

# HEALTH SERVICES COMMITTEE

The Health Services Committee was assigned the following responsibilities:

1. Section 1 of House Bill No. 1454 (2013) directed a study of how to improve access to dental services and ways to address dental service provider shortages, including the feasibility of utilizing mid-level providers, whether the use of incentives for dental service providers to locate in underserved areas in the state may improve access, and whether the state's medical assistance reimbursement rates impact access to dental services.
2. Section 2 of Senate Bill No. 2024 (2013) directed a study of the comprehensive statewide tobacco prevention and control plan used in this state. As part of the study, the Tobacco Prevention and Control Executive Committee and the State Department of Health must work together to create a single assessment of programs in both agencies, including funding sources for the programs, service providers, areas and populations served by the programs, and effectiveness of the programs on improving the health and policy environment in the state. The Tobacco Prevention and Control Executive Committee and the State Department of Health must present this assessment to the Legislative Management.
3. Senate Concurrent Resolution No. 4002 (2013) directed a study of the feasibility and desirability of community paramedics providing additional clinical and public health services, particularly in rural areas of the state, including the ability to receive third-party reimbursement for the cost of these services and the effect of these services on the operations and sustainability of the current emergency medical services (EMS) system.
4. Section 9 of Senate Bill No. 2004 (2013) directed a study of the funding provided by the state for autopsies and state and county responsibilities for the cost of autopsies, including the feasibility and desirability of counties sharing in the cost of autopsies performed by the State Department of Health and the University of North Dakota (UND) School of Medicine and Health Sciences.
5. 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 Section 54-03-28.
6. The Legislative Management also assigned the committee the responsibility to receive:
  - a. A report from the State Fire Marshal regarding findings and recommendations for legislation to improve the effectiveness of the law on reduced ignition propensity standards for cigarettes.
  - b. A report from the Department of Human Services, State Department of Health, Indian Affairs Commission, and Public Employees Retirement System (PERS) before June 1, 2014, 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.
  - c. A report from the North Dakota University System before November 15, 2013, regarding the findings of its study of the out-of-state programs in veterinary medicine, optometry, and dentistry; the access of North Dakota students to those programs; and the state's needs for dentists, optometrists, and veterinarians.

Committee members were Senators Judy Lee (Chairman), Howard C. Anderson, Jr., Robert Erbele, Joan Heckaman, Oley Larsen, and Tim Mathern and Representatives Dick Anderson, Alan Fehr, Curt Hofstad, Rick Holman, Jon Nelson, and Marvin E. Nelson.

## DENTAL SERVICES STUDY

Section 1 of House Bill No. 1454 directed a study of how to improve access to dental services and ways to address dental service provider shortages, including the feasibility of utilizing mid-level providers, whether the use of incentives for dental service providers to locate in underserved areas in the state may improve access, and whether the state's medical assistance reimbursement rates impact access to dental services.

### Background

The committee reviewed previous studies and reports relating to access to dental services and ways to address dental service provider shortages, including a report received by the 2007-08 interim Human Services Committee on the status of medical assistance recipients' access to dental services.

Medicaid dental-related expenditures totaled \$12.3 million for the 2005-07 biennium and \$14.5 million for the 2007-09 biennium. During the 2009-11 biennium, dental expenditures under Medicaid totaled \$23.5 million--a 62 percent increase from 2007-09 biennium expenditures. During the 2011-13 biennium and 2013-15 biennium, funding appropriated for Medicaid dental services totaled \$24 million and \$28.7 million, respectively.

## State Dental Care Programs

The committee reviewed state programs relating to dental care, including:

- **Medicaid** - An assistance program for eligible individuals without health insurance or for those whose health insurance does not cover all of their needs. Medicaid provides limited dental care services, and copayments may apply for certain recipients.
- **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.
- **Health Tracks** - Formerly early periodic screening diagnosis and treatment, Health Tracks is a preventative health program that is free for children aged 0 to 21 who are eligible for Medicaid. Health Tracks pays for screenings, diagnosis, and treatment services to help prevent health problems from occurring or help keep health problems from becoming worse. Health Tracks also pays for orthodontics.
- **Mobile dental care services** - In 2009 the Legislative Assembly provided \$196,000 of one-time funding from the general fund to the State Department of Health to help establish a mobile dental facility. An area foundation is responsible for ongoing costs estimated at \$400,000 per year. The 2013 Legislative Assembly provided an additional one-time appropriation of \$100,000 from the general fund to the State Department of Health for a grant to the organization to provide mobile dental care services, including dental treatment, prevention, and education services to low-income and underserved children in areas of the state with limited or unavailable dental services.
- **Donated dental services program** - Supported by a \$50,000 general fund appropriation to the State Department of Health during the 2013-15 biennium, the program provides dental care, through a network of 141 volunteer dentists and 29 dental laboratories, to disabled, elderly, or medically compromised individuals who cannot afford treatment. The committee learned 671 individuals have received over \$2 million in donated dental therapies since the program's inception in 2000.
- **Smiles for Life fluoride varnish program** - A school-based fluoride varnish and sealant program.

## Dental Service Provider Programs

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

- **Dental practice grant program** - Established in 2007 by the Legislative Assembly, the program allows a dentist who has graduated from an accredited dental school within the previous five years and is licensed to practice in North Dakota to submit an application to the Health Council for a grant to establish a dental practice in North Dakota cities with populations of 7,500 or less. The Health Council may award a maximum of two grants per year with a maximum grant award of \$50,000 per applicant to be used for buildings, equipment, and operating expenses. The community in which the dentist is located must provide a 50 percent match. The grant must be distributed in equal amounts over a five-year period, and the dentist must commit to practice in the community for five years.
- **State loan repayment program** - Established in 2001, the dentists' loan repayment program provides loan repayment benefits to dentists willing to serve in underserved communities in the state. Each year the Health Council may select up to three dentists to participate in the program. Successful applicants must enter a four-year, full-time, nonrenewable contract with the State Department of Health, must accept Medicare and Medicaid assignment, and may receive up to \$80,000 to repay eligible loans. The funds are payable over a four-year period (\$20,000 per year). The program provides the highest priority for acceptance into the program to dentists willing to serve the smallest and most underserved communities in North Dakota.
- **Public health and nonprofit dental loan repayment program** - A program providing loan repayment benefits to up to three dentists during the 2013-15 biennium willing to serve in public health and nonprofit dental settings that offer a discounted or sliding fee scale for patient billing. Successful applicants must serve full time for three years and may receive up to \$60,000 over two years to repay educational loans.
- **Federal/state loan repayment program (SLRP)** - A program providing loan repayment benefits to dentists serving in communities designated as dental health professional shortage areas (HPSAs). The program was established through a grant from the federal Health Resources and Services Administration (HRSA), is only available in communities designated as dental HPSAs, and requires the state must match federal funds.

Successful applicants may receive up to \$60,000 to repay educational loans and must agree to a two-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 two-year commitment. This program does not require matching funds, and providers may receive continuation awards.

### **North Dakota State College of Science Dental Programs**

The committee reviewed North Dakota State College of Science dental programs and options to expand those programs. The college offers two options, including a certificate and an associate in applied science. The college receives between 48 and 59 applicants per year for the dental assisting program which has a capacity of 20 students. The dental hygiene program graduates approximately 25 students per year with an Associate in Applied Science in Dental Hygiene degree, over half of which also obtain an Associate in Applied Science in Liberal Arts degree. Most of the students are from North Dakota cities with populations of less than 50,000. A bachelor's degree in dental hygiene would require 30 to 35 additional credit-hours.

The college has placed 100 percent of the dental assisting graduates each year since 2010. Placement rates for the dental hygiene program from 2010 to 2013 ranged from 91 percent in 2010 to 100 percent in 2011. In 2013 the average salary of a dental assistant was \$2,704 per month, and the average salary of a dental hygienist was \$4,132 per month.

### **Dental Health Workforce**

The committee reviewed a report on the health care workforce in the state. The UND School of Medicine and Health Sciences 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 in April 2014, there were 435 dentists, an increase of 10.9 percent from 2010. There were also 653 dental assistants and 747 dental hygienists in the state in April 2014.

Currently 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 three years, and counties are continually reviewed for HPSA status.

The committee received information regarding the distribution of dentists in the state and the appropriate number of dentists in a population. Nationally, the recommended ratio is one dentist per 1,612 residents and in North Dakota the ratio of dentists to population is approximately one dentist per 1,750 residents. This ratio compares favorably with South Dakota (1:1,890) and Iowa (1:1,825) but not with Minnesota (1:1,630). The committee learned North Dakota's growing economy has brought more dentists to the state to practice and the number of licenses issued by the State Board of Dental Examiners has been steadily increasing. The favorable ratio of dentists to population indicates the state does not have a shortage of dentists but rather a misdistribution of dentists around the state.

