HEALTH SERVICES COMMITTEE

The Health Services Committee was assigned the following responsibilities:

1. Senate Concurrent Resolution No. 4004 (2015) provided for a study of dental services in the state, including the effectiveness of case management services and the state infrastructure necessary to cost-effectively use mid-level providers to improve access to services and address dental service provider shortages in underserved areas of the state.
2. House Concurrent Resolution No. 3004 (2015) provided for a study of medicolegal death investigation in the state and how current best practices, including authorization, reporting, training, certification, and the use of information technology and toxicology, can improve death investigation systems in the state. In addition Section 7 of 2015 House Bill No. 1004 directed the study of the feasibility and desirability of the University of North Dakota (UND) acquiring the building that houses the UND Forensic Pathology Center. These directives were combined into one study.
3. House Concurrent Resolution No. 3049 (2015) provided for a study of issues relating to employment restrictions in public assistance programs.
4. The Legislative Management assigned the committee the responsibility to receive a recommendation from the Insurance Commissioner on an entity to provide a cost-benefit analysis on legislative measures mandating health insurance coverage of services or payment for specified providers of services or amendments that mandate such coverage or payment pursuant to North Dakota Century Code (NDCC) Section 54-03-28.
5. The Legislative Management also assigned the committee the responsibility to receive the following reports from:
    a. The Board of Addiction Counseling Examiners, Board of Counselor Examiners, North Dakota Board of Social Work Examiners, State Board of Psychologist Examiners, State Board of Medical Examiners, and North Dakota Marriage and Family Therapy Licensure Board regarding plans for administration and implementation of licensing and reciprocity standards for licensees and any legislative changes necessary to implement those plans.
    b. The Board of Addiction Counseling Examiners regarding the status of the periodic evaluation of the initial licensure coursework requirements and clinical training requirements.
    c. The State Fire Marshal regarding findings and recommendations for legislation to improve the effectiveness of the law on reduced ignition propensity standards for cigarettes.
    d. The Department of Human Services (DHS), State Department of Health, Indian Affairs Commission, and Public Employees Retirement System (PERS) before June 1, 2016, 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.
    e. The State Department of Health before June 1, 2016, regarding 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.
    f. The Tobacco Prevention and Control Advisory Committee and the State Department of Health by September 1, 2016, regarding grant expenditures, the granting process, and reporting requirements of a $500,000 grant provided to the State Department of Health by the advisory committee to assist in funding the department's Centers for Disease Control and Prevention's (CDC) *Best Practices for Comprehensive Tobacco Control Programs - 2014* during the 2015-17 biennium.
    g. The State Department of Health on the status of the health professional assistance program study.

Committee members were Senators Judy Lee (Chairman), Howard C. Anderson, Jr., Tyler Axness, Joan Heckaman, Dave Oehlke, and John M. Warner and Representatives Rich S. Becker, Alan Fehr, Dwight Kiefert, Gail Mooney, Gary Paur, Todd Porter, Karen M. Rohr, Jay Seibel, and Marie Strinden.

DENTAL SERVICES STUDY

Senate Concurrent Resolution No. 4004 directed the continuation of a study of dental services in the state that began during the 2013-14 interim. The resolution directed a study of dental services in the state, including the effectiveness of case management services and the state infrastructure necessary to cost-effectively use mid-level providers to improve access to services and address dental service provider shortages in underserved areas of the state.

Background

The committee reviewed previous studies and reports relating to access to dental services and ways to address dental service provider shortages, including reports by the 2013-14 interim Health Services Committee regarding its study of how to improve access to dental services and ways to address dental service provider shortages. The committee learned Medicaid dental services totaled $27 million during the 2011-13 biennium, and $28.7 million during the 2013-15 biennium. The 2015 Legislative Assembly appropriated $29.5 million to DHS for Medicaid dental services during the 2015-17 biennium. The committee reviewed proposals considered by the 2013-14 interim Health Services Committee to increase access to dental services, including a proposed case management program in communities with the most need and creating mid-level providers and expanded function dental assistants and dental hygienists to increase access to dental services.

State Dental Care Programs

The committee reviewed the following programs available in the state to provide free or low-cost dental care:

- **Medicaid** - An assistance program for eligible individuals without health insurance or for those whose health insurance does not cover all of their needs. Traditional Medicaid covers an estimated 66,000 individuals in the state, approximately half of which are children. Traditional Medicaid provides dental coverage for qualified adults, including diagnostic, preventative, and restorative dental services, including dentures every 5 years. Medicaid provides limited dental care services, and copayments may apply for certain recipients. Because dental services were not part of the benchmark coverage selected for Medicaid Expansion, dental services are not covered for the approximately 20,000 individuals enrolled under Medicaid Expansion. According to an analysis done by the DHS's contracted actuary, using a similar administrative percentage that Sanford Health Plan receives for expansion, the estimated cost to add dental services to the Medicaid Expansion benefit plan would be between $32.51 and $40.50 per member per month.
- **Healthy Steps** - The state children's health insurance program (CHIP) provides premium-free health coverage to uninsured children in qualifying families. It is intended to help meet the health care needs of children from working families that earn too much to qualify for full Medicaid coverage, but not enough to afford private insurance. Healthy Steps-covered services include dental services; however, copayments are required for certain services.
- **Caring for Children** - A benefit program for eligible North Dakota children up to age 19 who do not qualify for Medicaid or Healthy Steps and have no other insurance. Benefits include primary and preventative medical and dental care.
- **North Dakota Health Tracks** - Formerly early periodic screening diagnosis and treatment, North Dakota Health Tracks is a preventative health program that is free for children aged 0 to 21 who are eligible for Medicaid. North Dakota Health Tracks pays for screenings, diagnosis, and treatment services to help prevent health problems from occurring or help keep health problems from becoming worse. North Dakota Health Tracks also pays for orthodontics.
- **Donated dental services** - Supported by the general fund ($50,000 per biennium), the donated dental services program provides dental care through a network of 135 North Dakota volunteer dentists and 12 dental laboratories to the disabled, elderly, or medically compromised individuals who cannot afford treatment.
- **Smiles for Life fluoride varnish program** - Funded by a DentaQuest Foundation grant, the program provides outreach and training to health care providers in the application of fluoride varnish.
- **School-based fluoride varnish and Seal! ND Dental Sealant Program** - Funded through a CDC oral disease prevention program grant and a federal Health Resources and Services Administration's oral health workforce grant, the Seal! ND Dental Sealant Program is a school-based fluoride varnish and sealant program. Services include an initial screening, sealant placement, and fluoride varnish application. Schools with 45 percent or greater of their students in the free or reduced school lunch program are given priority for the program.
- **Ronald McDonald Care Mobile** - The mobile dental clinic provides services to rural and underserved populations in the western half of the state. The mobile clinic's priorities include schools with 40 percent or greater of their student population in the free or reduced school lunch program, Head Start and Early Head Start, American Indian reservation areas, and community health centers without dental services.
- **Safety net clinics** - Three federally qualified health centers (FQHC) provide dental services in Fargo, Grand Forks, Minot, Rolette, and Turtle Lake. In addition Northland Community Health Center received a New Access Point grant in 2015 to open a medical clinic in Ray and is preparing to open a dental clinic. The clinics serve patients with or without insurance, regardless of their ability to pay, and discounts are offered based on a sliding fee scale to those who qualify. A fourth FQHC, Coal Country Community Health Centers, does not offer dental services, but offers dental vouchers for preventive services for those who are unable to afford services and who qualify for their sliding fee program.

Dental Service Provider Programs

The committee received information regarding the following dental service provider programs:

- **State loan repayment program** - In 2015 Senate Bill No. 2205, the Legislative Assembly included dentists willing to serve in public health and nonprofit dental clinics in the same loan repayment program as dentists serving small communities. The dentists are eligible to receive funds, not to exceed a total of $100,000 per applicant, for the repayment of their educational loans. The funds are payable over a 5-year period ($20,000 per year). Total funding available for the combined dental loan repayment program based on defined need during the 2015-17 biennium is $720,000, of which $360,000 is from the general fund and $360,000 is from the student loan trust fund.
- **Federal/state loan repayment program** - A program providing loan repayment benefits to dentists serving in communities designated as dental health professional shortage areas (HPSA). The program was established through a federal grant from Health Resources and Services Administration (HRSA), is only available in communities designated as dental HPSAs, and requires state matching funds. Successful applicants may receive up to $60,000 to repay educational loans and must agree to a 2-year contract at a site that accepts Medicare and Medicaid assignment and offers a reduced rate or no fee for services.
- **National Health Service Corps loan repayment program** - A federal program providing loan repayment benefits to dental providers serving in communities designated as dental HPSAs. Providers are selected for the program based on the community's HPSA score. Providers receive $50,000 in loan repayment funds for a 2-year commitment. This program does not require matching funds, and providers may receive continuation awards.
- **Nonprofit clinic dental access project** - The Department of Human Services, to increase dental provider access, developed the nonprofit clinic dental access project. The program supports the recruitment of additional dentists willing to serve Medicaid and CHIP patients by assisting dentists with school loan repayment. A part-time dentist may receive up to $10,000 per year for 3 years, or a maximum of $30,000, and the maximum for a full-time dentist is $60,000.

