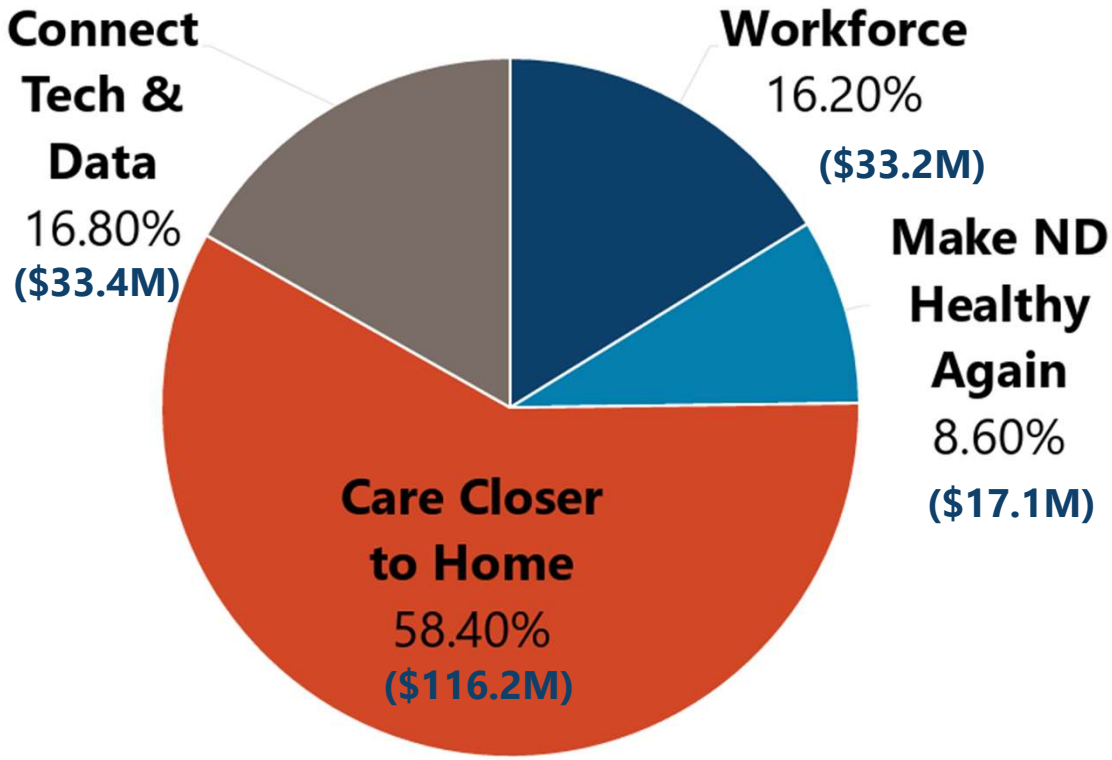
- Devils Lake
- Drayton
- Ellendale (2)
- Enderlin
- Forman
- LaMoure
- Milnor

# Guaranteeing Success

- RHTP Leadership
- Coordinators for each initiative
- RHTP Tribal Liaison
- Accounting / Procurement
- Compliance / Legal
- Behavioral Scientists
- Data Analysts
- Consultants / Technical Assistance
- Communication / Education Specialists
- Evaluators
- Diet, Exercise and Workforce Experts

**Note:** Dedicated full-time employees, temporary staff, or contracted resources as needed to ensure timely delivery, accountability, and completeness. HHS will not increase the number of FTE in the block grant.

# Preliminary Funding Allocations By Initiative




**Note:** Initiative allocations above reflect **estimates** which will vary based upon provider readiness, project implementation guidelines, and CMS approval.

# Strategic Priorities and Key Themes

## Strengthen and Stabilize Rural Health Workforce

- Expand Rural Healthcare Training Pipelines
- Improve Retention in Rural and Tribal Communities
- Use Tech as Extender for Rural Providers
- Provider TA and Training for Existing Workforce

## Bring High-Quality Health Care Closer to Home

- Rightsizing Rural Health Care Delivery Systems for the Future
- Coordinating and Connecting Care
- Clinics without Walls
- Sustaining Revenue
- Ensuring Safety Net Service Delivery
- Ensuring Transportation