### **Access to Dental Services**

The committee received information regarding an environmental scan and contextual assessment of the oral health of North Dakota's residents done in 2012 by the Center for Health Workforce Studies at the School of Public Health, University at Albany, New York. The report indicated oral health professionals are located mostly in urban areas of the state and several counties are without a practicing dentist. The federal government has designated 31 dental health professional shortage areas in the state which lack sufficient providers to meet the dental needs of the population. The environmental scan and assessment indicated, while the state has made progress in increasing access to oral health services, some populations still have limited access to these services, including children, especially the very young and those Medicaid-eligible; rural populations; low-income adults; the elderly; and American Indians. A shortage of dentists willing to accept Medicaid patients has resulted in a small number of dentists in the state 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.

The committee learned barriers to accessing oral health care exist in the state and 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. Additional barriers, particularly in reservation communities, include insufficient federal funding and administrative challenges in clinics. Indian Health Service (IHS)

procedures are onerous for volunteers and it can take six months to nine 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 and access to dentists and dental services on the reservations has been limited for decades.

A 2008 survey reported less than one-fourth of North Dakota dentists accept all Medicaid patients, one-third of dentists limit the number of new Medicaid patients, and rural dentists are more likely to accept all Medicaid patients than urban dentists.

The committee learned 40 counties had a dentist that provided a service to 1 to 49 children (ages 0 to 20 years) enrolled in Medicaid, 26 counties had a dentist that provided a service to 50 to 99 children enrolled in Medicaid, and 18 counties had a dentist that provided service to 100 or more children enrolled in Medicaid.

The committee learned Medicaid payments for dental services are approximately 61.6 percent of billed charges in North Dakota. Increasing the Medicaid reimbursement to the 75th percentile would encourage more dental service providers to serve that population.

The committee learned the state has four safety net dental clinics, three of which are federally qualified health centers (FQHCs). The dentists at safety-net clinics often perform extractions that could have been prevented with timely access to comprehensive education and preventative care. Safety-net clinics have few places to refer patients needing more complex procedures, and patients often go without necessary care. Providers at safety net clinics struggle with the limited scope of practice and not practicing to the full extent of their training results in higher turnover rates at these clinics.

Legislation was approved in 2009 authorizing general supervision of licensed dental hygienists for procedures authorized in advance by a dentist. In 2011 four public health hygienists employed by the State Department of Health and paid through a federal grant began applying fluoride varnish and dental sealants to children in prekindergarten through sixth grade and in some schools grades 7 through 12. Since 2011, the program has served approximately 1,700 students per year. However, loss of the federal grant has resulted in a significant reduction in the number of students served.

The committee learned a HRSA workforce grant will provide \$400,000 per year for school-based dental health prevention services. Part of the funding will be contracted to Ronald McDonald House Charities and Bridging the Dental Gap to expand their service area and the remainder will be used for the department's sealant program. When the department received the federal funding to reestablish school-based dental health prevention services in September 2014, the target population was 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. The additional cost to serve all students in the state eligible for free or reduced lunches would be approximately \$2.6 million.

## **Proposals to Increase Access**

### **Case Management**

The committee received information regarding a proposed case management program in communities with the most need. The program could provide oral health education and coordinate dental care to help eliminate the "no-show" problem faced by dental providers. 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 has been shown to reduce barriers to care for Medicaid recipients. Case management would include educating individuals, identifying barriers to care, and following up to remove barriers and link the patient to a dental home.

Grant funding is available as part of a pilot project for the reimbursement of outreach services and administrative costs of a case management program study. State support would be needed for matching grants to implement the model. The five-year pilot project would provide an opportunity to prove case management is a cost-effective service and that it has the potential to significantly reduce dental costs, improve oral health, and decrease tooth decay.

### **Expanded Function Dental Auxiliary**

The committee learned creating expanded function dental assistants and hygienists would free up dentists to provide other services. The expanded function dental auxiliary (EFDA) exists in 44 states, the District of Columbia, Public Health Service, Indian Health Service, and the United States military. Expanded function dental auxiliaries have been shown to improve efficiencies which can lead to increased access and lower costs. Benefits to employing an EFDA include: dentists already have a working relationship with the EFDAs and the increased function will provide for

efficiencies, existing staff would not have to leave the community for training, investments made in the existing workforce living and working in the area are less likely to practice elsewhere.

The committee reviewed amendments to Article 20-01 of North Dakota Administrative Code proposed by the State Board of Dental Examiners to expand the functions of dental assistants and hygienists. The proposed amendments broaden the scope of practice for the licensed dental hygienist and the registered dental assistant by creating two categories for each profession--the restorative function endorsement and the anesthesia assistant endorsement. Oral assessment and oral hygiene treatment planning have been expanded, and the list of duties includes additional restorative and anesthesia functions performed under appropriate supervision.

### **Mid-Level Dental Providers**

Dental therapists have practiced in New Zealand and the United Kingdom for decades. Existing comprehensive program accreditation processes include standards on admission policies and procedures, curriculum, clinic, administration, preparation for practice, student assessment and examination, evaluation procedures and outcomes, research, and articulation pathways (team integration experience). Minnesota recognizes dental therapists to provide specific dental services. Two models exist in Minnesota--the dental therapist (DT) and the advanced dental therapist (ADT). In Alaska dental therapists only provide care within the tribal health system. Dental therapists may educate patients, perform oral examinations and preventative procedures, drill and repair early stages of tooth decay, and assist in other procedures.

**Minnesota** - The dental therapy program at the School of Dentistry, University of Minnesota, is in its fifth year, and through December 2013, the program graduated 27 dental therapists in three classes. Dental therapy students are fully integrated into the existing accredited dental and dental hygiene education programs. The Board of Dentistry of Minnesota has accredited the program. The federal Centers for Medicare and Medicaid Services (CMS) has demonstrated interest in the dental therapy model by awarding a \$45 million state innovation model grant to the Minnesota Department of Health and the Minnesota Department of Human Services. The goal of the innovation model is to expand the use of innovative provider types within primary care practices, and the grant will support the integration of new providers, such as dental therapists, into clinical practices. Minnesota's dental therapists are employed in private practice, group practice, nonprofit community clinics, and FQHCs. They are employed in urban and rural areas, and feedback from employers has been positive. The committee received a report entitled *Early Impact of Dental Therapists in Minnesota* presented to the Minnesota Legislature in February 2014. Preliminary results included in the report indicate:

- Clinics employing DTs/ADTs see more patients, and most are on public programs and are underserved;
- DTs/ADTs improve efficiency of clinics, allowing dentists to handle more complex procedures;
- DTs/ADTs have reduced wait times and travel distances for patients;
- DTs/ADTs produce direct cost-savings to dental clinics;
- Dental clinics use most savings from DTs/ADTs to see more public program and underserved patients;
- No quality or safety concerns; and
- Further research is needed since the program is new and the number of DTs/ADTs is relatively small.

**Alaska** - Dental therapists in Alaska only provide care within the tribal health system; however, they may treat nonnative patients only if there is no access to a dental service provider and there is a compact agreement with the IHS to treat nonnative patients. A 2010 study funded by the W.K. Kellogg Foundation, the Rasmuson Foundation, and the Bethel Community Service Foundation, confirmed that dental therapists are filling a vital need in Alaska, expanding the services of dentists, and allowing those in remote areas to receive care. The evaluation suggests alternative workforce models like dental therapists can be part of the solution as they expand the outreach of the dental team, provide treatment and alleviate pain for vulnerable families and children who have not had regular access to care, and often return to practice in the underserved communities where they grew up. In Alaska dental therapists have been providing preventative and basic dental care in remote tribal villages since 2005. In 2013, 25 certified dental therapists were working in over 80 villages in Alaska to provide care to over 30,000 individuals who previously had limited or no access to dental care. A 2010 study found that 95 percent of patients were satisfied or very satisfied with care received from dental therapists.

### **North Dakota Center for Rural Health Assessment**

The committee received a report from the North Dakota Center for Rural Health regarding findings included in its preliminary report titled *North Dakota Oral Health Report: Needs and Proposed Models, 2014*. The report was the result of a Center for Rural Health assessment of the oral health needs in the state. Based on data, input member responses, and stakeholder meetings, three primary oral health needs were identified, including prevention programs,

dental insurance revision and/or care access, and greater workforce and improved access to care. The greatest need for oral health literacy and prevention was among special populations--children, aging, Medicaid patients, low-income, homeless, new Americans, American Indians, rural, and those with physical/mental disabilities. Increased Medicaid reimbursement would incentivize dentists to accept more Medicaid patients and services to long-term care residents could be restructured to fit current Medicare reimbursement. There is a need to adjust the uneven distribution of the current workforce. In 2013, 67 percent of all licensed dentists in the state worked in the four largest counties.