The committee received information from the State Department of Health regarding state loan repayment program application deadlines; review process; penalties; and dentists participating in the loan repayment program from 2005 through 2016, including the dentists' original service location and current location. The number of loan repayment contracts issued each biennium is dependent upon funding. In April 2016 the Health Council approved eight applications based on the availability of funds; however, two dentists declined the contract because of the penalty section. If a dentist does not fulfill the contract, provisions of the loan repayment contract require full repayment of funds received. Of the six dentists granted dental loan repayments in 2015, five are currently enrolled with Medicaid. Of the 37 dentists participating in the state's dental loan repayment program from 2005 through 2016, most are still in their original contract location and six dentists have either withdrawn from the program or live in communities other than the one they served as part of the loan repayment contract.

Dental Health Workforce

The committee learned the UND School of Medicine and Health Sciences (SMHS) conducted research on the health care workforce in the state, including dental providers, and published a report entitled *2010 Snapshot of North Dakota's Health Care Workforce*. The committee learned there were 392 dentists in the state in 2010, and 458 dentists in September 2016, an increase of 16.8 percent. There were also 821 dental assistants and 721 dental hygienists in the state in September 2016. In September 2016 Medicaid had 340 dental providers enrolled in the North Dakota Health Enterprise Medicaid management information system (MMIS).

In 2014, 34 percent of the counties in the state are either fully or partially designated as dental HPSAs, down from 36 percent in 2010. To be designated a dental HPSA, based on reasonable services areas, the population-to-provider ratio must be greater than 5,000 to 1 and contiguous areas are over-utilized, excessively distant, or inaccessible to the population of the area under consideration. A dental HPSA designation is valid for 3 years, and counties are continually reviewed for HPSA status. North Dakota has 55.36 dentists per 100,000 residents compared to the national average of 60.89. While 50 percent of the state's population lives in urban communities, over 60 percent of dental assistants, dental hygienists, and dentists practice in urban areas.

The committee received information from the North Dakota State College of Science regarding the college's role in educating dental professionals in the future. Although there is a need for dental hygienists, the greatest need is for qualified dental assistants, especially in the western part of the state. As a result, the North Dakota State College of Science will seek approval to begin offering the dental assisting program online and through a hybrid delivery system to target students in the western part of the state. There are currently 50 applicants for 20 available dental assisting slots, but when implemented, the hybrid class delivery system will allow the school to increase class size. North Dakota State College of Science has a bachelor's degree articulation agreement with Minnesota State University in Mankato and is developing an articulation agreement with Metropolitan State University, which has a dental therapist program in

conjunction with Normandale Community College. The North Dakota State College of Science does not anticipate developing a dental therapy program.

Access to Dental Services

Barriers to accessing oral health care include poverty, geography, workforce, an insufficient number of providers that accept Medicaid patients, lack of oral health education, language, cultural barriers, fear, and age, especially those in nursing homes. A shortage of dentists willing to accept Medicaid patients has resulted in a small number of dentists treating the majority of children on Medicaid and limiting the availability of oral health services even in areas of the state where there is an adequate supply of dental professionals. Additional barriers, particularly in reservation communities, include insufficient federal funding and administrative challenges in clinics. Indian Health Services (IHS) procedures are onerous for volunteers and it can take 6 to 9 months to be authorized to perform services at an IHS clinic. The complex and lengthy federal credentialing process makes it difficult to recruit dentists within the IHS system.

The committee received reports from the North Dakota Center for Rural Health regarding dental services. A 2015 survey of long-term care facilities identified oral health as a priority among participating facilities; however, many facilities had no overall system in place to meet the oral health needs of residents.

Data from the 2015-16 State Department of Health's Basic Screening Survey and the National Youth Risk Behavioral Surveillance System indicates American Indian and lower-income youth in North Dakota are at a greater risk of tooth decay, rampant decay, need for treatment, and need for urgent treatment. The rate of untreated decay in the state is higher for American Indian (51 percent), and other minority children (41 percent) than for their Caucasian peers (24 percent).

The committee learned Medicaid fee-for-service reimbursement in North Dakota as a percentage of private dental benefit plan charges for child dental services is 68 percent, compared to 49 percent nationally. North Dakota has one of the highest Medicaid reimbursement rates in the nation, 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. The committee learned the North Dakota Dental Association is encouraging dentists to see additional Medicaid patients and has formed a Medicaid advisory committee to work with DHS to address administrative barriers related to the department's transition to a new MMIS.

The committee learned a survey of hospitals in the state indicated patients may access emergency rooms for toothaches, abscesses, or other dental issues, most of which could have been addressed by a dentist. Common reasons patients seek care in the emergency room include conditions that arise outside of normal dental office hours or on weekends, inability to find a dentist enrolled in Medicaid, or potential access to narcotics. Dental services provided in an emergency room are more costly to the state than if the services were provided in a dental office and most of the patients seeking dental care in emergency rooms were in urban hospitals and either uninsured or covered by Medicaid. Family HealthCare Dental Services in Fargo has an agreement with Sanford Emergency Center to serve any dental pain patients within the next day and 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 volunteer dentists. Stakeholders in Bismarck are assessing the level of commitment to a similar diversion program.

The Ronald McDonald House Charities has partnered with the State Department of Health in a program funded by a 3-year HRSA grant. The program will be administered by the Bridging the Dental Gap Dental Director and the Care Mobile Program Manager. The program has contracted a part-time dental hygienist to visit 24 sites to provide preventive services. With the addition of this new program, the Care Mobile anticipates serving approximately 1,400 children in 2016, 400 more than in previous years. The target population is schools where 45 percent or more of the students qualify for free or reduced lunches. Based on 2013 information available from the Department of Public Instruction, 89 schools would qualify for services during the 2014-15 school year.

Proposals to Increase Access

Case Management

The committee learned the North Dakota Dental Association supports Medicaid reimbursement for case management billing codes recently established nationally. The association also suggested current statute and rules be amended to specifically allow teledentistry and the virtual dental home in outreach settings and allow third-party reimbursement for these services. The case management model would enable registered dental assistants and hygienists to provide oral health assessments, fluoride varnish, sealants, and case management to high-risk patients in community settings. The services would be provided in preschools, elementary schools, medical settings, or long-term care facilities. Dental professionals would identify high-risk patients and link them to a dental home. Case management would include educating individuals, identifying barriers to care, and following up to remove barriers and link the patient to a dental home.

Expanded Function Dental Auxiliary

The committee learned the State Board of Dental Examiners approved amendments to North Dakota Administrative Code Title 20, which became effective April 1, 2015, to reorganize rules related to dental auxiliaries and expand the functions of registered dental assistants and dental hygienists. Expanded function dental auxiliaries must apply for and receive a permit from the State Board of Dental Examiners to perform the expanded duties, but there are currently no programs in the state that meet the training and education requirements necessary to perform the expanded functions.

The committee learned a written collaborative agreement designates authorization for the scope of services provided by a registered dental hygienist working under the general supervision of a dentist. The North Dakota Oral Health Coalition facilitated a collaborative practice discussion between North Dakota dentists, dental hygienists, and other key stakeholders, and provided a summary report to the committee. The North Dakota Collaborative Practice Task Force concluded existing statutory and administrative rules sections related to collaborative practice and supervision should remain. Dental hygienists are currently allowed to provide services without a dentist present under general supervision, allowing them to provide outreach services in public settings, such as schools or nursing homes, under a standing order from a dentist. Except for certain limitations, the dentist is not required to be in the treatment facility. While the State Department of Health and some of the safety net clinics have been successful in working with dentists to write standing orders to allow their employed hygienists to provide outreach services, many hygienists working in private dental offices have been unable to receive support from their supervising dentist. In Minnesota 71 percent of dental assistants and 18 percent of dental hygienists utilize their restorative function permit. The most cited reasons for nonutilization is a lack of delegation by the dentist or the individual's primary focus is dental hygiene.

Support for Safety Net Clinics

The committee learned limited reimbursement for more complex procedures makes those procedures less profitable and unless FQHCs have a number of private pay or insured patients, they provide primarily basic procedures. Because these providers are not practicing to their full scope of practice, turnover rates are high. Securing and retaining dental providers and qualified support staff are the most critical factors in maintaining and expanding dental services at FQHCs. The committee learned continued support of nonprofit safety net clinics through the dental loan repayment program will help recruit dentists who are paid less at the clinics than they could earn in private practice.

Mid-Level Dental Providers

The committee learned in Alaska dental therapists only provide care within the tribal health system, but in Maine, Minnesota, and Vermont, they are allowed to practice anywhere in the state. In Minnesota two models of dental therapy exist to provide specific dental services--the dental therapist and the advanced dental therapist. Dental therapists may educate patients, perform oral examinations and preventative procedures, drill and repair early stages of tooth decay, and assist in other procedures. Permitting dentists to supervise dental therapists while not at the same location allows private practices to offer evening or weekend services for routine care.

The committee learned dental therapists are less expensive to educate because they focus on a limited set of routine dental procedures--approximately 50 to 60 skills--depending on the program, compared to approximately 500 competencies learned by dentists. Additional infrastructure is not needed to employ dental therapists in the state, nor does the state need to establish an educational curriculum to train dental therapists. Programs are available in Minnesota, where the necessary regulations have been established to license dental therapists and the Medicaid agency is able to reimburse dentists for services provided by dental therapists.