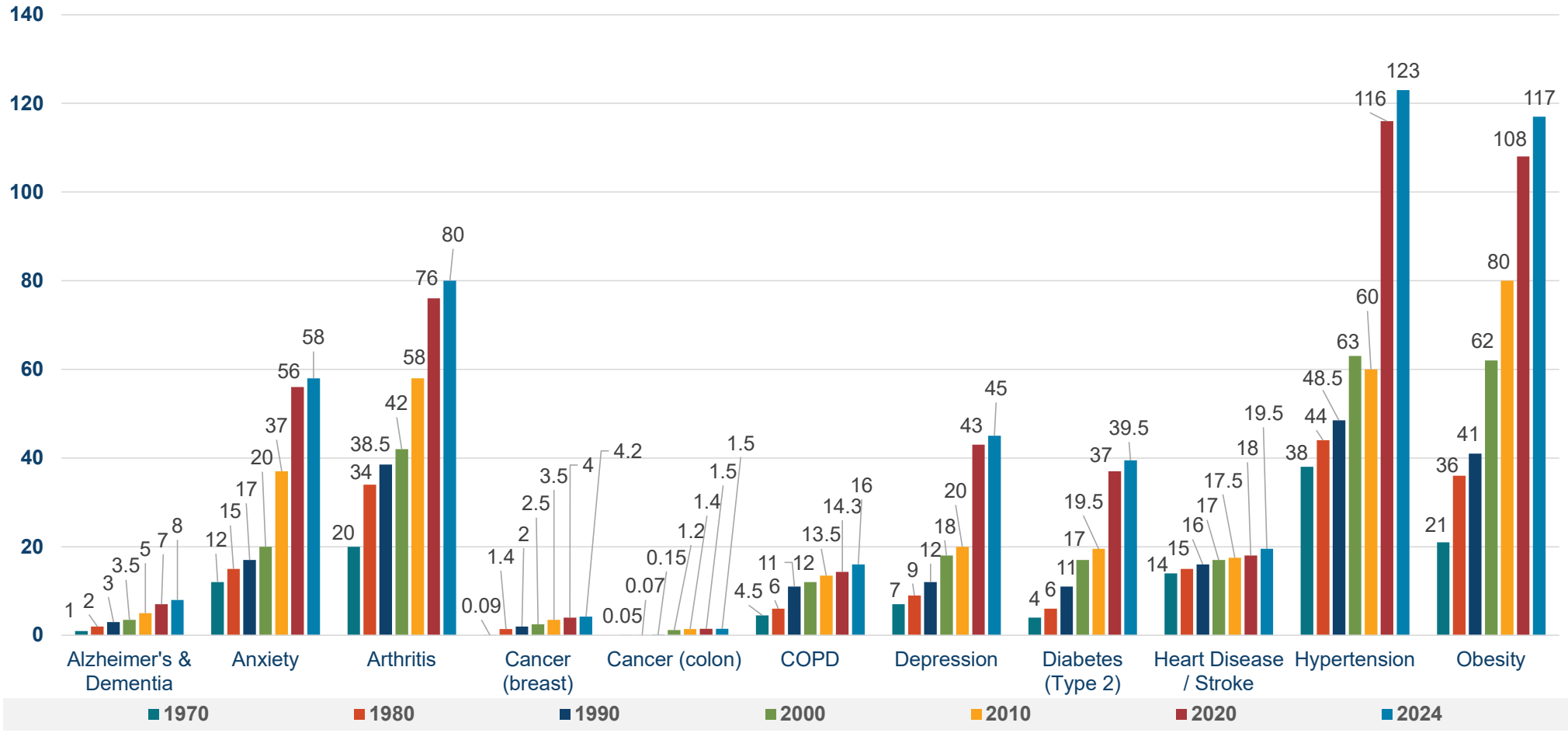
## Make ND Healthy Again

- Building Connection and Resiliency
- Eat Well North Dakota
- Investing in Value
- ND Moves Together

## Connect Tech, Data and Providers for a Stronger ND

- Cooperative Purchasing for Tech and Other Infrastructure
- Breaking Data Barriers
- Harnessing AI and New Tech