The stakeholder and input groups developed and discussed 24 possible oral health models and the stakeholder working group identified the following top five stakeholder priority models:

1. Increase funding and reach of safety-net clinics to include services provided in western North Dakota, using models/idea/support from nonprofit oral health programs similar to Apple Tree Dental and Children's Dental to promote hub-and-spoke models of care.
2. Increase funding and reach of the Seal!ND program to include using dental hygienists to provide care and incorporating case management and identification of a dental home as proposed under the North Dakota Dental Association's case management model, including Medicaid reimbursement for services rendered.
3. Expand scope of dental hygienists and utilize dental hygienists at the top of their current scope of work to provide community-based preventive and restorative services and education among populations of high need.
4. Create a system to promote dentistry professions among state residents and encourage practice in North Dakota through a consolidated loan repayment program and partnership/student spots at schools of dentistry.
5. Increase Medicaid reimbursement.

### **North Dakota Oral Health Coalition**

The committee received information regarding the recommendations of the North Dakota Oral Health Coalition. The coalition's recommendations are similar to the models identified by the North Dakota Center for Rural Health and include:

- Expand the Seal!ND program through the State Department of Health oral health programs to target low-income children at public schools;
- Expand funding for dental safety net clinics to include mobile, nonprofit and FQHCs;
- Expand, simplify, and consolidate the North Dakota dental loan repayment programs;
- Provide funding for the case management outreach model supported through the State Department of Health and the North Dakota Dental Association;
- Facilitate the expansion of duties for dental assistants and hygienists through innovative, nontraditional, outreach education programs to minimize geographic and employment barriers for the current workforce.

### **Other Information and Testimony**

The committee conducted a tour of Family HealthCare, Fargo, one of four safety net dental clinics in the state. The committee learned patients are served regardless of ability to pay, and services are billed on a sliding fee scale. The committee learned the state public health dentist loan repayment program has helped the clinic recruit dentists. However, because the clinic is only able to perform basic procedures and must refer patients for additional services, such as crowns, partials, and dentures, providers are unable to perform to their full scope of practice, resulting in high turnover rates.

The committee received information and testimony from other interested persons, including representatives of the dental therapy training programs in Minnesota and Alaska, The Pew Charitable Trusts, North Dakota Center for Rural Health, North Dakota State College of Science, and the North Dakota State Board of Dental Examiners, various dental professionals, professional organizations, the Indian Affairs Commissioner, community health centers, senior housing and assisted living centers, and other stakeholders. Major comments and information provided include:

- A not-for-profit organization is serving adults with disabilities, long-term care residents, and low-income children and their families in urban and rural communities using a hub and spoke model of care delivery providing clinical student rotations for dental students, dental residents, DTs, dental hygienists, dental assistants, nurses, and certified nursing assistants. Mobile equipment and web-based information technology allow the organization to provide services in nursing facilities, including oral health education for patients and staff, preventative care, dental screenings, and triage and care coordination.
- The dental loan repayment programs have been successful in providing access to dental care in many rural and underserved communities.

- Public health clinics are an integral part of the state's oral health delivery system and dental loan repayment programs encourage dentists to work in safety net clinics.

### **Recommendation**

The committee recommends a concurrent resolution [[15.3027.02000](#)] directing the Legislative Management to continue to study 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.

### **COMPREHENSIVE STATEWIDE TOBACCO PREVENTION AND CONTROL STUDY**

Section 2 of Senate Bill No. 2024 directed a study of the comprehensive statewide tobacco prevention and control plan used in this state. As part of the study, the Tobacco Prevention and Control Executive Committee and the State Department of Health must work together to create a single assessment of programs in both agencies, including funding sources for the programs, service providers, areas and populations served by the programs, and effectiveness of the programs on improving the health and policy environment in the state. The Tobacco Prevention and Control Executive Committee and the State Department of Health must present this assessment to the Legislative Management. In addition, the bill provides the study may include:

- a. A review of the service delivery system for the comprehensive statewide tobacco prevention and control programs provided by the two agencies, whether the delivery system is fiscally efficient, and how the delivery system is consistent with the Centers for Disease Control and Prevention's (CDC) *Best Practices for Comprehensive Tobacco Prevention and Control Programs*;
- b. A review of the effectiveness of the comprehensive statewide tobacco prevention and control programs provided in the state and ways to improve the health and policy outcomes of the programs; and
- c. A review of how the comprehensive statewide tobacco prevention and control programs provided by the two agencies address the Native American population on the Indian reservations.

### **Background**

The committee reviewed information relating to the comprehensive statewide tobacco prevention and control plan provided to the 2011-12 interim Health Services Committee, including smoking rates and related trends in tobacco prevention and control spending, cigarette tax rates, and smoke-free environment laws. The committee learned cigarette use is measured based on data from the CDC behavioral risk factor surveillance survey. The committee received information regarding adult cigarette use in each state and the District of Columbia from 2000 to 2010. Overall adult cigarette use in North Dakota declined from 23.2 percent in 2000 to 17.4 percent in 2010. The 5.8 percent reduction in adult cigarette use from 2000 to 2010 in the state ranked North Dakota 18<sup>th</sup> among the 50 states and the District of Columbia.

The committee received information regarding a multistate settlement agreement negotiated between various states' Attorneys General and tobacco manufacturers, which resulted in annual distributions of tobacco settlement proceeds to the state. The 1999 Legislative Assembly established a plan for the use of this money through the passage of House Bill No. 1475 (Section 54-27-25), which established a tobacco settlement trust fund. Tobacco settlement payments received by the state under the Master Settlement Agreement are derived from two subsections of the Master Settlement Agreement. Subsection IX(c)(1) of the Master Settlement Agreement provides payments on April 15, 2000, and on April 15 of each year thereafter in perpetuity, while subsection IX(c)(2) of the Master Settlement Agreement provides for additional strategic contribution payments that began on April 15, 2008, and continue each April 15 thereafter through 2017. Section 54-27-25, created by 1999 House Bill No. 1475, did not distinguish between payments received under the separate subsections of the Master Settlement Agreement and provided for the deposit of all tobacco settlement money received by the state into the tobacco settlement trust fund. Money in the fund, including interest, is transferred into the community health trust fund (10 percent), common schools trust fund (45 percent), and water development trust fund (45 percent).

The November 2008 voter approved Initiated Measure No. 3 amended Section 54-27-25 to establish the tobacco prevention and control trust fund. The measure provided for tobacco settlement money received under subsection IX(c)(1) of the Master Settlement Agreement to continue to be deposited in the tobacco settlement trust fund and tobacco settlement money received under subsection IX(c)(2) of the Master Settlement Agreement relating to strategic contribution payments to be deposited from 2009 to 2017 into the tobacco prevention and control trust fund.

The measure also established the Tobacco Prevention and Control Advisory Committee and an executive committee to develop and fund a comprehensive statewide tobacco prevention and control plan consistent with the CDC's Best Practices for Comprehensive Tobacco Control Programs.

## Comprehensive Tobacco Control Programs and Funding and Centers for Disease Control and Prevention Best Practices

State programs for tobacco prevention and control are administered by the State Department of Health and the North Dakota Center for Tobacco Prevention and Control Policy. Funding for the programs is provided from the tobacco prevention and control trust fund, the community health trust fund, and federal funds. The Legislative Assembly appropriated a total of \$21,360,079 for tobacco prevention and control programs for the 2013-15 biennium, \$3,220,354 of which is from the community health trust fund and \$2,323,897 of federal funds to the State Department of Health and \$15,815,828 of which is from the tobacco prevention and control trust fund to the Center for Tobacco Prevention and Control Policy. The 2013-15 biennium ending balance in the tobacco prevention and control trust fund is estimated to be \$46.4 million and the ending balance in the community health trust fund is estimated to be \$337,000.

The committee received information regarding CDC established "best practices" guidelines to help states plan and administer effective tobacco use prevention and control programs. The CDC published its *Best Practices for Comprehensive Tobacco Control Programs*, including related funding recommendations, in October 2007. Recommended program intervention budgets totaled \$14.67 per capita per year in 2007 for North Dakota, and the CDC-recommended annual investment was \$9.3 million or \$18.6 million per biennium. Based on CDC guidelines, not adjusted for inflation or population growth, the biennial funding for recommended program budgets outlined in the publication by intervention is:

- State and community interventions - \$9,344,640.
- Health communication interventions - \$2,358,480.
- Cessation interventions - \$4,462,140.
- Surveillance and evaluation - \$1,623,780.
- Administration and management - \$810,960.

The Tobacco Prevention and Control Executive Committee provided information to the 2013 Legislative Assembly regarding CDC-recommended funding levels for tobacco control programs and the effect of inflation and population changes on the recommended funding level for North Dakota. The executive committee indicated, based on published consumer price index changes and Moody's Analytics consumer price index changes for 2013 and 2014, the recommended annual per capita funding rates for the recommended interventions would total \$17.02 and \$17.44 for 2013 and 2014, respectively. Total CDC-recommended funding based on these rates and state population totals, adjusted proportionally for recent growth, would total \$25 million for the 2013-15 biennium.