The committee received an update on an earlier report on the impact of dental therapists provided to the Minnesota Legislature in 2014. Reimbursement rates for dental therapists in Minnesota are the same as if the dentist would have performed the procedures. This allows dental clinics to charge the same fee for an employee that is paid less than a dentist. Because the reimbursement rates are the same for dentists and dental therapists, there were no immediate savings to the state from the dental therapy model. However, dental therapists have made it possible to expand capacity and have the potential to reduce unnecessary emergency room visits. Minnesota requires all dental therapists to engage in a collaborative management agreement with a dentist and no more than five dental therapists can enter into an agreement with one dentist. Collaborative management agreements must include practice settings and populations served; limitations on services to be provided; age and procedure specific protocols; plans for medical emergencies and quality assurance; and protocols for dental records, medications, complex patients, and referrals. A dental therapist survey performed by the Minnesota Department of Health Office of Rural Health and Primary Care indicated that in August 2016 there were 64 dental therapists in Minnesota, of which 26 were advanced dental therapists. Dental therapists in Minnesota are required to serve at least 50 percent low-income, uninsured, and underserved patients. Dental therapists are licensed and regulated by the Board of Dentistry in Minnesota and are eligible for loan forgiveness in Minnesota, similar to other health care professionals. The committee received information from various dentists regarding the efficiency and challenges of certain dental therapists in the Minnesota program.

To implement a dental therapy model, the committee learned, the state would need to approve legislation to allow the licensure of advanced practice dental hygienists. The committee reviewed 2015 Senate Bill No. 2354, considered, but not approved, by the 2015 Legislative Assembly. The bill included provisions that would have allowed supervising dentists to limit, through a collaborative management agreement, procedures performed by the dental therapist to those procedures the dentist deemed appropriate.

Other Information and Testimony

The committee received information and testimony from other interested persons, including representatives of the National Academy for State Health Policy, Family HealthCare in Fargo, Community HealthCare Association of the Dakotas, North Dakota Hospital Association, Sanford Health Emergency Department, the Indian Affairs Commissioner, a former Secretary of the United States Department of Health and Human Services, Commission on Dental Accreditation, University of Florida College of Dentistry, Minnesota Department of Health Office of Rural Health and Primary Care, Children's Dental Services in Minnesota, North Dakota Center for Rural Health, North Dakota State College of Science, the North Dakota State Board of Dental Examiners, various dental professionals, professional organizations, community health centers, and other stakeholders. Major comments and information provided include:

- Opportunities to improve access to oral health care for vulnerable populations include augmenting the oral health workforce, building physical and virtual infrastructure to deliver oral health services, and integrating oral health and primary care.
- Federally qualified health centers may provide the infrastructure for dental service providers, including dental therapists and dentists practicing in collaborative or remote supervisory roles. California and Colorado are piloting a virtual dental home model where a network of dental hygienists, supervised by dentists based at FQHCs through telemedicine, are allowed to perform preventative services, screenings, and interim restorations in women, infants, and children clinics; Head Starts; schools; and nursing homes.
- Prior to Medicaid Expansion, qualified refugees could access traditional Medicaid, or they could receive federal refugee medical assistance, which includes adult dental and vision coverage for up to 8 months after they arrive in the United States. Currently a refugee who does not qualify for Medicaid is evaluated for Medicaid Expansion and then refugee medical assistance as a last resort. Medicaid Expansion does not include dental coverage for adults (ages 21 through 65), so as a result those that do not qualify for traditional Medicaid will most likely be without dental and vision coverage, because they typically qualify for Medicaid Expansion.
- Reservations assuming responsibility for dental services through a Public Law 93-638 contract may have more flexibility when hiring dental professionals.
- In February 2016 the Commission on Dental Accreditation adopted the process of accreditation for dental therapy education programs and began accepting applications for accreditation of dental therapy programs. Dental therapy accreditation standards consider institutional effectiveness; educational program; faculty and staff; educational support services; and health, safety, and patient care provisions. Licensing and practice oversight is the responsibility of states and their professional licensing boards.

Recommendation

The committee recommends a bill [17.0283.01000] to change the dental loan repayment program to provide for a prorated payback of loan repayment funds if a dentist breaches the loan repayment contract.

DEATH INVESTIGATION AND FORENSIC PATHOLOGY CENTER STUDY

House Concurrent Resolution No. 3004 directed the continuation of a study of medicolegal death investigation in the state that began during the 2013-14 interim. The study was to review medicolegal death investigation in the state and how current best practices, including authorization, reporting, training, certification, and the use of information technology and toxicology, can improve death investigation systems. In addition Section 7 of House Bill No. 1004 directed a study of the feasibility and desirability of UND acquiring the building that houses the UND Forensic Pathology Center. These directives were combined into one study.

Background

1995 Legislative Assembly amended NDCC Chapter 23-01 to allow the State Department of Health to perform autopsies and to employ a State Forensic Examiner to conduct investigations into cause of death. North Dakota Century Code Chapter 11-19.1 requires, under most circumstances, each organized county to have a county coroner. Coroners are appointed by each county commission and the State Forensic Examiner provides expert consultation. A coroner investigates deaths that are the result of criminal or violent means, such as homicide, suicide, and accident; deaths of individuals who die suddenly when in apparent good health; or deaths of a suspicious or unusual manner. A coroner works closely with law enforcement to determine if a crime may have been committed and provides a medical perspective on the investigation. The coroner, the coroner's medical deputy, the sheriff, or a state's attorney may direct an autopsy be performed. Issues of public health and safety, such as unusual contagious infections or deaths from environmental

hazards, may be raised by a coroner or medical examiner. In the absence of a medical professional willing to serve as the county coroner, the duty falls to the sheriff or anyone willing to serve. Coroner candidates must complete 8 hours of training in death investigation offered by the State Forensic Examiner. In January 2016 the duties of county coroner were performed by medical doctors (22 counties), sheriffs or police officers (18 counties), funeral home directors (9 counties), emergency medical technicians (2 counties), one nurse, and one rancher.

The committee reviewed 2013-14 interim Health Services Committee information regarding the system of death investigation, state and county autopsy costs, medicolegal death investigation system funding models, and recommendations for improvements to the medicolegal death investigation system in the state. That committee determined further study was needed regarding:

- Facilities in Bismarck and Grand Forks;
- Education and training of investigators and first responders;
- Financing and cost-sharing;
- National accreditation plan;
- Training and distribution of qualified and certified medicolegal death investigators in all regions of the state; and
- Governance.

State Funding for Death Investigation

The number of autopsies performed by the State Forensic Examiner increased from 196 in 2004 to 367 in 2012. Accreditation standards indicate one forensic examiner should perform 225 to 250 autopsies per year. The number of forensic autopsies performed by the State Forensic Examiner exceeded the number of autopsies recommended by the National Association of Medical Examiners in 2012. In addition to the services provided by the State Forensic Examiner in Bismarck, the 2013 Legislative Assembly provided $480,000 from the general fund to the State Department of Health to contract with University of North Dakota School of Medicine and Health Sciences (SMHS) to perform autopsies in the eastern part of the state during the 2013-15 biennium.

The committee learned three forensic pathologists at SMHS performed autopsies at a morgue facility in Grand Forks during the 2013-15 biennium. The contract provided, beginning September 1, 2013, SMHS serve 13 counties in eastern North Dakota. Beginning July 1, 2014, eight additional counties began receiving services through SMHS for a total of 21 counties. The State Department of Health also contracts with the SMHS to provide services, when necessary due to department workload or vacation, at a rate of $2,000 per case. During the 2013-15 biennium, the State Forensic Examiner performed 552 autopsies, including 17 autopsies performed by SMHS under the contract that provides services while the State Forensic Examiner is away. Expenditures for the State Forensic Examiner were estimated to total $1,432,081 during the 2013-15 biennium, not including expenditures for SMHS eastern counties' contract, or approximately $2,594 per case. Actual expenditures for the UND Forensic Pathology Center during the 2013-15 biennium totaled $1,105,138, including 4.85 full-time equivalent (FTE) positions, of which $459,432 was provided through the State Department of Health contract. The University of North Dakota School of Medicine and Health Sciences performed 448 autopsies during the 2013-15 biennium at a contract cost of $459,432, or $1,025 per case. A combined total of 1,000 autopsies were done by the State Forensic Examiner and SMHS during the 2013-15 biennium. Counties requesting the most autopsies include Cass (174), Grand Forks (124), Burleigh (86), Williams (72), and Ward (63). Of the 53 counties in the state, 25 requested 5 or fewer autopsies.

The 2015 Legislative Assembly provided $480,000 from the general fund to the State Department of Health to contract with SMHS for autopsy services in the eastern part of the state and $160,000 from the general fund to SMHS for Department of Pathology services to provide a total of $640,000 from the general fund, $160,000 more than the 2013-15 biennium. The Legislative Assembly also provided $44,000 of one-time funding from the general fund for digital x-ray equipment for the State Forensic Examiner, and $1,502,924 from the general fund to continue funding for existing forensic examiner staff (3 FTE positions) during the 2015-17 biennium, including bond payments related to the State Department of Health facility in Bismarck.

The University of North Dakota School of Medicine and Health Sciences will continue to serve the 21 eastern counties during the 2015-17 biennium. The Forensic Pathology Center budget for the 2015-17 biennium includes funding for 4.40 FTE positions and totals $1,836,370, of which $160,000 is provided from the general fund directly to SMHS, and $480,000 is provided through the State Department of Health contract for autopsy services. Remaining funding for the Forensic Pathology Center is provided through other funds, including fees for autopsy services for individuals, hospitals, and other jurisdictions.

The committee learned the Bismarck facility serves 32 counties with 51 percent of the state's population and the Grand Forks facility serves 21 counties with 49 percent of the state's population. While the State Department of Health

has one pathologist in Bismarck, the 4,837 square foot facility is able to accommodate two forensic pathologists. The Bismarck facility accepts bodies for autopsy 24-hours per day, 7-days a week, and autopsies are generally conducted the next business day. The Grand Forks facility has 4 forensic pathologists (1.8 FTE positions) and provides services 7 days per week. In addition to autopsy services, the SMHS Forensic Pathology Center serves an educational mission.