## U.S. Adults (18+) Living with Major Chronic Conditions, 1970-2024 (in Millions)*

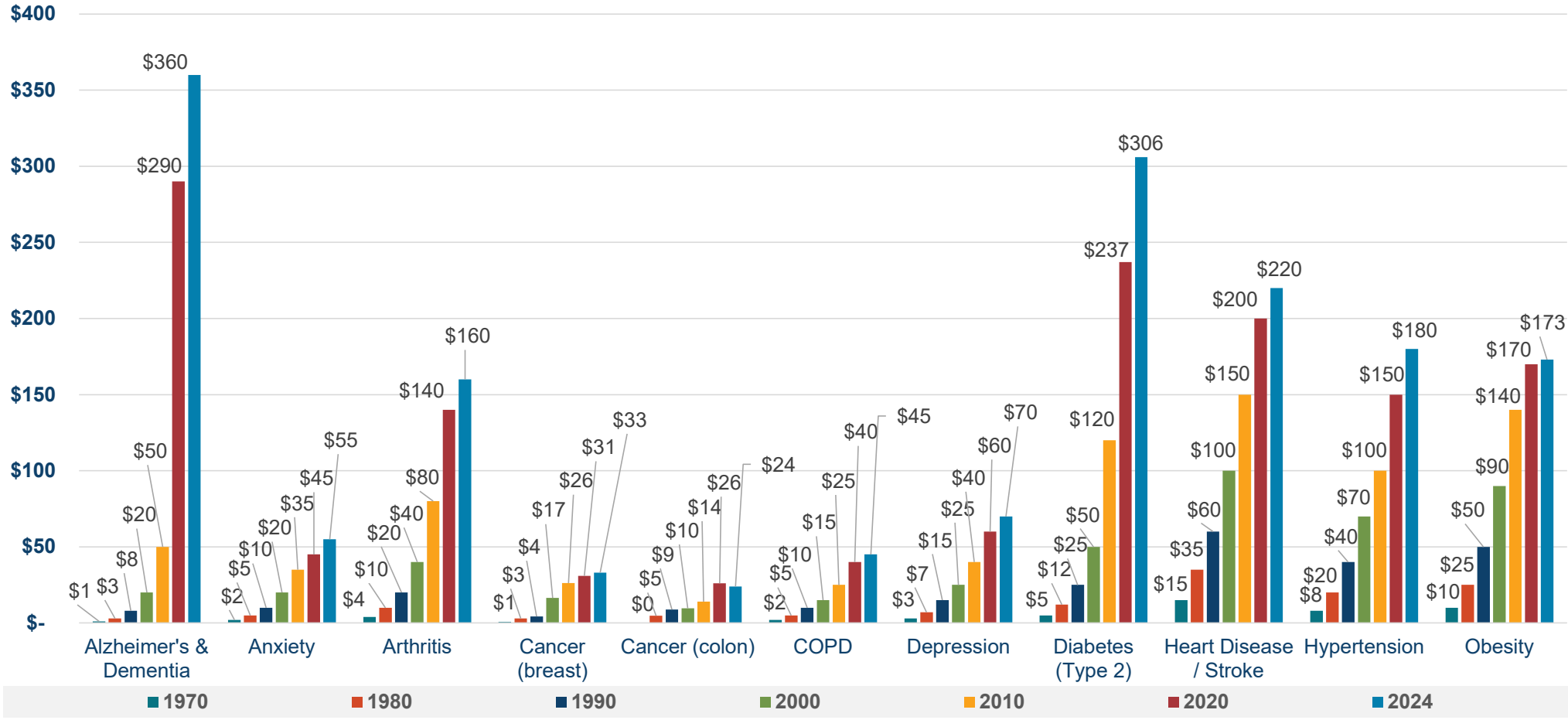



**Source Citation**

The figures are primarily derived from data collected through national health surveys, specifically the **National Health Interview Survey (NHIS)** and the **Behavioral Risk Factor Surveillance System (BRFSS)**, which are analyzed and published by the Centers for Disease Control and Prevention (CDC) and the National Institutes of Health (NIH).

***DRAFT** – Under review of ND DHHS, December 2025.*

# Annual Direct Healthcare Costs by Chronic Condition for U.S. Adults (18+), 1970-2024 (in Billions)*




**Source Citation**

These figures are primarily based on analyses from the National Cancer Institute (NCI) and data from the Centers for Disease Control and Prevention (CDC).

***DRAFT** – Under review of ND DHHS, December 2025.*

# North Dakota Stats

## Deaths and Chronic Disease in ND:

- Heart disease and cancer are the leading causes of death in North Dakota.
- About 71% of North Dakota adults are classified as overweight (BMI ≥ 25-29.9; 35% of those classified are considered obese (BMI ≥ 30).
- 240,000 North Dakotans have high blood pressure.
- Approximately 1 in 5 in North Dakota are affected by heart disease and stroke risk factors
- 58,000 North Dakotans have Type 2 Diabetes; 183,000 have pre-diabetes.
- There are almost 4,000 new cases of cancer diagnosed in ND each year.

***DRAFT** – Under review of ND DHHS, January 2026.*

# ND MOVES TOGETHER

## The single most impactful thing Americans could do to prevent chronic diseases:

Become and stay physically active – specifically, meet the full Physical Activity Guidelines (150+ minutes moderate aerobic plus 2+ days strength training per week).

| OUTCOME | RISK REDUCTION FROM REGULAR PHYSICAL ACTIVITY | SOURCE |
|---|---|---|
| Diabetes (Type 2) | 30-58% reduction | CDC, Diabetes Prevention Program |
| Heart Disease / Stroke | 30-40% reduction | AHA, NHS England meta-analysis |
| Hypertension | 30-50% lower incidence | ACSM position stand |
| Obesity | 30-50% lower risk of obesity | NIH / WHO |
| Colon Cancer | 24-40% reduction | NCI / IARC |
| Breast Cancer | 12-30% reduction | ACS |
| Depression | 20-35% reduction | JAMA Psychiatry |
| Anxiety | 25-35% reduction | Lancet Psychiatry |
| Dementia / Alzheimer's | 28-45% reduction | HHS Physical Activity Guidelines |
| All-cause Mortality | 19-35% reduction | Multiple studies |

If every Americans did only one thing, getting 30-40 minutes of brisk walking (or equivalent) most days plus two short strength sessions per week would prevent more heart disease, diabetes, cancer, depression, and dementia than any drug, diet, or policy ever invented.