The committee reviewed information regarding the service delivery systems for the comprehensive statewide tobacco prevention and control programs provided by the State Department of Health and Center and how the delivery systems are consistent with the CDC's *Best Practices for Comprehensive Tobacco Control Programs*.

The committee received information regarding a comparison of State Department of Health and North Dakota Center for Tobacco Prevention and Control Policy funding allocations for the 2011-13 biennium to the CDC-recommended funding allocations:

<b>2011-13 Biennium Tobacco Prevention and Control Funding Allocation</b>				
	<b>State Department of Health</b>	<b>Tobacco Prevention and Control Executive Committee</b>	<b>Total</b>	<b>CDC-Recommended Funding Allocation</b>
State and community interventions	5%	40%	45%	50%
Health communications		12%	12%	13%
Cessation	21%	10%	31%	24%
Surveillance and evaluation	2%	5%	7%	8%
Administration and management	2%	3%	5%	5%
<b>Total</b>	<b>30%</b>	<b>70%</b>	<b>100%</b>	<b>100%</b>

The committee learned total tobacco prevention and control spending by the State Department of Health and the North Dakota Center for Tobacco Prevention and Control Policy for the 2009-11 and 2011-13 bienniums, compared to the CDC-recommended funding levels for each focus area, was less than recommended by the CDC, as adjusted for inflation and population; however, there is no penalty for spending at levels less than the CDC-recommended level. The committee received the following information regarding the estimated allocation of the \$21.4 million provided to the State Department of Health and the Center for Tobacco Prevention and Control Policy for tobacco prevention and control programs during the 2013-15 biennium and the CDC-recommended funding for the same period:

**Estimated Allocations of the 2013-15 Biennium Tobacco Prevention and Control Funding Appropriation and CDC-Recommended Funding**

	<b>State Department of Health<sup>1</sup></b>	<b>Tobacco Prevention and Control Executive Committee</b>	<b>Total</b>	<b>CDC-Recommended Funding Allocation<sup>2</sup></b>
State and community interventions	\$942,522	\$9,614,644	\$10,557,166	\$11,725,765
Health communications		2,639,944	2,639,944	2,952,430
Cessation	3,880,976	1,486,282	5,367,258	5,597,024
Surveillance and evaluation	388,098	1,408,221	1,796,319	2,028,921
Administration and management	332,655	666,737	999,392	1,021,457
<b>Total</b>	<b>\$5,544,251</b>	<b>\$15,815,828</b>	<b>\$21,360,079</b>	<b>\$23,325,597<sup>2</sup></b>

<sup>1</sup>The State Department of Health allocation by focus area is based on 2011-13 allocation percentages.

<sup>2</sup>The CDC-recommended funding allocation provided is based on known inflation and population at the time the budget is drafted. A CDC-recommended funding allocation based on anticipated increases in population and inflation during the 2013-15 biennium would result in total recommended funding of \$25 million, approximately \$3.6 million more than the funding appropriated by the 2013 Legislative Assembly.

The committee learned, for the 2011-13 biennium, based on 142,795 estimated tobacco users in the state and average annual expenditures of \$8.6 million, tobacco prevention and control expenditures averaged \$60.38 per tobacco user in the state. For the 2013-15 biennium, based on average annual tobacco prevention and control expenditures budgeted \$10.7 million and an estimated 192,105 tobacco users in the state, tobacco prevention and control expenditures are anticipated to total \$55.59 per tobacco user in the state during the 2013-15 biennium. Expenditures during the 2013-15 biennium are estimated to total \$14.57 per capita statewide, \$2.43 less than the CDC recommendation, adjusted for estimated inflation, of \$17 per capita.

The committee received information on the programs provided by intervention category as follows:

**State and Community Interventions**

State and community interventions include work with disparate populations. These populations are more susceptible to certain diseases or risk factors. Groups at high risk for tobacco use in North Dakota include American Indians, adults aged 18 to 24, pregnant women, individuals with lower education status or lower economic earnings, and other groups such as members of the military, members of the lesbian/gay/bisexual/transgender (LGBT) communities, homeless people, bar and casino workers, new Americans (refugees, immigrants), rural residents, and people with mental or physical disabilities.

State Department of Health programs dedicated to assisting the disparate populations include:

- Tribal tobacco programs which provide grant funds, guidance, and technical assistance to each reservation.
- The Campus Tobacco Prevention Project (CTPP) which is a partnership between the State Department of Health tobacco prevention and control program and the North Dakota University System Consortium for Substance Abuse Prevention. The project addresses challenges North Dakota campuses are facing regarding awareness of tobacco cessation services among the campus community, including disparate populations.
- Baby and Me Tobacco Free is a cessation program created to reduce the burden of tobacco use on pregnant women and new mothers.
- Million Hearts Community Action Grant "S" (smoking cessation) program provides funding to the major health care systems in North Dakota to establish "cessation centers."
- NDQuits partners with Medicaid to provide coverage for all seven of the Food and Drug Administration-approved medications for cessation to Medicaid enrollees who want to quit tobacco and enroll in counseling.
- Lesbian/gay/bisexual/transgender/Fargo-Moorhead Pride includes providing information in partnership with Fargo-Moorhead Pride Collective about disparate tobacco use among LGBT populations and about quitting tobacco use through NDQuits.
- Other partnerships that are not related to a specific program but have an impact on tobacco use in disparate populations include the Department of Public Instruction, North Dakota School Boards Association, Governor's Prevention Advisory Council on Drugs and Alcohol, mental health and substance abuse prevention through the Department of Human Services, Statewide Epidemiological Outcomes Workgroup, Prevention Expert Partners Workgroup, and the North Dakota Center for Persons with Disabilities.

The North Dakota Center for Tobacco Prevention and Control Policy has 3 full-time equivalent (FTE) positions that manage 100 grants relating to local policy grants, tobacco settlement state aid grants, and special initiative grants and contracts.

## **Health Communications**

Health communications at the North Dakota Center for Tobacco Prevention and Control Policy includes 1 FTE position and one temporary position for administering one to five contracts. Staff is responsible for the implementation of the statewide plan and for daily assistance to other staff, grantees, and contractors on public education to assure health communications is combined with state and community interventions.

## **Cessation**

Cessation services provided by the State Department of Health and the Center include NDQuits, the PERS cessation program for state employees and eligible family members, the city/county cessation program for county employees and eligible family members, and the public health service guidelines initiative to Ask-Advise-Refer patients. All seven federal Food and Drug Administration (FDA) approved cessation medications are available in the PERS cessation program; however, liability concerns limit the NDQuits program to over-the-counter cessation products. Tobacco settlement state aid grants to local public health units provided by the North Dakota Center for Tobacco Prevention and Control Policy support cessation by requiring health units to ask clients about tobacco use, advise clients on quitting, and referring them to the NDQuits.

## **Surveillance and Evaluation**

Surveillance, as defined by the CDC's *Best Practices for Comprehensive Tobacco Control Programs*, is the process of monitoring tobacco-related attitudes, behaviors, and health outcomes at regular intervals of time. The State Department of Health tobacco prevention and control program is involved with surveys that measure the adult and youth smoking and tobacco usage rates in North Dakota. Evaluations of the cessation programs offered through the State Department of Health are conducted on an ongoing basis and are used to assess program activities and to guide program improvement.

The North Dakota Center for Tobacco Prevention and Control Policy has 1 FTE position involved in statewide evaluation efforts involving one to three contracts. Staff is responsible for evaluation of the statewide plan and its impact and provides daily assistance to other staff, grantees, and contractors on evaluation.

## **Administration and Management**

The tobacco prevention and control program within the State Department of Health is the lead for state and community interventions disparities activities; cessation, including promotion and evaluation related to the cessation services; and surveillance and evaluation only for cessation programs. The department has approximately 4.5 FTE positions working directly on tobacco prevention and control, including administrative support.

In addition to 8 FTE positions at the North Dakota Center for Tobacco Prevention and Control Policy, the Tobacco Prevention and Control Executive Committee provides funding for tobacco prevention and control employees at the local public health units.

Administration and management at the State Department of Health (2 percent) and the North Dakota Center for Tobacco Prevention and Control Policy (3 percent) accounted for 5 percent of all tobacco prevention and control expenditures during the 2011-13 biennium, consistent with CDC-recommended funding allocations.

## **Native Americans**

The Intertribal Tobacco Use Coalition, made up of tribal tobacco prevention staff from each reservation, community members, the Indian Affairs Commission, and the Northern Plains Tribal Tobacco Technical Assistance Center, coordinate tribal tobacco prevention activities and resources in the state. The Cansasa Coalition provides education regarding the differences between commercial and traditional tobacco and seeks to shift cultural norms so commercial tobacco use is no longer socially acceptable. Chemical additives found in commercial tobacco take away from tobacco's original purpose in tribal ceremonies, and cigarettes and chewing tobacco have no connection to Native American spirituality.