The committee learned 235 coroner cases were accepted for autopsy from January through June 2016, of which 118 (50 percent) were accepted by the State Forensic Examiner's office in Bismarck and 117 (50 percent) were accepted by the Department of Pathology at UND.

Forensic Pathology Center

In August 2009 UND entered into a lease agreement with Aurora Medical Park, LLC, Fargo, for a 7,167 square foot building located within the Aurora Medical Center in Grand Forks. The lease agreement, for 120 months, was contingent upon the approval of a change of scope request for a federal HRSA grant which would provide funding for a portion of the total cost of construction. Construction costs totaled $1,944,000, of which $998,645 was paid through the HRSA grant. The remaining cost of $945,355 was the basis for the lease ($94,535 per year or $7,878 per month). Lease costs do not include property taxes or facility-related fees. Subsequent lease amending agreements changed the lease term to 25 years and transferred the landlord's interest to 52nd Avenue Investments, LLC. In addition to the cost of construction, HRSA funds totaling $652,356 were used to purchase major equipment and local funds, available from the Forensic Pathology Center forensic services, totaling $150,000, were used for furnishings, signage, and small office equipment. The Forensic Pathology Center, constructed in 2010, began accepting cases in 2011. Information provided by SMHS indicates, based on an insurance estimate, the current value of the building is $1.5 million. In addition, the Department of Pathology leases 1,870 square feet for office and storage needs.

The Forensic Pathology Center lease payments total $94,535 annually and the term is 25 years, from January 2011 through December 2035. During years 11 through 25 of the lease, the lease price is adjusted by the local consumer price index. The University of North Dakota School of Medicine and Health Sciences is responsible for utilities, maintenance, repairs, fire insurance, and a prorated share of special assessments and the landlord's insurance. Office and storage space lease payments total $24,000 annually and the term is 3 years, expiring January 31, 2019. The committee learned neither lease contains a "buyout" option.

Recommendations for Improvements to the Medicolegal Death Investigation System in the State

The 2013-14 interim Health Services Committee received recommendations from a stakeholder group for improvement to the death investigation system in the state. The 2015-16 interim Health Services Committee received an update on the implementation of these prior recommendations. The committee learned the recommendations have been addressed by the State Department of Health as follows:

- Maintain a manageable workload at the State Forensic Examiner's office in Bismarck - The department continues to contract with SMHS for autopsies in the eastern part of the state during the 2015-17 biennium;
- Provide authority to the State Forensic Examiner to review non-natural deaths and amend the cause and manner of death if necessary - The department reviewed NDCC Section 11-19.1-18 and determined the State Forensic Examiner has the authority to assume jurisdiction over a body and to make changes to the cause and manner of death, if warranted;
- Develop a system to prompt health care providers to consult with the local coroner in all deaths that are not natural deaths - The State Department of Health's Division of Vital Records is developing a change to the electronic death certificate system to remind the provider to consult with the local coroner before certifying a non-natural cause of death;
- Allow copies of toxicology reports generated by the State Crime Laboratory to be sent to the State Forensic Examiner - The State Crime Laboratory has updated their toxicology request forms to include an option for local officials to send a copy of the results to the State Forensic Examiner;
- Increase the number of people in the state trained in death scene investigation - Plans for training the vital records nosologist are ongoing and the UND death investigation course is available online. The State Forensic Examiner offers training; however, additional funding for travel costs related to annual training for coroners, law enforcement, paramedics, and other first responders was not approved by the 2015 Legislative Assembly;
- Develop the capacity of the State Crime Laboratory to produce quantitative toxicology results - Although the State Crime Laboratory does not see quantitative toxicology as a priority currently, the laboratory will work toward offering quantified toxicological testing as staffing and other resources allow;
- Allow the State Forensic Examiner and SMHS Department of Pathology to review death records electronically and allow these entities to send the electronic record to other medical providers for further review or correction - The estimated cost for modifications to the State Department of Health's Division of Vital Records software was

between $10,000 and $20,000; however, this funding was not included in the department's 2015-17 biennium budget; and

- Develop a mass fatality response plan for the state - The Emergency Preparedness and Response Section of the State Department of Health is coordinating a review of current mass fatality plans. The department is taking the lead in the planning and coordination for a mass fatality exercise tentatively scheduled for fall 2016.

The committee learned certain cases that should be reported may not be forwarded to county coroners or the state's forensic pathologists. Changes are needed to the process of coroner reporting to align the state's system with more modern systems while maintaining local responsiveness. The committee learned autopsies provide a wealth of health-related data and the committee requested the assistance of the SMHS Advisory Council in the death investigation study regarding how autopsy services relate to population health. The advisory council assigned a subcommittee to study the request and report their findings to the advisory council. The report contained a number of suggestions, but the most significant was that further study of the topic is necessary. The advisory council determined the complexity of death investigation and reporting, including the presence of two major units that oversee death investigations and provide forensic services, made it apparent that specific recommendations would be premature. The advisory council recommended the State Department of Health and SMHS conduct, before the start of the legislative session, a more complete study of death investigation and forensic services in the state and provide recommendations to the 65th Legislative Assembly.

The committee learned the State Forensic Examiner's office reconvened its 2013-14 interim stakeholder group to further develop recommendations for improvement to the death investigation system in the state. The stakeholder group proposed the following:

1. Maintain a manageable workload at the State Forensic Examiner's office in Bismarck by continuing the contractual agreement between the State Department of Health and SMHS.
2. Increase and improve the knowledge and skills of coroners, death investigators, and others who may conduct death investigations or assist in death investigations and increase the number of people in the state who have training in death scene investigation by:
   a. Providing funding for travel costs for coroners or the coroner's designee to attend annual training offered by the State Forensic Examiner ($29,375);
   b. Encouraging medical personnel, law enforcement, and first responders to attend death scene investigation training; and
   c. Providing scholarships to offset travel costs for five county coroners per year or the coroner's designee to attend training provided by the Hennepin County Coroner in Minnesota on death investigation ($10,000).
3. Develop the capacity of the State Crime Laboratory to produce quantitative toxicology results.
4. Allow for electronic review of death records by the State Forensic Examiner and SMHS, including the ability of both agencies to send electronic records to other medical providers for further review or correction.

Other Information and Testimony

The committee received additional information and testimony relating to the death investigation and forensic pathology center study from representatives of the North Dakota Association of Counties, North Dakota Funeral Directors Association, State Department of Health, SMHS Department of Pathology, SMHS Advisory Council, North Dakota University System, county coroners, and other stakeholders. The information and testimony included:

- Counties are supportive of the current regulations related to death investigation and autopsies, including that counties pay transportation costs to either the State Forensic Examiner in Bismarck or the UND Department of Pathology.
- Prior to the addition of service at the UND Department of Pathology, bodies were transported to Bismarck for autopsy, adding time and cost. Funeral directors are supportive of the addition of services at the UND Department of Pathology and support continuing to contract with the UND Department of Pathology for autopsy services.
- In a mass casualty situation, the State Department of Health and the SMHS Department of Pathology facilities can store up to 10 and 30 decedents, respectively. In addition to storage available at the State Department of Health and the SMHS Department of Pathology facilities, 18 facilities reported functioning cold storage for up to 94 decedents for a total capacity of 134 decedents.
- Information regarding the duties and reporting responsibilities of local coroners.
- Drug overdose data is available to the State Department of Health from ambulance information. In addition the department entered into a data use agreement with the Minnesota Hospital Association, which receives hospital

discharge data from North Dakota facilities. The department will receive hospital discharge data from 2010 through 2015 for 16 North Dakota facilities (approximately 95 percent of the hospital discharge data available in the state) in an electronic format and will continue receiving the data annually. Health care-related data may assist officials in their discussion of the impact of opioid use and abuse in the state and trends in drug use and abuse.

Recommendation

The committee makes no recommendation related to its study of medicolegal death investigation in the state and how current best practices, including authorization, reporting, training, certification, and the use of information technology and toxicology, can improve death investigation systems in the state.

The committee makes no recommendation related its study of the feasibility and desirability of UND acquiring the building that houses the UND Forensic Pathology Center

STUDY OF EMPLOYMENT RESTRICTIONS IN PUBLIC ASSISTANCE PROGRAMS

House Concurrent Resolution No. 3049 directed a study of issues relating to employment restrictions in public assistance programs. Because workforce shortage issues are a major challenge for business development in the state, the study should determine a means to allow employees to work additional hours without automatically losing public assistance benefits.

Background

The committee reviewed a report by the 2007-08 interim Human Services Committee of the temporary assistance for needy families (TANF) program administered by DHS. The 2007-08 interim Human Services Committee learned the TANF program may be used to address areas of worker shortage in North Dakota. Successful welfare-to-work programs emphasize employment and provide a wide range of services that include a strong education and training component. The job opportunities and basic skills (JOBS) program is the employment and training component of the state's TANF program which helps TANF recipients become economically self-sufficient. Through the JOBS program, DHS has the ability to match TANF clients with various career options.

National Conference of State Legislatures

The committee reviewed National Conference of State Legislatures research related to assistance programs. Assistance programs such as the supplemental nutrition assistance program (SNAP), TANF, child care assistance, and some tax credits do not necessarily restrict work, but when income increases beyond the eligibility threshold, participants are no longer eligible for assistance. In some cases, the additional income does not offset the loss of benefits. If a TANF cash grant, lost due to increased hours or income, exceeds the additional earnings, the participant has a decrease in net pay and benefits for the month as a result of accepting additional work hours or a wage increase. This dropoff in benefits that occurs when a person exceeds the income threshold is often referred to as the "cliff effect."