**The Tragedy: Only ~24% of U.S. adults currently do it – and it's essentially free.**

# ND EATS WELL

Below is a clear, evidence-based breakdown of how diet (*independent of physical activity*) impacts the top chronic health conditions in America. A healthy diet impacts risk reduction, prevention, or disease progression.

| OUTCOME | RISK REDUCTION CONSUMING A HEALTHY DIET | SOURCE |
|---|---|---|
| Diabetes (Type 2) | 30-50% reduction | The Lancet, NHS \| HP Follow-up Study |
| Heart Disease / Stroke | 20-40% reduction | NEJM |
| Hypertension | 25-50% lower incidence | NEJM |
| Obesity | 30-60% lower risk of obesity | Cell Metabolism |
| Colon Cancer | 30-40% reduction | WCRF/AICR |
| Breast Cancer | 9-14% reduction | WCRF/AICR |
| Depression / Anxiety | 20-30% reduction | BMC Medicine |
| Dementia / Alzheimer's | 20-35% reduction | Alzheimer's & Dementia |
| Chronic Kidney Disease | 20-40% | CJASN |
| All-cause Mortality | 23-30% reduction | NHANES |

**Important framing:** Diet affects chronic disease through inflammation, insulin sensitivity, blood pressure, cholesterol, gut microbiome, and body weight. For several conditions, diet is one of the strongest modifiable risk factors.

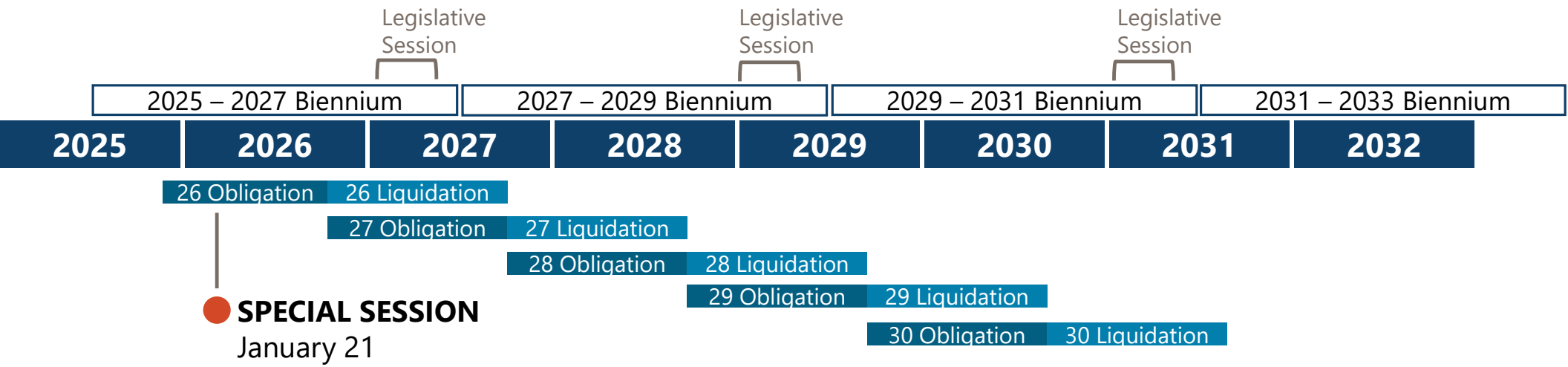
*Above ranges commonly cited by the CDC, NIH, American Heart Association, American Cancer Society, and large cohort studies.*

# Funding Timeline

| Grant Year | Baseline Funding Amount | Workload Funding Amount | Award Year Start Date | Obligation Deadline | Liquidation Deadline |
|---|---|---|---|---|---|
| FFY 2026 | $100,000,000 | $98,936,970 | 12/29/2025 | 10/30/2026 | 9/30/2027 |
| FFY 2027 | $100,000,000 | TBD | 10/31/2026 | 10/30/2027 | 9/30/2028 |
| FFY 2028 | $100,000,000 | TBD | 10/31/2027 | 10/30/2028 | 9/30/2029 |
| FFY 2029 | $100,000,000 | TBD | 10/31/2028 | 10/30/2029 | 9/30/2030 |
| FFY 2030 | $100,000,000 | TBD | 10/31/2029 | 10/30/2030 | 9/30/2031 |

# Authorization of Funding

- Funding will span 4 biennia.
- HHS will request authority through regular legislative appropriations process in future biennia.