The committee received information on the percentage of smokers in the state by race. Tobacco use among all adults in the state was 27.1 percent in 2011 and 26.2 percent in 2012. Tobacco use among white adults in the state was 25.3 percent in 2011 and 24.5 percent in 2012, while tobacco use among Native Americans was 59.7 percent in 2011 and 56.1 percent in 2012. While American Indians comprised 5.2 percent of the state's adult population in 2012, they represented 11.2 percent of the state's adult tobacco users.

The State Department of Health has been providing tobacco prevention and control grants to tribes since 2002. The State Department of Health provides funding and technical assistance to each tribe to implement tobacco prevention and control initiatives on each of the reservations. Each reservation has a tribal tobacco prevention coordinator who is an enrolled member of the tribe. The tribes are required to report outcomes. The primary objectives of tribal tobacco prevention and control programs are to:

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

On each reservation, tribal tobacco program staff works closely with tribal prevention program staff to coordinate activities between programs. Tribal tobacco program staff also collaborates with tribal health programs and ensures their respective tribal councils are kept informed of tribal prevention activities. All of the reservations have smoke-free tribal buildings, and several schools on each reservation have adopted tobacco-free policies. The State Department of Health is partnering with the Intertribal Tobacco Abuse Coalition to advocate for smoke-free casinos statewide.

A tribal tobacco tax agreement with the Standing Rock Indian Reservation was signed in 1993. The agreement provides for the collection of the state tobacco tax on the reservation. The state retains 25 percent and returns the remaining 75 percent to the tribe. The Turtle Mountain Band of Chippewa Indians implemented a tobacco user's fee in May 2014. The fee is five cents per package on both smoke and smokeless tobacco and is generating from \$12,000 to \$13,000 per month in revenue. The funding provides medical assistance for tribal members receiving referrals for medical care off the reservation.

The committee learned the North Dakota Center for Tobacco Prevention and Control Policy awarded a special initiative grant to American Nonsmokers' Rights Foundation to advance commercial tobacco prevention policies on tribal lands and a contract to the Public Health Law Center to develop model comprehensive tobacco-free and smoke-free policies. Although the model comprehensive tobacco-free and smoke-free policies provide the greatest health protection possible, are enforceable, are equitable, and meet several specific criteria to be considered comprehensive, tribal tobacco program staff expressed concern regarding the lack of flexibility. The Center for Tobacco Prevention and Control Policy maintained that, although there are other practices that work, the Center for Tobacco Prevention and Control Policy has a fiduciary responsibility to use best practices. The North Dakota Center for Tobacco Prevention and Control Policy, the State Department of Health, and the Indian Affairs Commission agree collaboration is needed with regard to tobacco prevention and control among Native Americans.

### **Outcomes**

The committee learned, since 2009, 11 communities have adopted local smoke-free policies and statewide the percentage of the state's population covered by comprehensive smoke-free air laws rose from 19.5 percent to 100 percent with the passage of a statewide measure in 2012. Based on the behavioral risk factor surveillance survey, adult smokeless tobacco use changed slightly from 2011 (7.2 percent) to 2012 (7.3 percent).

State Department of Health tobacco prevention and control program assessments during fiscal year 2009 and fiscal year 2014 indicate a reduction in smoking among pregnant women from 17 percent in 2009 to 15.1 percent in 2014.

Smoking rates among Native American youth were reduced from 43.9 percent in 2009 to 29.4 percent in 2014. Based on the youth risk behavior survey, statewide youth (grades 9 to 12) cigarette use declined from 22.4 percent in 2009 to 19 percent in 2014 and smokeless tobacco use declined from 15.3 percent in 2009 to 13.8 percent in 2014. However, youth who report trying e-cigarettes increased from 4.5 percent in 2011 to 13.4 percent in 2013.

Data from fiscal year 2013 indicates 31.2 percent of participants in the NDQuits program were abstinent from tobacco for 30 days or more at the time of the followup survey seven months after enrollment.

### **Collaboration**

The North Dakota Center for Tobacco Prevention and Control Policy reported that the Center for Tobacco Prevention and Control Policy's management of tobacco prevention and control funds, because it is an entity separate from the State

Department of Health, allows a focus on prevention in ways the State Department of Health cannot. The Center for Tobacco Prevention and Control Policy engages partners across the state to change public policy regarding tobacco and facilitate large-scale efforts through legislative action or ballot measures. Tobacco Free North Dakota is a statewide nonprofit organization based in Bismarck that, with the support of the Center for Tobacco Prevention and Control Policy, has engaged partners in the public and private sector who share a common interest in reducing tobacco use.

The North Dakota Center for Tobacco Prevention and Control Policy reported its mission is more narrow by law because it is required to follow CDC's *Best Practices for Comprehensive Tobacco Control Programs*. Best practices are supported by scientific evidence and are the most cost effective. Although the Tobacco Prevention and Control Executive Committee is pursuing best practices, promising practices, such as those administered by the State Department of Health, may have merit and should not be ignored.

The committee learned State Department of Health programs that could benefit from collaboration with the North Dakota Center for Tobacco Prevention and Control Policy include the tribal tobacco prevention and control program, the city-county employee cessation program, the PERS cessation program, and the Million Hearts Program. The State Department of Health and the Center for Tobacco Prevention and Control Policy plan a joint effort to establish baseline data to measure the prevalence of tobacco use on the reservations.

The committee learned the North Dakota Center for Tobacco Prevention and Control Policy and State Department of Health collaborate on a work plan to implement the state plan, which outlines which agency is lead on different objectives. The Center for Tobacco Prevention and Control Policy is working with the Indian Affairs Commissioner to build relationships with the tribes and to improve collaboration.

### **Other Information and Testimony**

The committee received additional information and testimony from tribal representatives, local public health units, the Indian Affairs Commissioner, Tax Commissioner, and Tobacco Free North Dakota, relating to the comprehensive statewide tobacco prevention and control study, including:

- Cigarette sales volume increased 7.3 percent and tobacco revenue increased 11 percent, from \$6.2 million to \$7 million, from fiscal year 2013 to 2014.
- Based on reports received from tobacco wholesalers in the state, 1.5 million cigarettes were sold on reservations in the state during calendar year 2013. These sales were not taxed and accounted for 8.7 percent of all cigarettes sales in the state.
- The state tobacco tax remains one of the lowest in the nation. The cigarette excise tax is currently \$2.83 in Minnesota, \$1.70 in Montana, \$1.53 in South Dakota, and \$.44 in North Dakota.
- The state's overall tobacco prevention and control grade is low due to the state's low tobacco tax. Education programs work, but increasing the price is far more effective at preventing and reducing youth tobacco use. Nationwide, raising the tobacco tax by one dollar reduces youth smoking by 10 percent. Increasing the tobacco tax has also been shown to reduce tobacco use in lower socioeconomic populations.

### **Recommendation**

The committee makes no recommendation as a result of its study of the comprehensive statewide tobacco prevention and control plan used in this state.

## **COMMUNITY PARAMEDIC STUDY**

Senate Concurrent Resolution No. 4002 directed a study of the feasibility and desirability of community paramedics providing additional clinical and public health services, particularly in rural areas of the state, including the ability to receive third-party reimbursement for the cost of these services and the effect of these services on the operations and sustainability of the current EMS system.

### **Background**

The committee reviewed previous studies relating to the state's EMS system, including studies by the 2007-08 interim Public Safety Committee of the state's EMS system, including the funding, demographics, and impact on rural areas and the 2009-10 Public Safety and Transportation Committee of emergency medical services funding within the state.

The Legislative Assembly in 2011 House Bill No. 1044 created Chapter 23-46 which requires the State Department of Health to establish and update biennially a plan for integrated EMS in the state.

The committee reviewed information received by the 2011-12 interim Health Services Committee regarding its study of EMS services. A rural EMS study conducted by SafeTech Solutions, LLP, identified the following challenges facing EMS in rural North Dakota:

- Lack of adequate rural, out-of-hospital EMS.
- Reliance on donations, local tax revenues, and volunteer labor.
- Increasing demand for services, primarily in western North Dakota.
- Need for specific training and environmental challenges.
- Aging population.

The 2011-12 interim Health Services Committee also received information from the State Health Officer regarding community paramedics. The committee learned there is the potential for community paramedics to provide additional cost-effective clinical and public health services, particularly in rural areas of the state. The ability to receive reimbursement for these services could enhance the sustainability of the current EMS system. The committee learned EMS systems can function with volunteer personnel by responding to up to approximately 350 emergency calls per year, while fee-for-service systems are generally not sustainable until the service responds to at least 650 emergency calls per year. Increased demand is causing some communities with volunteer responders to increase to more than 350 emergency calls but still less than 650. The committee learned if the role of paramedics could be expanded to that of community paramedics, fee-for-service EMS systems could likely be sustained. The committee learned appropriately trained community paramedics could provide billable services, including:

1. Community mid-level clinical evaluation and treatment;
2. Community-level call-a-nurse service and advice;
3. Chronic disease management support;
4. Case management of complex cases;
5. Worksite wellness facilitation and onsite clinical support; and
6. School wellness and mid-level clinical services.