The committee learned the National Conference of State Legislatures has conducted research on the "cliff effect" and outlined strategies states use to address the issue. The focus of the research was on the income eligibility thresholds for various programs, including phase outs, how to define or establish those thresholds based on cost of living and a state definition of "self-sufficiency," and tax credits and other work supports that bridge the gap. Some states have established phase-out or tiered levels of eligibility to allow a person to gradually transition off assistance as their wages increase.

North Dakota Labor Force

The North Dakota labor force consists of all individuals ages 16 years and over who are either employed or unemployed and actively seeking employment. Labor force data does not account for other factors, such as those that are underemployed, students, family caregivers, and the unemployed not seeking work. The labor force participation rate refers to the labor force as a proportion of the entire population ages 16 and over. The unemployment rate refers to the unemployed portion of the labor force as a percentage of the total labor force. In 2014 North Dakota ranked first in the nation for labor force participation with an adjusted rate of 72.8 percent. North Dakota has maintained a very low unemployment rate in recent years. Much like the state's labor force participation, North Dakota's unemployment rate, which has historically outperformed the national average, reached a high in 2009 of 4.1 percent and dropped to 2.8 percent in 2014, the lowest in the nation. According to an annual Job Service North Dakota publication, the top five industries by highest average employment in the state in 2014 were health care and social assistance, retail trade, accommodation and food services, construction, and educational services. Employment in these five industries is also projected to increase more than other industries in the state between 2012 and 2022. Based on a June 2015 monthly Job Service North Dakota report, total employment in North Dakota increased to 470,200, from 468,300 in June 2014. While mining employment decreased, increases in construction, retail trade, and other services more than offset the reduction.

Job Service North Dakota maintains data identifying open and available positions in the state and the *Job Openings Report* is a real-time publication available online. The report includes aggregate job openings, on a monthly basis, for all 53 counties from June 2008. Statewide, Job Service North Dakota provides information by major occupational group by month by planning region. The committee learned in October 2015 there were 16,684 job openings in the state, including jobs related to healthcare (1,749), sales (1,748), administrative support (1,683), and food service (1,367). Earnings data is available by industry, but not by occupation, for individual counties in the Quarterly Census of Employment and Wages program. The *Employment and Wages by Occupation* publication provides wage estimates by occupation and certain geographic areas within the state. Data related to skills, education, and training required for various occupations is available in the *Careers in North Dakota* publication on the Job Service North Dakota website.

Public Assistance Program Eligibility

The committee learned while there are some federal rules that determine who may qualify for TANF-funded cash assistance, states determine the financial eligibility criteria and cash assistance benefit amounts. Income thresholds that determine whether a family is eligible for cash assistance and the benefit amounts paid vary widely among states.

The committee received a summary of income eligibility limits and work requirements for the child care assistance program, low income home energy assistance program (LIHEAP), Medicaid, SNAP, and TANF. The child care assistance program and the LIHEAP programs do not include work requirements. Medicaid provisions do not include work requirements, except for the workers with disabilities coverage group. With some exceptions, the SNAP and TANF programs include certain work requirements. From 2014 to 2015, there was a decline in the number of participants employed in many of the programs.

The committee learned unless determined to be exempt, individuals who receive a TANF cash grant are required to participate in the JOBS program. Exceptions to this requirement include, a caretaker or parent over age 65, a caretaker or parent of a child younger than 4 months of age, and teens who are enrolled in school full-time. Program participants are required to complete a minimum number of hours each week in one or more of the approved work activities, including job readiness, job search, paid employment, high school, general educational development, education directly related to employment, job skills directly related to employment, on-the-job training, vocational training, unpaid work experience, community service, or child care for another participant involved in community service. Involvement in education and training is limited and must be approved by a JOBS program coordinator. Unless responsible for the care of a child who is younger than 6 years of age, participants must complete a minimum average of 30 hours per week in one or more approved work activities. If caring for a child under age 6, an individual must complete a minimum average of 20 hours per week in an approved work activity. The job opportunities and basic skills program offers some supportive services to help participants become self-sufficient, including transportation, child care, job readiness, relocation, and tuition assistance; money for license, certification, and examination fees; tools for employment; and care of incapacitated household members. Some of these supportive services may be provided to former TANF participants for up to 6 months after their TANF case closes in order to help them succeed in the workforce. Individuals who fail or refuse to participate in the JOBS program without a good reason, can be sanctioned.

The committee learned LIHEAP income limits and child care assistance program income limits and copayments are adjusted based on state median income. Supplemental nutrition assistance program, Medicaid, and Healthy Steps income limits are adjusted based on the federal poverty level. The temporary assistance for needy families program is adjusted based on appropriations. The committee learned the state's median income is $55,759 and changes to the benefits of one program may affect the benefits of another program. Public assistance benefits may also be affected by housing assistance and Women, Infants, and Children (WIC) benefits.

The committee learned TANF is the only benefit that would be affected by changes in income on a monthly basis. Many programs are reviewed every 6 months, so benefit changes related to income are not immediate. The supplemental nutrition assistance program benefits are directly affected by TANF benefits, but because SNAP reviews occur every 6 months the effects of TANF benefit changes are not immediate. Child care assistance program benefits are determined based on anticipated monthly income and verified, but are paid based on the actual billing for the prior month.

The committee reviewed information regarding the effect of increased work hours on eligibility for various assistance programs. If a family becomes ineligible for TANF due to an increase in earnings, transition assistance of $200 per month is available for 6 months to offset some of the "cliff effect." Participants receive TANF supports and must continue to comply with TANF requirements during the transition period. There are also consequences in the SNAP program; however, federal regulations determine work requirements. The state's TANF work participation rate for federal fiscal year 2014 of 71 percent exceeds the 50 percent requirement under TANF and ranks second in the nation. Due to high unemployment rates, three reservations in the state are exempt from the lifetime TANF limit; however, they are not exempt from the work requirement.

The committee received a summary of annually updated program limits and an update on the JOBS program, including number of participants, number of hours for various types of work activities, cost, and average number of months individuals

participate in the program. The committee learned the number of TANF and JOBS participants decreased from 2,809 in 2014, to 2,583 in 2015, and the average time on assistance increased from 10 to 11 months over the same period.

The committee learned the basic employment skills training program is the employment and training component of SNAP. Because federal funding is limited, the program only operates in Burleigh and Cass Counties. The federal grant is based on the number of mandatory work registrants and able-bodied adults without dependents participating in the program. The Department of Human Services partners with Job Service North Dakota to provide services, including orientation, needs assessments, employment plan development, job search, referrals for other services, and job skills training. Clients are required to participate 20 to 25 hours per week until they find employment, move, or become exempt. Although referred to the basic employment skills training program, the individual may decide not to participate and is disqualified. Individuals can only participate in the SNAP program for 3 out of 36 months unless they are working an average of 20 hours per week.

Child Care Assistance Review

The committee requested DHS review child care subsidies and provide recommendations regarding gradual reductions in benefits to mitigate the "cliff effect" on participants when work hours are increased. The department made no recommendation regarding polices to mitigate the "cliff effect." The committee learned that, due to the 2015-17 general fund budget reductions, effective April 1, 2016, DHS revised the child care sliding fee schedule from 85 percent of state median income to 60 percent of state median income and increased family's monthly copayments. Families eligible for TANF are not subject to the sliding fee schedule and were not affected by the change. The child care assistance program caseload decreased from 2,049 in April 2016, to 1,549 in June 2016.

The committee learned new provisions in the federal Child Care and Development Block Grant Act of 2014 and proposed federal regulations for the block grant include "family friendly" eligibility policies that are likely to address the "cliff effect." Final federal regulations are not available, but the proposed eligibility policies include:

- Establish a 12-month eligibility redetermination period for child care assistance families, regardless of changes in income, as long as income does not exceed the federal maximum of 85 percent of state median income, or temporary changes in participation in work, training, or education activities. The Department of Human Services anticipates implementing this change in October 2016.
- Continue assistance for parents who lose employment for at least 3 months, allowing time to find employment without losing child care assistance program eligibility. The department anticipates implementing this change in October 2016.
- Provide for a graduated phase-out of assistance for families whose income has increased above 60 percent of the state median income at the time of the 12-month review, but remains below the federal maximum of 85 percent of state median income. The provision allows for an additional 12 months of eligibility, thereby preventing the "cliff effect." Due to the complexity of the provision, the current system cannot accommodate the programming, so the department estimates this change will not be implemented until August 2017.

Other Information and Testimony

The committee received other information and testimony from representatives of DHS and other stakeholders. Key comments and information include:

- In August 2014 electronic benefit transfer (EBT) retailers were required to pay for their EBT equipment and supplies. There were 475 participating EBT retailers in the state in November 2014 and the average number of participating retailers from July 31, 2014, through July 31, 2015, was 459.
- Research on the "cliff effect" done by The Women's Foundation of Colorado, the Women and Family Action Network Coalition, and the Indiana Institute for Working Families, included changes enacted to allow for a phasing out of benefits as income increases, and recommendations to smooth out benefit phaseouts, implement broad-based categorical eligibility, change monthly income eligibility limits, and raise the income tax threshold for state income tax.
- Recommendations of the National Commission on Hunger to Congress and the Secretary of the United States Department of Agriculture include establishing a mechanism for cross-agency collaboration to facilitate improved public assistance programming and evaluation through enhanced technology, data sharing, and coordinated funding streams that protect effective programs and encourage coordinated efforts to address larger issues of poverty.