# Continued / Future Funding Guidelines

- Conditional on recipient satisfactory performance
  - Process in implementing initiatives approved by CMS
    - Adherence to the implementation plan and timeline
    - Process on self-imposed performance metrics
  - Progress in implementing State policy actions
  - Accurate, complete, comprehensive, and timely submission of quarterly and annual progress report
  - Quality and timely communication with CMS
  - CMS will recalculate recipient's technical score and corresponding workload funding amount for subsequent budget periods
- CMS can decrease, recover funding or terminate an award if requirements not met.
- CMS will redistribute unexpended or unobligated funds in the nearest following fiscal year using the same structure to recalculate technical score
- HHS is allowed to seek prior approval to revise budget and program plans throughout the award year

# Unallowable Costs and Limits

**10% - $19.89MM** Cap on Admin Costs Across All Funding

- Pre-award costs.
- Meeting matching requirements for any other federal funds or for local entities.
- Services, equipment or supports that are the legal responsibility of another party under federal, State or tribal law.
- Supplanting existing State, local, tribal, or private funding of infrastructure or services.
- New construction, building expansion, or purchasing of buildings.
  - Renovations or alterations are allowed if they are clearly linked to program goals. Cannot include cosmetic upgrades or significant retrofitting of buildings.
  - Renovation or alterations cannot exceed **20% - $39.8MM** of total funding in budget period.
- Replacing payment(s) for clinical services that could be reimbursed by insurance.
  - Direct health care services may be funded if not currently reimbursable, will fill a gap in care coverage, and/or may transform current care delivery model.
  - Provider payments can't exceed **15% - $29.8MM** of total funding budget period.

# Unallowable Costs and Limits
*(continued…)*

**10% - $19.89MM** Cap on Admin Costs Across All Funding

- No more than **5% - $9.9MM** of total funding in a budget period can support funding the replacement of an electronic health record (EHR) system if a previous HITECH certified EMR is in place as of September 1, 2025.
- Funding toward initiatives similar to the "Rural Tech Catalyst Fund Initiative" cannot exceed the lesser of **10% - $19.89MM** of total funding or $20 million of total funding awarded in a budget period.
- Financial assistance to households for installation and monthly broadband internet costs.
- Clinician salaries/wages for facilities that subject clinicians to non-compete clauses.
- Meals and food.

# Anticipated Implementation Challenges

- Provider/Vendor readiness and ability to successfully deploy investments in RHT priorities
- Short timeframe for funding obligation and liquidation
- Detailed Federal review and approval of all awards
- Length of procurement, grant and contracting process
- Federal reporting
- IT Resources
- Communication of opportunities

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# Processes

HHS anticipates using several mechanisms to award funds:

| Direct Contracts | Grants | Requests for Bid (RFB) | Requests for Proposal (RFP) |
|---|---|---|---|

- Ensure funding is prioritized to benefit citizens in rural communities.
  - Internal/external subject matter expert collaboration.
- HHS intends to limit administrative burden as much as possible within the award process.

**Note:** Funding awards must be made in compliance with all federal award guidance and requirements. All sub-awards will be approved by CMS.

# Investment & Award Process Example


***Note:** Application & implementation technical assistance will be offered when necessary

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# Anticipated Funding Opportunities in Q1 2026

Subaward opportunities released on a rolling basis.

- Create workforce recruitment/retention grant opportunities for rural providers.
- Technical assistance, training, equipment and remodeling grants for providers filling a gap in the current service delivery system or expanding outreach and telehealth supports to underserved communities.
- Rightsizing service delivery for rural hospitals utilizing technical assistance and analytical consultants.
- Explore structure for a unified electronic health record (EHR) option for providers.

# Policy Provisions Related to RHTP Funding

***for the 5-year award period**

**Currently working with CMS to verify award allocations per state policy action**

- **Presidential fitness test**
  - Estimated 0.93% of total award **($9M)**
  - https://ndlegis.gov/sites/default/files/resource/miscellaneous/25.1383.01000.pdf
- **Nutrition continuing medical education**
  - Estimated 1.75% of total award **($17.5M)**
  - https://ndlegis.gov/sites/default/files/resource/miscellaneous/25.1384.01000.pdf
- **Physician assistant compact**
  - Estimated 0.35% of total award **($3.5M)**
  - https://ndlegis.gov/sites/default/files/resource/miscellaneous/25.1385.01000.pdf
- **Scope of practice for pharmacists**
  - Estimated 0.4% of total award **($3.9M)**
  - https://ndlegis.gov/sites/default/files/resource/miscellaneous/25.1386.01000.pdf

# How will HHS communicate about subaward opportunities?

- RHTP Webpage
- Email groups
  - RHTP Email Distribution
  - Tribal Consultation Email
- HHS Committees/Councils
  - Tribal Consultation
- Listening Sessions
- Legislative Committees

# Links:

- ND Rural Health Transformation Website
- Sign up for RHTP Announcements Here!

# Contact information


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Medical Services
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# 2026 JOINT STANDING COMMITTEE MINUTES

**Policy Committee**
Pioneer Room, State Capitol

SB 2401
1/21/2026

| |
|---|
| Relating to physician continuing requirements; to provide a statement of legislative intent; and to provide an effective date. |

12:34 p.m. Co-Chairman Lee called the meeting to order.