The committee reviewed information regarding EMS licensing, supervision, and training and certification. Chapter 23-27 provides the State Department of Health is the licensing authority for EMS operations and may designate their service areas. The Health Council is responsible for establishing rules for licensure. Section 23-27-04.4 allows certified or licensed emergency medical technician-intermediates and paramedics, who are employed by a hospital, to provide patient care within a scope of practice established by the State Department of Health. These EMS professionals are under the supervision of the hospital's nurse executive.

## **Pilot Project**

### **Overview**

The Legislative Assembly approved, in 2013 Senate Bill No. 2004, \$276,600 from the general fund for 1 FTE position (\$135,000) for the State Department of Health to implement a community paramedic/community health care worker pilot project and educational startup costs (\$141,600) during the 2013-15 biennium.

The State Department of Health request for pilot project funding indicated the program would coordinate workers to utilize the downtime of paramedics between ambulance calls in order to assist community health workers. Community paramedics would deliver services, including assessments, chronic disease management, blood draws, diagnostic cardiac monitoring, fall prevention, and medication reconciliation in places such as homes, schools, and places of employment. Paramedicine exists in 17 states and 40 states are anticipated to implement the services in the next two years. Minnesota and Colorado are two of the states that offer community paramedic services.

The committee learned oversight and coordination of the pilot project was assigned to the Community Paramedic Subcommittee of the EMS Advisory Council.

Proposals to participate in the pilot project, including impact, utilization, effectiveness, delivery systems, and required funding, were solicited from licensed ambulance services. Four proposals were reviewed and approved--Heart of America Medical Center in Rugby, F-M Ambulance in Fargo, Southwest Health Systems in Bowman, and Billings County EMS in Belfield/Medora/Beach--additional proposals were pending from Carrington Health Center/Ambulance and Essentia Health in Fargo. The project sites approved have a combined eight paramedics that have participated in training and five additional paramedics were to begin training in August 2014.

### **Training**

The Community Paramedic Subcommittee and staff from the Division of Emergency Medical Services and Trauma reviewed draft curricula to identify training issues. Staff also developed evaluation metrics to assist in the evaluation of the success of the pilot project and the program. Community paramedic training is currently done through Hennepin

Technical College in Minnesota and includes 196 hours of clinical training. The department anticipates training in the state could be provided by the state's higher education institutions. Nationally there is a movement for EMS providers to attain a bachelor's degree with the community paramedic receiving additional training. The School of Medicine, North Dakota State University (NDSU), North Dakota State College of Science, and Lake Region State College have all expressed interest in establishing a community paramedic program.

### **Licensing and Supervision**

State Department of Health currently licenses all levels of EMS providers and the community paramedic licensure is an extension of the existing paramedic license for those individuals completing additional training. The community paramedic can practice under existing paramedic licensure and changing the community paramedic scope of practice is not necessary because it is defined by the practice environment and protocols are reviewed and approved by the physician medical director.

Referral sources include case management, care coordinator nurses, emergency department, primary care providers, and home health nurses.

There are currently no federal standards for community paramedics. In North Dakota certification is through the National Registry of Emergency Medical Technicians and licensure is by the State Department of Health. The national registry has not yet recognized the community paramedic, so there is currently no accrediting body. The department anticipates the national registry will address this new type of provider and develop a curriculum, but until then, states must develop their own standards.

The North Dakota Center for Nursing suggested the 2015 Legislative Assembly:

- Develop a scope of practice to better define the community paramedic's role and skill set and to include a provision for advanced practice registered nurses to also supervise community paramedics.
- Ensure that advanced practice registered nurses are able to supervise/delegate to community paramedics.
- Provide definitions and lines of reporting for accountability and a mechanism for documentation of care.

### **Services and Reimbursement**

In addition to ambulance services, high-frequency users of emergency medical services also burden state and local law enforcement, fire departments, behavioral health professionals, and emergency departments. The current reimbursement model encourages transport because it is the only way the ambulance service is able to bill for services. Many of the frequent callers do not qualify for home health care, but if a community paramedic could visit on a regular basis, some calls could be avoided.

The Minnesota Legislature established funding sources for its community paramedic program through Medicaid. The state received federal approval to make community paramedic programs eligible for Medicaid reimbursement in February 2012. Covered services include health assessments, immunizations, chronic disease monitoring and education, collection of laboratory specimens, medication compliance checks, hospital discharge followup care, and minor medical procedures approved by a medical director.

The State Department of Health is reviewing options for third-party payers, including discussion with Blue Cross Blue Shield of North Dakota and the Department of Human Services.

To be authorized for reimbursement, the Department of Human Services recommends services be based on an individual care plan created by the primary care provider in consultation with the medical director of the ambulance service. Conditions for authorization of services could be limited to recipients of frequent hospital emergency department services; recipients for whom community paramedic services would likely prevent admission to, or would allow discharge from, a nursing facility; or recipients to prevent readmission to a hospital or nursing facility. Based on Medicaid coverage in other states, reimbursable services may include health assessments, chronic disease monitoring and education, medication compliance, immunizations and vaccinations, laboratory specimen collection, hospital discharge followup care, and minor procedures. Services must be coordinated with services from other community providers to prevent duplication. For North Dakota Medicaid to enroll and provide payment for services provided by community paramedics, the Department of Human Services must submit, for federal approval, a state plan amendment to the federal Centers for Medicare and Medicaid Services. To bill for services, community paramedics would need to enroll as providers with North Dakota Medicaid.

Third-party payers expressed support for the overall goals and objectives of the community paramedic pilot program, and indicated they would consider reimbursement when a globally accepted scope of practice, national accreditation and curriculum standards, and Medicaid reimbursement are established; roles are defined so community

paramedics complement local public health; outcomes data is available; they are able to internally establish a defined set of reimbursable services; and there is a demonstrated need by members.

### **Other Information and Testimony**

The committee received other information and testimony from representatives of the North Dakota Nurse Practitioner Association, North Dakota Center for Nursing, ambulance services, third-party payers, pilot project participants, and other stakeholders. Key comments and information include:

- Essentia Health in Fargo implemented a community paramedic program on October 1, 2014. The community paramedic practices within the existing scope of practice.
- In a pilot project supported by Sanford Health, Fargo-Cass Public Health, Southeast Human Service Center, and F-M Ambulance, five paramedics have completed a portion of community paramedic training and are participating in targeted clinical internships in behavioral health, social work, case management, emergency medicine, medical detox, chronic illness management, and public health. A limited deployment of the community paramedics was to begin in September 2014.

### **Recommendation**

The committee recommends a bill [[15.0263.02000](#)] to require the Department of Human Services adopt rules entitling licensed community paramedics to payment for health-related services provided to recipients of medical assistance, subject to limitations and exclusions the department determines necessary consistent with how limitations are set for other medical assistance services.

## **AUTOPSY FUNDING STUDY**

Section 9 of Senate Bill No. 2004 directed a study of the funding provided by the state for autopsies and state and county responsibilities for the cost of autopsies, including the feasibility and desirability of counties sharing in the cost of autopsies performed by the State Department of Health and the School of Medicine and Health Sciences.

### **Background**

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

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

The executive budget recommendation for the State Department of Health in Senate Bill No. 2004 provided \$640,000 from the general fund for professional services to contract with the School of Medicine to perform autopsies in the eastern part of the state. The Legislative Assembly reduced the funding to provide a total of \$480,000 of one-time funding from the general fund and added a section to the bill to provide for a study of autopsy funding and state and county responsibilities for the cost of autopsies. In addition, the Legislative Assembly provided \$1,360,585 to continue funding for existing forensic examiner staff (3 FTE positions) for a total of \$1,840,585 from the general fund for autopsy services during the 2013-15 biennium.

## **Current System of Death Investigation**

In North Dakota coroners are appointed by each county commission and the State Forensic Examiner provides expert consultation. A survey of counties found the duties of county coroner are performed by medical doctors (23 counties), sheriffs (13 counties), funeral directors (11 counties), registered nurses (3 counties), the medical school (1 county), a 911 coordinator/emergency manager, and a police chief.

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 particular medical perspective on the investigation. 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. A coroner signs death certificates for those deaths investigated indicating the cause of death and manner of death, whether that be homicide, suicide, accident, natural causes, or undetermined. The State Forensic Examiner assumes jurisdiction over a dead body when requested to do so by a coroner or state's attorney. Because not all counties have a trained death investigator, not all deaths that warrant review may be investigated. If a coroner decides an autopsy is not necessary, the family may make arrangements for an autopsy and is responsible for the cost.