Recommendation

The committee makes no recommendation as a result of its study of issues relating to employment restrictions in public assistance programs.

REPORTS OF BEHAVIORAL HEALTH-RELATED BOARDS

The committee was assigned to receive the following behavioral health-related reports:

- A report from the Board of Addiction Counseling Examiners, Board of Counselor Examiners, North Dakota Board of Social Work Examiners, State Board of Psychologist Examiners, State Board of Medical Examiners, and North Dakota Marriage and Family Therapy Licensure Board regarding plans for administration and implementation of licensing and reciprocity standards for licensees and any legislative changes necessary to implement those plans (Section 1 of 2015 House Bill No. 1048).
- A report from the Board of Addiction Counseling Examiners regarding the status of the periodic evaluation of the initial licensure coursework requirements and clinical training requirements (Section 4 of 2015 House Bill No. 1049).

Background

The committee reviewed the 2013-14 interim Human Services Committee report on a study of behavioral health needs pursuant to Section 1 of 2013 Senate Bill No. 2243. The 2013-14 interim Human Services Committee received a summary of the licensing requirements for various behavioral health-related professions. The 2013-14 interim committee received a number of recommendations relating to behavioral health professional workforce and training including:

1. Expand the behavioral health workforce by improving oversight for licensing issues and concerns and increasing the use of lay persons to expand treatment options.
2. Establish professional licensing board standards to allow:
   a. One year of practice if licensed in another state;
   b. A process for meeting North Dakota licensing standards during the 1-year period;
   c. Reciprocity of licenses between Montana, South Dakota, and Minnesota; and
   d. A method for issuing licenses within 30 days.
3. Expand the number of licensed addiction counselors by establishing a stipend program for licensed addiction counseling interns that would be forgiven if the licensed addiction counselor practices in the state for 4 years.
4. Expand the number of licensed addiction counselor training slots by providing stipends for organizations that offer the training.
5. Establish a student loan buydown program for licensed behavioral health clinical staff.

Report Pursuant to House Bill No. 1048

The committee received a consolidated report from the Board of Addiction Counseling Examiners, Board of Counselor Examiners, North Dakota Board of Social Work Examiners, North Dakota Marriage and Family Therapy Licensure Board, State Board of Psychologist Examiners, and the North Dakota Board of Medicine. The boards agree that North Dakota should match national standards to allow for professional mobility and that minimal statutory changes would be needed to align state standards with national occupation-specific standards. The boards reported workforce-related issues are not due to regulatory barriers or board inefficiencies and the boards have no authority over employment standards or insurance reimbursement requirements. The boards made the following recommendations:

- Require North Dakota employers and insurance carriers to use North Dakota occupational licensing standards when setting employee requirements;
- Maintain autonomous boards with North Dakota standards mapped to national occupational standards;
- Adopt an expedited licensure model for mobility and portability of licensure;
- Appropriate funds to the Governor's office to expand operational efficiencies for smaller boards;
- Appropriate funds to the Governor's office for the designated purpose of annual meetings of all regulatory board chairs and board managers;
- Require background checks for all new issue licenses;
- Standardize continuing education reporting and renewal processes;
- Develop a mechanism to share disciplinary action between North Dakota boards and the public;

- Develop consistent telepractice laws and rules across all behavioral health boards; and
- Provide for consistency in statutory language for all licensing professions by using model language to promote consistent format, mechanism, procedures, and issuance of licenses.

The committee learned 25 percent of the 49 states contacted by the Board of Counselor Examiners regarding reciprocity agreements responded. The committee learned none were willing to enter into a reciprocity agreement with North Dakota. While some of North Dakota's requirements are more strict than other states, others are not. No states were willing to alter their requirements for reciprocity. The committee learned nationwide, education standards have been increasing.

Report Pursuant to House Bill No. 1049

The committee received a report from the Board of Addiction Counseling Examiners. The board provided a summary of recent changes, including the addition of a new training consortium, regular review of licensure requirements, streamlined applications, flexible consortium training start dates, and collaboration to allow for a national certification in addiction counseling. The board is also proposing changes related to tiered licensure levels, academic requirements, clinical training, and reciprocity. The board is proposing a four-tier system of certification and the "career ladder" would allow the board to provide out-of-state professionals credentialing while they complete their academic and clinical training requirements. The board is also proposing to remove certain academic requirements, the completion of which is implied by other coursework. Regarding clinical training, the board reviewed requirements in surrounding states and is proposing a reduction in clinical training hours. The committee learned there is value in the consortium, but the board is also proposing an individualized training plan at the universities, if a consortium is not possible for an individual. The board is also proposing changes to reciprocity rules, including plans to prorate clinical hours for reciprocity.

The committee reviewed the clinical supervision requirements of the three levels of licensure available through the Board of Counselor Examiners. If licensed professional counselors (LPCs) or licensed professional clinical counselors (LPCCs) are not available to supervise licensed associate professional counselors and LPCs, licensees are unable to advance their credentials. Only individuals with LPCC licensure are reimbursable by third-party insurers. The committee learned there are 18 LPCs and 65 LPCCs in the state and most novice counselors seek supervision from LPCCs because it shortens the licensure process. A licensed associate professional counselor who obtains a counseling position at an agency, which does not employ an LPC or LPCC supervisor must secure third-party supervision at an additional cost of $5,000 to $10,000. North Dakota is 1 of 13 states that either require a professional counselor, pursuing licensure, to obtain supervision by a more advanced professional counselor, or do not explicitly state supervisor requirements. Remaining states allow affiliated licensed mental health professionals to provide supervision to novice counselors, seeking more advanced licensure. Potential supervisors include psychologists, psychiatrists, addiction counselors, social workers, and marriage and family therapists. The committee learned novice counselors would seek employment in agencies that could provide supervision by an affiliated mental health professional, reducing the need to pay for supervision and some of these agencies could be in rural communities.

Other Information and Testimony

The committee received additional information and testimony from representatives of the State Board of Medicine, North Dakota Medical Association, The Council of State Governments National Center for Interstate Compacts, Education Standards and Practices Board, University System, North Dakota Nurses Association, Department of Corrections and Rehabilitation, DHS, Mental Health America of North Dakota, Heartview Foundation, Western Area Health Education Center, SHMS, UND School of Law, counselors, behavioral health educators, and various other stakeholders relating to its review of reports received from the behavioral health-related boards, including:

- An interstate medical licensure compact may make it easier for physicians to gain licensure in multiple states.
- The Council of State Governments National Center for Interstate Compacts has facilitated collaborative agreements between state governments, federal agencies, and the private sector regarding a variety of issues. Initiatives in license portability and reciprocity have resulted in compacts for the licensure of physicians, nurses, emergency medical services personnel, psychology, and physical therapy.
- The Education Standards and Practices Board is the licensing agency for counselors and psychologists providing services in schools. Both licenses fall into the "restricted license" category, indicating a specialization rather than a regular professional education core. School social workers are licensed by an external board and credentialed by the Department of Public Instruction.
- The University System provided information regarding the number of internships available to behavioral health-related students and graduates and plans to update a 2007 report on the status of the behavioral health workforce in the state.
- Of the 13,000 registered nurses in the state, 3 percent are working in behavioral health, yet behavioral health nurses make up the largest portion of the professional workforce for acute inpatient psychiatric services. The

North Dakota Nurses Association recommends establishing a plan to provide financial support for the education and training of behavioral health nurses, increasing incentives for the retention of new nursing graduates in the state, and offering incentives for faculty in the psychiatric and mental health nurse practitioner program.

- Information regarding a comparison of the referral requirements for Medicaid reimbursement of the various behavioral health professions, including information regarding the length of time services may be reimbursed for various behavioral health professionals.
- Difficulties encountered by licensed professional clinical counselors moving to North Dakota from other states.
- Dual licensure is a burden to the counselors and agencies and has made addiction counseling less attractive as a profession. Any person practicing addiction counseling in the state is required to be licensed by the Board of Addiction Counseling Examiners and licensed addiction counselors providing addiction counseling or addiction treatment services are also required to have a program license issued by DHS.
- The Mental Health America of North Dakota recently received a targeted technical assistance grant to develop peer-support specialist training curriculum and standards of practice for peer-support specialists. Certification will require an 80-hour course and passing a final examination.
- A plan for Area Health Educational Centers to administer behavioral health and other internships and proposed funding for health care internships in the state.
- Collaboration between SMHS and the UND School of Law to provide behavioral health experiences for health sciences and law school students.
- A proposal for a behavioral health and addiction in North Dakota program which is an interprofessional, collaborative, and team-based approach to providing behavioral health services from a central office.

The committee considered, but did not recommend, a bill draft to remove the matching funds requirement for behavioral health professionals in the loan repayment program.

Recommendation

The committee recommends a bill [17.0284.02000] to provide for clinical supervision of behavioral health professionals by behavioral health professionals outside of their respective professions and to provide for a report to the Legislative Management.

MANDATED HEALTH INSURANCE COVERAGE COST-BENEFIT ANALYSIS

North Dakota Century Code Section 54-03-28 provides a legislative measure mandating health insurance coverage may not be acted on by any committee of the Legislative Assembly unless accompanied by a cost-benefit analysis. The committee was assigned the responsibility of recommending a private entity, after receiving recommendations from the Insurance Commissioner, for the Legislative Council to contract with to perform the cost-benefit analysis for the 2017 legislative session. The Insurance Commissioner must pay the costs of the contracted services, and each cost-benefit analysis must include:

1. The extent to which the proposed mandate would increase or decrease the cost of services.
2. The extent to which the proposed mandate would increase the use of services.
3. The extent to which the proposed mandate would increase or decrease the administrative expenses of insurers and the premium and administrative expenses of the insured.
4. The impact of the proposed mandate on the total cost of health care.