Members Present: Co-Chairman Senator Lee, Co-Chairman Ruby Boschee, Senator Clemens, Cory, Gerhardt, Hogan, Kessel, Myrdal, Powers, Roers, Rummel, Van Oosting, Walen, Weston, Representative Beltz, Davis, Dobervich, Dressler, Frelich, Heinert, Jonas, Klemin, Novak, Porter, Rohr, Vollmer, Weisz

**Discussion Topics:**

- Diabetes treatment
- Physician education
- Occupation Therapy Compact

12:34 p.m. Krista Fremming, Interim Director of Medical Services with the Department of Health and Human Services testified in favor and submitted testimony #45437.

12:37 p.m. Marvin Nelson testified in favor and submitted testimony #45411.

12:50 p.m. Senator Roers moved amendment LC#25.1384.01001.

12:50 p.m. Senator Myrdal seconded the motion.

12:50 p.m. Voice vote passed.

12:52 p.m. Senator Roers moved Do Pass as amended.

12:53 p.m. Representative Weisz seconded the motion.

| **Senators** | |
|---|---|
| Senator Judy Lee | Y |
| Senator Joshua Boschee | N |
| Senator David Clemens | N |
| Senator Claire Cory | Y |
| Senator Justin Gerhardt | Y |
| Senator Kathy Hogan | Y |
| Senator Greg Kessel | Y |
| Senator Janne Myrdal | Y |
| Senator Michelle Powers | Y |
| Senator Kristin Roers | Y |
| Senator Dean Rummel | Y |
| Senator Desiree Van Oosting | Y |
| Senator Chuck Walen | Y |

| | |
|---|---|
| Senator Kenton Weston | Y |

Motion passed 12-2-0.

| **Representatives** | |
|---|---|
| Representative Matt Ruby | Y |
| Representative Mike Beltz | Y |
| Representative Jayme Davis | Y |
| Representative Gretchen Dobervich | Y |
| Representative Ty Dressler | Y |
| Representative Kathy Frelich | Y |
| Representative Pat Heinert | Y |
| Representative Jim Jonas | Y |
| Representative Lawrence Klemin | Y |
| Representative Anna Novak | Y |
| Representative Todd Porter | AB |
| Representative Karen Rohr | Y |
| Representative Dan Vollmer | Y |
| Representative Robin Weisz | Y |

Motion passed 13-0-1

12:56 p.m. Senator Myrdal will carry the bill.

12:56 p.m. Representative Frelich will carry the bill.

12:56 p.m. Co-Chairman Lee closed the meeting.

*Andrew Ficek, Committee Clerk*

25.1384.01001
Title.02000

Prepared by the Legislative Council staff for Senator Roers
January 20, 2026

Sixty-ninth
Legislative Assembly
of North Dakota

**PROPOSED AMENDMENTS TO**

VC
1/21/26
1 of 3

**SENATE BILL NO. 2401**

Introduced by

Legislative Management

(Joint Policy Committee)

A BILL for an Act to create and enact a new subdivision to subsection 2 of section 12-60-24 of the North Dakota Century Code, relating to criminal history record checks by the board of occupational therapy practice; to amend and reenact section 43-17-27.1 of the North Dakota Century Code, relating to physician continuing education requirements; to provide a statement of legislative intent; and to provide an effective date.

**BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:**

**SECTION 1.** A new subdivision to subsection 2 of section 12-60-24 of the North Dakota Century Code is created and enacted as follows:

The board of occupational therapy practice for applicants, licensees, or investigations under chapters 43-40 and 43-40.1.

**SECTION 2. AMENDMENT.** Section 43-17-27.1 of the North Dakota Century Code is amended and reenacted as follows:

**43-17-27.1. Physician continuing education requirements.**

1. The board shall promote a high degree of competence in the practice of medicine by establishing rules requiring every physician licensed in the state to fulfill continuing education requirements. Compliance with these rules must be documented at such times and in such manner as is required by the board. Physicians failing to comply with continuing education requirements in the time and manner specified by rule of the board will be assessed a fee up to three times the licensure fee, in addition to such other penalties as are authorized by law.

VC

2 of 3

2. The board shall require physicians to complete a minimum of one hour of continuing education on nutrition and metabolic health each renewal cycle.

3. Before a license may be renewed, the physician shall submit evidence to the board establishing that all continuing education requirements prescribed by the rules adopted by the board have been met.

~~3.~~4. The board may accept current certification, maintenance of certification, or recertification by a member of the American board of medical specialties, the American osteopathic association, or the royal college of physician and surgeons of Canada in lieu of compliance with continuing education requirements.

~~4.~~5. The board may exempt a physician from the requirements of this section in accordance with rules adopted by the board.

~~5.~~6. Notwithstanding subsection 1, if an individual fails to file a timely response, the board may determine whether the individual's failure to file a timely response to an audit constitutes an admission of noncompliance with this section and whether the individual's license should be subject to action by the board. If the board determines that the individual's failure to file a timely response is an admission of noncompliance and that the individual's license should be subject to action by the board, the board shall hold a hearing in accordance with chapter 28-32 to take any appropriate action.