Professional medicolegal death investigation requires adequate resources and well-trained personnel. In addition to qualified personnel, adequate equipment and facilities are also a necessity. Counties often rely on local funeral homes for assistance in the handling and storage of deceased bodies. If a body requires examination in more detail or toxicology specimens, these procedures must be done in the funeral home's preparation rooms, raising concerns regarding the chain of custody of decedents. Because autopsies are not done in the county, arranging appropriate transportation to Bismarck and Grand Forks can also be an issue. Coroners work closely with local funeral homes and the ambulance services to coordinate care of the deceased individuals and transportation as needed.

The committee received information regarding the regions in which autopsies are originating, the demographics of those autopsied, regional gaps in autopsy services, the cost of an autopsy, and state and county responsibilities for the cost. In 2012 the most autopsies were performed in the west central region (83 autopsies), including 55 autopsies in Burleigh County. Among counties, Cass County performed the most with 58 autopsies. The fewest autopsies were performed in the southwest region (20 autopsies). While more forensic autopsies are performed on older adults aged 30 to 59, the number of autopsies among adults aged 20 to 29 has been increasing in the past two years. The number of forensic autopsies performed in North Dakota has been steadily increasing. A total of 240 forensic autopsies were performed in North Dakota in 2004, and in 2012, 434 autopsies were performed--an 80.8 percent increase over nine years.

Due to the increase in the workload of the State Forensic Examiner's office, the 2013 Legislative Assembly provided \$480,000 of one-time funding from the general fund for the State Department of Health to contract with the School of Medicine and Health Sciences Department of Pathology to provide forensic consultations and autopsies for the eastern part of the state. The State Department of Health used \$21,000 to purchase an autopsy table and the remaining \$459,000 was contracted to the Department of Pathology at the School of Medicine to conduct all of the autopsies in eastern North Dakota. The contract has been in place since September 2013 and three forensic pathologists at the School of Medicine perform autopsies at a morgue facility recently constructed in Grand Forks. During fiscal year 2014, the School of Medicine will perform autopsies for 13 eastern counties, and during fiscal year 2015, an additional 8 counties will send bodies to the School of Medicine for autopsies. The contract resulted in 29 fewer autopsies being performed by the State Forensic Examiner during the first quarter of 2014.

During the 2011-13 biennium, 764 autopsies were performed by the State Department of Health. Actual expenditures for the 2011-13 biennium were \$1,395,243, and the cost per autopsy for the biennium was \$1,826. As required in Section 11-19.1-18, counties are responsible for the cost of transporting the body to the morgue in Bismarck and other costs associated with the investigation or inquiry into the death, but the state pays all of the costs to conduct the autopsy, which consists of staff, medical supplies, and laboratory testing.

## **County Autopsy Costs**

Prior to the creation of the State Forensic Examiner's office in 1995, counties were responsible for death investigations. Increasing costs to counties and a desire to remove the perceived disincentive to requesting necessary autopsies and to increase consistency and professionalism led to legislation to shift part of the cost of conducting autopsies to the state. The shared responsibility acts as both an incentive and a disincentive to refer cases. The cost of local coroners and transportation of the bodies for autopsy provides for a balance. There is concern that if counties were required to pay for autopsies, there would be more of a disincentive to refer cases.

Counties spent \$622,399 of property tax revenue in calendar year 2013 for coroner and autopsy services and have budgeted \$722,759 for calendar year 2014. Statewide in 2013, approximately 78 percent of those costs were related

to coroner fees, 18 percent were for body transport, 2 percent were for autopsy fees (Grand Forks County \$10,609 and Cass County \$2,000), and 2 percent were for supplies and other costs. Prior to the 2013-15 biennium, Grand Forks County paid for the cost of autopsies from Grand Forks County performed at the medical school, rather than sending bodies to the State Forensic Examiner. Grand Forks County has budgeted \$11,000 for autopsy fees during calendar year 2014.

Some counties pay the coroner by case, while others budget for annual contracts for services and salaries. Other costs include transportation, toxicology, supplies, and other expenses of the office. The University of North Dakota Pathology Department sends qualitative and quantitative testing to out-of-state laboratories and the cost of the testing is included in the autopsy fee. The State Department of Health receives qualitative testing services from the State Crime Laboratory and sends positive qualitative tests to an out-of-state laboratory for quantitative analysis. In some cases law enforcement may pay laboratories for quantitative toxicology services.

The State Department of Health contract with the School of Medicine and Health Sciences for conducting autopsies has resulted in transportation cost-savings for counties.

### **Medicolegal Death Investigation System Funding Models**

The committee received information regarding possible funding models for death investigation. The committee learned the per capita model may be appropriate for smaller counties because costs may influence autopsy decisions in the "fee-for-service" model. Cases should be investigated based on the merit of the case, not funding available.

The committee received information regarding a pure state model versus a pure county model of death investigation and forensic pathology. North Dakota is currently a hybrid model.

In a pure state model, the state is responsible for the entire system. This model is generally used in geographically small states. There is generally a single, centrally located office, and all personnel involved in death investigation are from the state office. Advantages and disadvantages of the pure state model include:

#### Advantages:

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

#### Disadvantages:

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

In the pure county model, each county is responsible for its own system. This model is most effective in counties with a population in excess of one million people. Advantages and disadvantages of the pure county model include:

#### Advantages:

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

#### Disadvantages:

- Fragmentation within an area and a state possible. Significant differences in services and quality within a state.
- Often large discrepancies in services and investigations across county lines.
- Limited coordination of public health and other data to the state.
- Generally more difficult to ensure quality assurance and control initiatives.

- May not have independence from law enforcement or judicial systems.
- Not possible for small and rural counties.

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

Medicolegal death investigation provides a service to families and benefits law enforcement and public health. Although the role of forensic death investigation is often associated with criminal justice, a greater role is played in public and population health. The sharing of knowledge and education benefits practitioners, clients, regulators, and future generations. Certification and accreditation are fundamental to the public health system. Accreditation through the National Association of Medical Examiners assures the public that the office of the medical examiner has the proper facilities, policies, and procedures to perform modern, scientific death investigations. There are currently no accredited facilities for forensic autopsies in the state, however the School of Medicine is endeavoring to become accredited.

The committee learned if judicial and public health missions of the medicolegal death investigation system are met in a manner which accomplishes full accreditation of the system, the metric of number of autopsies needed per population base is constant at one autopsy per 1,000 of population. The concept of regional medical examiners could expand services in North Dakota but would require adding an examiner's office in the western part of the state. The appropriate goal for travel times to autopsy facilities is generally less than 120 minutes.

The State Forensic Examiner's office collaborated with counties and other stakeholders to develop recommendations for a system approach to death investigation and recommendations for the framework of a regional death investigation system and for the establishment and implementation of statewide standards for death investigation. The committee received the following recommendations for improvement to the medicolegal death investigation system in the state:

- Maintain a manageable workload at the State Forensic Examiner's office in Bismarck. The group recommends the State Department of Health receive continued funding to maintain the contractual agreement between the department and the School of Medicine and Health Sciences for forensic autopsy services.
- Provide authority to the State Forensic Examiner to review nonnatural deaths and amend the cause and manner of death if necessary. The State Department of Health anticipates this could be accomplished through a change to the North Dakota Administrative Code.
- Develop a system to prompt health care providers to consult with the local coroner in all deaths that are not natural deaths. The State Department of Health is developing a component in its electronic death certificate system for this.
- Allow copies of toxicology reports generated by the State Crime Laboratory to be sent to the State Forensic Examiner. The State Department of Health anticipates this can be implemented by the State Crime Laboratory.
- Increase the number of people in the state trained in death scene investigation. Increase and improve the knowledge and skills of coroners, death investigators, and others who may conduct death investigations or assist in death investigations, including a mechanism to offset travel costs for the training of coroners. The department estimated this initiative would require an appropriation of \$29,375. In addition, scholarships to assist in travel costs for five county coroners per year to attend training provided by the Hennepin County Coroner in Minnesota on death investigations would require an additional appropriation of \$10,000.
- Develop the capacity of the State Crime Laboratory to produce quantitative toxicology results. Currently, the laboratory can provide only qualitative results. The State Forensic Examiner sends samples for qualitative drug and toxicology testing to the State Crime Laboratory. Those samples in which drugs or toxins are detected are then sent to NMS Labs in Pennsylvania for quantified analysis. The cost for the State Forensic Examiner's office, the University of North Dakota Pathology Department, and all county coroners to contract for forensic quantitative toxicology testing by an out-of-state laboratory is estimated to total \$93,855 for the biennium. The estimated cost of implementing quantitative toxicology analysis at the State Crime Laboratory is \$437,028, including 2 FTE positions (\$178,514 each) and related operating costs (\$80,000). The Attorney General anticipates adding the quantitative toxicology analysis in the future when it is determined the additional analysis will not cause delays in current screening services. Implementing quantitative toxicology analysis without additional resources will delay current screening results.
- Allow the State Forensic Examiner and School of Medicine and Health Sciences Department of Pathology to review death records electronically and allow these entities to send the electronic record to other medical providers for further review or correction. The Division of Vital Records at the State Department of Health anticipates working with the Information Technology Department to make the necessary modifications. The

modifications are estimated to cost between \$10,000 and \$20,000. The authority for the State Forensic Examiner could be accomplished with a rule change.