North Dakota Century Code Section 54-03-28 provides any legislative measure mandating health insurance coverage may only be effective for the next biennium and is limited to the public employees health insurance program. For the subsequent Legislative Assembly, PERS must prepare and request introduction of a bill to repeal the expiration date and expand the mandated coverage to all accident and health insurance policies. In addition PERS is required to prepare a report which is attached to the bill regarding the effect of the mandated coverage or payment on the system's health insurance program. The Public Employees Retirement System must include information on the utilization and costs relating to the mandated coverage and a recommendation on whether the coverage should continue. The 2009-10 interim Health and Human Services Committee learned PERS is not required to use a consultant when evaluating legislative measures mandating health insurance coverage. However, if a future analysis does require additional resources, NDCC Section 54-52.1-06.1 provides a continuing appropriation to PERS for consulting services related to the uniform group insurance program.

The Insurance Commissioner has budgeted $15,000 to pay the costs of the contracted services for the 2017 legislative session, $5,000 less than the amount provided for the 2015 legislative session.

Health Insurance Mandate Analysis Costs

The committee received information regarding recent costs incurred by the Insurance Department for health mandate-related cost-benefit analyses. During the 2007 legislative session, there were no health insurance mandates referred for cost-benefit analysis. The Insurance Department paid a total of $28,070 to Milliman USA for analyses of three bills during the 2009 legislative session, and $14,982 to Milliman USA for analysis of one bill during the 2011 legislative session. There were no health insurance mandates referred for cost-benefit analysis during the 2013 legislative session. During the 2015 legislative session, the Insurance Department paid a total of $26,564 to Milliman USA for analyses conducted on three bills.

Legislative Rules Regarding Bills That Include Health Insurance Mandates

Beginning with the 2009 legislative session, the House changed House Rule 402 relating to bill introduction deadlines for measures subject to cost-benefit analysis under NDCC Section 54-03-28. The rule, as changed, provides a current legislator may submit a mandated health insurance bill to the Employee Benefits Programs Committee no later than April 1 of the year before a regular legislative session. Any new legislator taking office after November 30 of the year preceding the legislative session may submit a mandated health insurance bill for consideration by the Employee Benefits Programs Committee no later than the first Wednesday following adjournment of the organizational session. The Senate has not yet adopted this change relating to mandated health insurance bills.

Insurance Commissioner Recommendation

The Insurance Commissioner solicited proposals through an informal solicitation from 165 potential vendors for the cost of performing health insurance mandate cost-benefit analyses. Proposals, received from Milliman, Inc. and Acumen Actuarial LLC, were evaluated 60 percent on bidder qualifications and 40 percent on cost. The Insurance Commissioner recommended, based on the proposal received, the Legislative Council contract with Acumen Actuarial LLC to perform the cost-benefit analyses during the 65th Legislative Assembly.

Recommendation

The committee recommends the Legislative Council contract with Acumen Actuarial LLC, for cost-benefit analyses of legislative measures considered by the 65th Legislative Assembly mandating health insurance coverage pursuant to NDCC Section 54-03-28.

STATE FIRE MARSHAL REPORT

The 2009 Legislative Assembly approved House Bill No. 1368, which created NDCC Chapter 18-13 relating to reduced ignition propensity standards for cigarettes and penalties for wholesale and retail sale of cigarettes that violate the reduced propensity standards. North Dakota Century Code Section 18-13-02(6) requires the State Fire Marshal to review the effectiveness of test methods and performance standards and report each interim to the Legislative Council the State Fire Marshal's findings and any recommendations for legislation to improve the effectiveness of the law on reduced ignition propensity standards for cigarettes. The committee was assigned the responsibility to receive this report.

The chapter provides for enforcement of the standards by the State Fire Marshal, Tax Commissioner, and Attorney General and for monetary violations to be deposited in the fire prevention and public safety fund to be used by the State Fire Marshal to support fire safety and prevention programs. No funds were deposited into the fire prevention and public safety fund during the 2013-15 biennium, and there was no balance in the fund as of June 30, 2015. In addition fees collected for testing cigarettes are to be used by the State Fire Marshal for the purpose of processing, testing, enforcement, and oversight of ignition propensity standards. Cigarette manufacturers are required to pay the State Fire Marshal an initial $250 fee for certification, which is deposited in the Reduced Cigarette Ignition Propensity and Firefighter Protection Act enforcement fund. The committee learned deposits into the fund are estimated to total $85,000 during the 2013-15 biennium and expenditures are estimated to total $19,881. The balance in the Reduced Cigarette Ignition Propensity and Firefighter Protection Act enforcement fund was estimated to be $379,079 as of June 30, 2015.

The committee received a report from the State Fire Marshal, including a summary of test methods, performance standards, and certification results. According to the data collected from North Dakota's National Fire Incident Reporting System from January 2014 to September 2016, 147 fires within the state were caused by smokers, placing smoking as the sixth leading cause of fires in the state. There were 1,659 man hours invested in extinguishing these fires. From 2004 to 2013, North Dakota reduced its ranking from 6th to 26th for the greatest number of fire deaths. There are 27 different manufacturers that certify cigarettes and 14 different laboratories that test these cigarettes. The committee learned, as of January 1, 2016, there have been 692 cigarettes certified, which raised $173,000. The State Fire Marshal made no recommendation regarding changes to NDCC Chapter 18-13.

REPORT ON PLANS TO REDUCE THE INCIDENCE OF DIABETES IN THE STATE, IMPROVE DIABETES CARE, AND CONTROL COMPLICATIONS ASSOCIATED WITH DIABETES

House Bill No. 1443 (2013) requires DHS, the State Department of Health, the Indian Affairs Commission, and PERS to collaborate 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. Section 1 of the bill requires before June 1 of each even-numbered year, DHS, the State Department of Health, the Indian Affairs Commission, and PERS submit a report to the Legislative Management on the following:

1. The financial impact and effect diabetes is having on the agency, the state, and localities.
2. An assessment of the benefits of implemented programs and activities aimed at controlling diabetes and preventing the disease.
3. A description of the level of coordination existing between the agencies on activities; programmatic activities; and messaging on managing, treating, or preventing diabetes and diabetes complications.
4. The development or revision of detailed action plans for battling diabetes with a range of actionable items for consideration by the Legislative Assembly.
5. The development of a detailed budget blueprint identifying needs, costs, and resources required to implement the plan identified in item 4.

The committee was assigned the responsibility to receive this report.

The committee received the report from DHS, the State Department of Health, the Indian Affairs Commission, and PERS. The committee learned agency representatives shared information and examined data on the prevalence of diabetes and its financial impact. Agencies reviewed the status and benefits of current diabetes-related programs, funding, and collaborative efforts among agencies. Agencies identified action plans and recommendations to improve health outcomes in the state related to diabetes. The committee learned type 2 diabetes can be prevented with behavior changes at the individual level and at the population level. Agencies must collaborate to enact and support policies that make the healthy choice the default choice. The committee learned 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. The committee learned 49,000 adults in the state have diabetes and 202,000 have prediabetes. The committee received a summary of current efforts to address diabetes in the state including programs provided through the State Department of Health, DHS, and PERS. 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 health 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.

REPORTS ON THE STATE DEPARTMENT OF HEALTH HEALTH PROFESSIONAL ASSISTANCE PROGRAM STUDY

House Bill No. 1036 (2015) requires the State Department of Health evaluate state programs to assist health professionals, including behavioral health professionals, with a focus on state loan repayment programs for health professionals. The study must include:

1. Identification of state programs to assist health professionals;
2. Consideration of whether elements of the identified state programs could be standardized;
3. Evaluation of funding and usage of the identified state programs;
4. Evaluation of the effectiveness of these identified programs and how these programs could be revised to be more effective; and
5. Consideration of whether there are gaps or duplication in programs designed to assist health professionals.

Section 1 of House Bill No. 1036 requires, during the 2015-16 interim, the State Department of Health make periodic reports to the Legislative Management on the status of the study. In addition, before July 1, 2016, the department must report to the Legislative Management on the outcome of the study, including presentation of recommended legislation.

The Legislative Management may introduce legislation recommended by the department as part of the department's study report. The committee was assigned the responsibility to receive these reports.

The committee received a report from the State Department of Health. The committee learned 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. The health care professional student loan repayment program assists physicians and mid-level practitioners, as well as behavioral health practitioners. The new programs assist health care professionals by repaying student loans of licensed, practicing professionals who provide health care to underserved areas or populations. In addition to the dentists loan repayment program and the health care professional student loan repayment program, the study identified four 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.

The committee learned 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. If criteria were standardized, the two loan repayment 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. The two loan repayment 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. Because nearly all of the loan repayment slots are filled each year, the programs have been successful in bringing health care and dental professionals to underserved communities. Since 1993, 89.5 percent of program participants fulfilled their contracts. 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. 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. 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. Overall, 61.6 percent of participants have remained in an underserved area.