~~6.~~7. The board shall provide access on the board's website to an instructional course on chapters 12.1-19.1, 14-02.1, and 14-02.6 as the chapters relate to the practice of medicine. The instructional course must be developed by contract through the office of management and budget, in consultation with and with final approval from the attorney general. This section does not create a right of action against the board by a physician acting upon reliance of the instructional course. The instructional course must be updated periodically to accurately reflect state law.

**SECTION 3. LEGISLATIVE INTENT - HEALTH OCCUPATION BOARDS TO CONSIDER REQUIRING COMPLETION OF NUTRITION-RELATED CONTINUING EDUCATION.** It is the intent of the sixty-ninth legislative assembly that health-related occupation boards under title 43 consider requiring licensees to complete nutrition-related continuing education for the prevention and reduction of chronic disease.

VC

3 of 3

**SECTION 4. EFFECTIVE DATE.** This Act becomes effective upon its filing with the secretary of state.

## REPORT OF STANDING COMMITTEE
## SB 2401

**Joint Policy Committee (Sen. Lee, Co-Chairman)** recommends **AMENDMENTS (25.1384.01001)** and when so amended, recommends **DO PASS** (12 YEAS, 2 NAYS, 0 ABSENT OR EXCUSED AND NOT VOTING). SB 2401 was placed on the Sixth order on the calendar. This bill does not affect workforce development.

## REPORT OF STANDING COMMITTEE
## SB 2401

**Joint Policy Committee (Rep. M. Ruby, Co-Chairman)** recommends **AMENDMENTS (25.1384.01001)** and when so amended, recommends **DO PASS** (13 YEAS, 0 NAYS, 1 ABSENT OR EXCUSED AND NOT VOTING). SB 2401 was placed on the Sixth order on the calendar.

Testimony on SB2401, Joint Policy Committee. Special Session 1/21/2026

Good Morning, I am writing in support of adding continuing education in diet and metabolism.

The report on Diabetes presented to the Legislature claims 90% of health care spending is on metabolic conditions, not surprising since close to 90% of adults show at least one sign of metabolic syndrom, and under current treatment, typically conditions are chronic and progressive. The five indicators are visceral obesity, hypertension, insulin resistance, high triglycerides, and low HDL cholesterol.

If we look at insulin resistance, that is the body producing more than the normal amount of insulin in order to keep blood sugar under control, many conditions are either directly caused or strongly linked. This includes type 2 diabetes when blood sugar is no longer controlled, neurological disorders like neuropathy, but also mental health disorders, fatty liver, high blood pressure, weight gain, polycystic ovarian syndrome, kidney disease, stroke, cardiovascular disease, and some cancers to name a few.

If we look at type 2 diabetes, less than 1% following American Diabetes Association guidelines have put their diabetes into remission, blood sugars below diabetic levels without drugs for a period of time.

I went through this myself. I was diagnosed the last day of January, 690 blood sugar, Hba1c of 14.5, as high as their tester would go. Spent several days in the hospital on what seemed to be the never ending pasta bowl. Still had blood sugars over 300. Told I had a chronic progressive disease, told not to eat saturated fat or salt, and plenty of carbs to couteract the 80 units of insulin I was on. No carbs and the insulin would likely kill me.

I went home, saw Dr. Sarah Hallberg's Ted Talk.
https://www.youtube.com/watch?v=da1vvigy5tQ&t=9s

Started following her and ran into the Low Carb Down Under group of videos. They were rather unusual because they gave scientific references. Was sure interesting to hear of people cancelling knee replacements, controlling their sleep apnea, losing weight, and my focus, remission of diabetes. Controlling carbohydrates and fasting were the most effective treatments.

Only took three days to know what to do, and with the help of my continuous glucose monitor I started to taper carbs and insulin with the goal of blood sugar below 110. By the time I met the Endocrinologist a week after leaving the hospital, my blood sugars were below 100. I tapered such that by the end of February, I was using no insulin and having normal, nondiabetic blood sugars. At six weeks I gave myself a glucose challenge and according to that I wasn't even prediabetic.

Almost right from the start I was coming of drugs. I had puffy ankles for a long time. About a week into the taper I had ankles, a few days later I had to stop the diuretic. My knees hurt less without Celebrex than before with Celebrex. My lungs improved. And that brings up an

important point, insulin resistence is a state of inflammation. Inflammation is associated with all kinds of health problems.

Some people assume a ketogenic diet is bad for heart health. I have had two coronary arterial calcification scans 4 ½ years apart and plaque is low and more importantly, not progressing. Diabetics die from heart disease at an amazing rate.

But enough about me, I just show it is possible to do it, in a short time, starting from no knowledge. It is sad that many doctors have never seen a patient of theirs go into remission but that is becoming more rare because people aren't all waiting for doctors to catch up anymore.

I would also note that managing diabetes through diet is not only the most effective control, but costs a lot less, this just from the drugs not directly used for treatment of the diabetes. There are many other gains in health and productivity.

I tried to get this studied by the legislature when I was a Representative but it was rejected in the Senate. Not doing this has cost the PERS plan millions and the people of ND much more. I realize not every person would do it, but currently, they aren't even offered the option.

I would point to Dr. David Unwin in the UK. His medical practice went from one of the most expensive to one of the lowest cost when he offered a keto diet option to patients with about 70% choosing the diet, and diabetic drugs are cheap in the UK compared to here. He has published results about half of his patients which get 10 minute appointment once in awhile and he doesn't get to pick them have their diabetes in remission. Isn't that something standard care in US less than 1% while a general practitioner gets 50% and of course the other improve as well, just not reach remission. And kidney disease in his patients improves.
https://pubmed.ncbi.nlm.nih.gov/34468402/

I would also point to Virta Health who also use a ketogenic diet to treat diabetes. They are so confident their fees are at risk if clients do not see positive results. They have shown they are more effective than standard care at lower cost. And their most recent annual report with results currently in publication in scientific journals that in addition to improving blood sugar control, they reduced hearth attacks, strokes, and deaths but over 50% in their patients with diabetes. No drug offers that.
https://www.virtahealth.com/reversal-report

Once tapered, I basically followed what is refered to as the page 4 diet because it fit on page 4 of the handout of the Duke University no sugar no starch diet. Dr. Eric Westman at Duke has used it for many years for successful weight loss along with diabetes. He wrote a book, "End your Carb Confusion" that goes into more depth and tells you how to find your carbohydrate tolerance long term.
https://sites.duke.edu/dukeoutpatientclinic/files/2024/01/No-Sugar-No-Starch-Eating-Plan-Handout-DLWMC-2022-04-04.pdf

This is but one example. One thing that has caused me a lot of sadness is I don't know a medical

doctor I can refer diabetics to for help with remission in North Dakota. They aren't trained to do it. I had signs of elevated insulin for years, skin tags, and acanthosis nigricans, no medical provider said anything, they don't seem to be trained to recognize skin signs or what to do about it.

I would also point out that health insurance in North Dakota does not cover the most effective lowest cost treatment of diabetes or prevention of diabetes. In other states, many do. Many self insured businesses use it, and while I point to Virta Health because they are nationwide. They are not the only provider offering real health improvement through diet. There is no reason North Dakotans aren't offered this care by North Dakota Providers except lack of knowledge and lack of coverage.

I believe a lot of the problem in rural North Dakota is healthcare isn't really provided, instead it is disease management. Once people have something serious happen, they get referred or hauled to one of the bigger centers and their rural providers are pretty welll left out of the loop after that. The rural hospitals operating largely as a feeder system.

Thing in 1900 about 1 ind 10,000 hospital patients had diabetes. In 1960 it was close to 2% and today it is very close to 10% and other metabolic conditions have exploded as well. It bankrupts a lot of people and potentially the whole country, causes premature deaths and produces years of illness. The anwers are largely available if we get them in the hands of our providers, hopefully they don't get an hour of education in maintaining the status quo.

Thank you.

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**Testimony**
**Senate Bill No. 2401**
**Joint Policy Committee**
**Senator Judy Lee and Representative Matthew Ruby, Co-Chairman**
January 21, 2026

Chairman Lee and Chairman Ruby, and members of the Joint Policy Committee, I am Krista Fremming, Interim Director of Medical Services with the Department of Health and Human Services. I appear before you in support of Senate Bill No. 2401, which was introduced as part of North Dakota's Rural Health Transformation Program, requiring physicians to complete continuing education on nutrition and metabolic health.

Nutrition is foundational to health and well-being, playing a critical role in preventing and managing chronic diseases such as diabetes, cardiovascular disease, and obesity. Physicians are often the first point of contact for patients seeking guidance on health, and their ability to understand evidence-based nutrition and provide appropriate advice and referrals is essential for improving patient outcomes.

This bill ensures that every physician licensed in North Dakota will benefit from a better understanding of nutrition and metabolic health, which in turn benefits patients and communities across our state. By requiring at least one hour of continuing education on nutrition and metabolic health each renewal cycle, we are taking a meaningful step toward improving the quality of care and promoting preventative healthcare.

It is important to note that this initiative was supported by the interim Rural Health Transformation Committee and incorporated into North Dakota's Rural Health Transformation Program application. The state was awarded points and approximately $17.5 million for the 5-year grant based on the intention to pass this requirement. Following through on this commitment is critical to advance the goals of rural health transformation and retain awarded funds.

I urge the legislative assembly to support Senate Bill No. 2401 to ensure that North Dakota physicians are equipped with the knowledge necessary to guide patients toward healthier lives. Thank you for your consideration and for your commitment to improving health outcomes in our state.

This concludes my testimony. I would be happy to try to answer any questions the committee may have.