The committee learned the loan repayment programs would be more effective if additional funding were made available to increase the number of slots available for underserved communities. Increased communication, encouragement, and support to providers and their families would encourage more providers to continue to practice in underserved areas. The only gap noted in the study was that some health care professions are not eligible for the loan repayment program. There is interest in including optometry, pharmacy, chiropractic, and registered nursing programs to the health care professionals receiving loan repayment benefits. 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. Except for the DHS's 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. The State Department of Health recommended 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. The committee did not make any recommendations resulting from receiving this report.

REPORT ON THE CONTINUOUS IMPROVEMENT OF QUALITY OF CARE FOR INDIVIDUALS WITH STROKE

House Bill No. 1323 (2015) relates to the creation and implementation of a stroke system and provides for a report to the Legislative Management. The bill amended NDCC Section 23-43-04 to provide the State Department of Health establish and implement a plan for achieving continuous quality improvement in the quality of care provided under the state comprehensive stroke system for stroke response and treatment, establish a data oversight process, and implement a plan for achieving continuous quality improvement in the quality of care provided under the state comprehensive stroke system for stroke response and treatment. North Dakota Century Code Section 23-43-04(4) requires before June 1 of each even-numbered year, the department provide a report to the Legislative Management

regarding progress made toward the recommendations provided in NDCC Section 23-43-04 and any recommendations for future legislation. The committee was assigned the responsibility to receive this report.

The committee received a report from the State Department of Health and learned 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. 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. The committee received 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. The committee learned there are 24 critical access hospitals and 6 tertiary hospitals in the stroke registry and others are expected to join. 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. 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.

The committee learned 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. In 2015, hospitals received advance notification 77.4 percent of the time compared to 55.9 percent nationally. 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. The State Department of Health made no recommendation regarding future legislation.

REPORTS ON THE TOBACCO PREVENTION AND CONTROL ADVISORY COMMITTEE GRANT TO THE STATE DEPARTMENT OF HEALTH

House Bill No. 1024 (2015) included $500,000 from the tobacco prevention and control trust fund for a grant to the State Department of Health to be used for the CDC's *Best Practices for Comprehensive Tobacco Control Programs - 2014* during the 2015-17 biennium. Section 2 of the bill requires the Tobacco Prevention and Control Advisory Committee and the State Department of Health to report to the Legislative Management by September 1, 2016, regarding grant expenditures, the granting process, and reporting requirements of the grant. The committee was assigned the responsibility to receive this report.

The 2015 Legislative Assembly, in House Bill No. 1004, provided a total tobacco prevention appropriation of $6,910,177 to the State Department of Health, of which $3,440,864 is from the community health trust fund, $2,969,313 is from federal funds, and $500,000 is from a grant provided by the Tobacco Prevention and Control Advisory Committee from the tobacco prevention and control trust fund. Funding from the community health trust fund provides for community health tobacco programs, the Tobacco Quitline, and a tobacco prevention coordinator. Certain tobacco-related programs currently provided through the State Department of Health qualify as best practices as outlined by CDC. As a result, the funding for the Tobacco Prevention and Control Executive Committee is adjusted accordingly. The committee learned the State Department of Health was notified in March 2015 that funding for tobacco prevention and control activities provided by CDC would be reduced by approximately $500,000 for the 2015-17 biennium. Because the State Department of Health anticipated reductions in federal funding available for tobacco prevention and control, the Legislative Assembly increased 2015-17 biennium authority for the Tobacco Prevention and Control Executive Committee and the department to provide for a $500,000 grant from the tobacco prevention and control trust fund to the department.

The committee received reports from Center for Tobacco Prevention and Control Policy and the State Department of Health. Because promotion of NDQuits is included in both the department's and the advisory committee's work plan activities, the department used the funds to support advertising for NDQuits, the state's phone- and web-based quit services. The advisory committee provided a media plan that would meet its requirements for CDC *Best Practices for Comprehensive Tobacco Control Programs - 2014* and the department contracted with Odney Advertising to implement the media plan. The committee learned the $500,000 grant was provided for the period beginning July 24, 2015, and ending June 30, 2016. The department reported quarterly to the advisory committee, completed the grant project, and billed quarterly for the entire $500,000 contract. The committee learned from January through March 2016, compared to the same period in the previous year, telephone enrollments in NDQuits increased 100 percent, while web enrollments increased 13 percent.

OTHER INFORMATION RECEIVED

Health Care Workforce

The committee received a report from a health care workforce task force. The task force identified the following three goals:

- Explore the possibility of new Americans filling workforce needs in health care;
- Explore strategies to recruit health care providers in rural communities by providing more internships and preceptorships in rural health care facilities; and
- Develop more collaborative efforts to fill all of the slots available in nursing programs across the state and to provide nonaccepted applicants guidance in developing a health care career path.

The committee received information from the North Dakota Center for Nursing regarding nursing workforce capacity, including behavioral health nurses, nursing faculty recruitment and retention, and the need for advanced practice registered nurse preceptors. There are more applicants for the state's nursing programs than slots available. One of the barriers to expanding nursing programs is the lack of qualified faculty. Other advance degree career options are often considered more attractive and lucrative. The state's nursing programs have faculty positions they have been unable to fill or have filled with unqualified faculty working toward a master's degree.

The committee received information and testimony relating to the nursing work force from the UND College of Nursing, North Dakota State University School of Nursing, North Dakota Nurses Association, College and University Nursing Education Administrators, and American Association of Nurse Practitioners. The committee learned stakeholders recommend increasing funding for the health professional loan repayment program, adjustments to the program to remove the matching funds requirement, and including registered nurses and licensed practical nurses to the those eligible for loan repayment. Other recommendations include a new nursing faculty loan forgiveness program for nursing education program faculty to obtain master's and doctorate degrees while serving as faculty, an income tax credit of $1,000 for each clinical rotation of at least 160 hours for advanced practice registered nurses that serve as a preceptor, and adding advanced practice registered nurses to those authorized to order detoxification holds.

The committee considered, but did not recommend, a bill draft to provide for an income tax credit for advanced practice registered nurse preceptors.

Recommendation

The committee recommends a bill [17.0282.02000] to establish a loan forgiveness program for nursing faculty.

University of North Dakota School of Medicine and Health Sciences -
Health Issues for the State of North Dakota 2015

The committee received a report from the Center for Rural Health at SMHS entitled *Health Issues for the State of North Dakota 2015*, including an update on the construction of the new SMHS building. The biennial report includes information regarding the state's population, health care needs, physician and other health care workforce, health care infrastructure, quality and value of health care, workforce development, and recommendations for health care planning in the state. The Center for Rural Health will update the information and issue the fourth biennial report in December 2016, which will include information on dental workforce and oral health. The committee learned 13 counties in the state do not have a physician and 7 counties have one physician providing care for between 3,500 to 10,000 people. The ratio of physicians to 10,000 population is 24.1 in North Dakota, compared to 25.1 in the Midwest, and 27 nationally. The School of Medicine and Health Sciences has increased the medical school class size by 16 students per year, the number of residencies by 17 per year, and the number of other health sciences students by 15 percent. The School of Medicine and Health Sciences has also revised the medical school admissions process to admit students more likely to stay in the state. The new SMHS building will total 325,446 square feet, is on budget and opened on time in the summer of 2016. There will be approximately 78 doctors graduating from SMHS in 2020 and historically approximately 45 percent stay in the state. Between 1984 and 2014, approximately 22 percent of SMHS graduates have gone into primary care, while nationally 11 percent of medical school graduates enter primary care.

Survey of Agency Alcohol, Drug, Tobacco, and Risk-Associated Behavior Prevention and Treatment Programs

The committee received a report entitled *Survey of Agency Alcohol, Drug, Tobacco, and Risk-Associated Behavior Prevention and Treatment Programs*. The report identifies funds originally appropriated for prevention or treatment programs relating to risk-associated behavior, including whether programs relate to prevention, treatment, or enforcement of risk-associated behavior. Agencies reported a total of $144.7 million is budgeted for risk-associated programs during the 2015-17 biennium, $14.9 million less than the $129.8 million spent during the 2013-15 biennium. Of the $144.7 million budgeted for the prevention and treatment of alcohol, tobacco, 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.

Interagency Program for Assistive Technology

The committee received information regarding assistive technology and telehealth. North Dakota Interagency Program for Assistive Technology serves all ages and all types of disabilities. The committee learned North Dakota Interagency Program for Assistive Technology administers an Assistive Technology Act contract. The biennial budget for the program is approximately $1.3 million, including $700,000 from federal funds and $580,000 from the general fund. The program provides assistive technology equipment demonstrations, training, public awareness events, equipment loans, alternative financing programs, and an equipment reuse program. Other services include assistive safety device distribution; telecommunications equipment distribution; deaf-blind program; assistive technology financial loan program; Sprint telecommunications demonstrations; vocational rehabilitation transition program; and other services, such as assessments, consultations, and training.

Program of All-Inclusive Care for the Elderly

The committee received information regarding the program of all-inclusive care for the elderly (PACE). The committee learned Northland Healthcare Alliance began the PACE program in North Dakota in 2008, opening sites in Bismarck and Dickinson and since has added a site in Minot in July 2015. Northland PACE has served approximately 300 people since 2008. To be eligible for PACE, participants must be at least 55 years old, qualify for nursing home level of care, be able to live safely in your own home, and live within an area served by PACE. All PACE participants meet the standard minimum criteria for admission to a skilled nursing facility, but intervention allows them to maintain a better quality of life by remaining in their own homes for a longer period of time. Payment rates for PACE are less than skilled nursing facility care payments, resulting in Medicaid savings to the state. Northland PACE recommended the moratorium placed on the expansion of PACE during the last legislative session be removed and that the Legislative Assembly support the expansion and funding of PACE in additional communities.