- Develop a mass fatality response plan for the state.

The committee learned future study of the long range plan for medicolegal death investigation should continue to formulate recommendations for improvements to the state's medicolegal death investigation system. Other issues to be addressed may include:

- Facilities in Bismarck and Grand Forks - Including control or ownership of the forensic facility in Grand Forks, imaging equipment, biosafety, and disaster planning.
- Education and training of investigators and first responders.
- Financing and cost-sharing.
- Plan for national accreditation of all forensic facilities in the state.
- Design and implementation of a plan for training and distribution of qualified and certified medicolegal death investigators for all regions of North Dakota.
- Governance - In some models, governance of the death investigation system is independent of any state department and may be governed by a commission which includes various health department administrators, academics, and law enforcement professionals.

### **Other Information and Testimony**

The committee received additional information and testimony relating to the autopsy funding study from representatives of the North Dakota Association of Counties, the Cass County Coroner, University of North Dakota School of Medicine and Health Sciences Department of Pathology, and the Attorney General's office, including:

- A summary of county costs incurred for social services programs. The North Dakota Association of Counties compiled information provided by the Tax Commissioner, Department of Human Services, and county auditors to prepare summaries of fiscal year 2013 social service expenditures and reimbursements and calendar year 2014 county-dedicated mills and general fund allocations for social services programs. County social service costs increased \$6.1 million--or 14 percent--from fiscal year 2012 to fiscal year 2013. Net county social service costs for state fiscal year 2013 totaled \$50.5 million. Calendar year 2014 county budgets include approximately \$57 million in local revenue for social services.
- A new coroner's office and county morgue authorized by the Cass County Commission.

### **Recommendation**

The committee recommends a concurrent resolution [[15.3028.02000](#)] directing the Legislative Management to continue to study 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 recommends a bill [[15.0262.02000](#)] to provide appropriations to the State Department of Health for information technology costs related to the electronic review of death records and for the reimbursement of travel costs related to county coroner training and the planning of future coroner services in the state.

### **MANDATED HEALTH INSURANCE COVERAGE COST-BENEFIT ANALYSIS**

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 2015 legislative session. The Insurance Commissioner is to 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.

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, 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 \$20,000 to pay the costs of the contracted services for the 2015 legislative session, \$5,000 more than the amount provided for the 2013 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 2005 legislative session, two bills were referred for cost-benefit analysis at a total cost of \$8,323. In addition, the Insurance Department paid \$5,606 to Milliman USA for general project work during the 2005 legislative session for total payments during the 2005 legislative session of \$13,929. 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.

### **Length of Time Necessary to Complete Cost-Benefit Analyses**

The committee received information regarding the length of time necessary to complete cost-benefit analyses for health insurance mandates proposed during each of the last six legislative sessions. The 2003-04 and 2005-06 interim Budget Committees on Health Care, the 2007-08 interim Human Services Committee, the 2009-10 interim Health and Human Services Committee, and the 2011-12 interim Health Services Committee recommended the Insurance Department contract with Milliman USA for cost-benefit analysis services on health insurance mandates during the 2005, 2007, 2009, 2011, and 2013 legislative sessions. The committee learned the 2009-10 interim Health and Human Services Committee received information regarding the length of time necessary to complete cost-benefit analyses for health insurance mandates proposed during each of the last four legislative sessions. The committee learned the number of days required to perform the analyses ranged from 6 days to 19 days during the 2003 legislative session and 20 days for one bill proposed during the 2005 legislative session. The number of days required to perform the analyses ranged from 23 days to 24 days for the three bills introduced during the 2009 legislative session. Analysis performed on the one bill introduced during the 2011 legislative session took 14 days. There were no mandates proposed during the 2007 and 2013 legislative sessions.

### **Legislative Rules Regarding Bills That Include Health Insurance Mandates**

The committee learned the 2009-10 interim Health and Human Services Committee reviewed legislative rules relating to health insurance mandate legislation. The committee learned in September 2008 the 2007-08 interim Legislative Management Committee recommended proposed amendments to House and Senate Rules 402 relating to bill introduction deadlines for measures subject to cost-benefit analysis under Section 54-03-28. The proposed rules amendment provided 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. During the December 2008 organizational session, the House adopted the proposed amendment to House Rule 402, but the Senate has not yet adopted the amendment.

### **Insurance Commissioner Recommendation**

The Insurance Commissioner recommended, based on the proposal received, the Legislative Council continue to contract with Milliman, Inc., for cost-benefit analyses during the 64<sup>th</sup> Legislative Assembly.

### **Recommendations**

The committee recommends the Legislative Council contract with Milliman, Inc., for cost-benefit analyses of legislative measures considered by the 64th Legislative Assembly mandating health insurance coverage pursuant to Section 54-03-28.

## **STATE FIRE MARSHAL REPORT**

The Legislative Assembly in 2009 approved House Bill No. 1368, which created 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. 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. 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 this fund totaled \$120,000 during the 2011-13 biennium, and contract expenditures totaled \$25,352. As of June 30, 2013, the balance in the reduced cigarette ignition propensity and Firefighter Protection Act enforcement fund was \$313,960.

The committee received a report from the State Fire Marshal. Pursuant to Chapter 18-13, any cigarette made available and distributed by wholesalers to retail outlets in the state must be tested in accordance with the American Society of Testing of Materials standard and meet the ignition propensity safety standards for all cigarettes. The committee learned 734 manufacturer brand styles are sold in the state and all are certified and recertified every three years. The State Fire Marshal's office conducts random checks on retail outlets for brand or trade name on the package, cigarette style, Fire Safer Cigarette stamp, and whether the cigarette has been certified and approved for sale in North Dakota. The committee learned that although the number of fires caused by cigarettes over the past five years in North Dakota has increased, the state benefits from the overall program to require only certified low propensity ignition cigarettes be sold in the state. The State Fire Marshal recommended no changes to Chapter 18-13.

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

The Legislative Assembly in 2013 approved House Bill No. 1443 which requires the Department of Human Services, State Department of Health, Indian Affairs Commission, and PERS 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, the Department of Human Services, State Department of Health, Indian Affairs Commission, and PERS submit a report to the Legislative Management on the following:

- a. The financial impact and reach diabetes is having on the agency, the state, and localities. Items included in this assessment must include the number of lives with diabetes impacted or covered by the agency, the number of lives with diabetes and family members impacted by prevention and diabetes control programs implemented by the agency, the financial toll or impact diabetes and diabetes complications places on the agency's programs, and the financial toll or impact diabetes and diabetes complications places on the agency's programs in comparison to other chronic diseases and conditions.
- b. An assessment of the benefits of implemented programs and activities aimed at controlling diabetes and preventing the disease. This assessment must document the amount and source for any funding directed to the agency from the legislative assembly for programs and activities aimed at reaching those with diabetes.
- c. 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.
- d. The development or revision of detailed action plans for battling diabetes with a range of actionable items for consideration by the legislative assembly. The plans must identify proposed action steps to reduce the impact of diabetes, prediabetes, and related diabetes complications. The plan must identify expected outcomes of the action steps proposed in the following biennium while also establishing benchmarks for controlling and preventing relevant forms of diabetes.
- e. The development of a detailed budget blueprint identifying needs, costs, and resources required to implement the plan identified in subdivision d. This blueprint must include a budget range for all options presented in the plan identified in subdivision d for consideration by the legislative assembly.

The committee was assigned the responsibility to receive this report.

The committee received a report from the Department of Human Services, State Department of Health, Indian Affairs Commission, and PERS. The number of individuals in the state diagnosed with diabetes has increased more than 2.5 times over the past 16 years, and in 2007, diabetes cost the state over \$400 million. The committee received information regarding programs related to diabetes prevention and management at the State Department of Health, Department of Human Services, and PERS. Although the agencies included in the report have individual plans, they agree a collaborative effort is necessary to reduce and manage diabetes in the state. Goals and strategies to reduce diabetes in the state include:

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

## **REPORT ON THE UNIVERSITY SYSTEM STUDY OF PROFESSIONAL STUDENT EXCHANGE PROGRAMS**

The Legislative Assembly approved 2013 Senate Bill No. 2160 which requires the University System to study the out-of-state programs in veterinary medicine, optometry, and dentistry. The study must include the accessibility of North Dakota students to the programs; the provision of state funding for students attending the programs; the amount of debt incurred by students attending the programs; and the state's short-term and long-term needs for dentists, optometrists, and veterinarians. Section 1 of the bill requires the University System to report its findings to the Legislative Management by November 15, 2013. The committee was assigned the responsibility to receive this report.

### **Professional Student Exchange Program**

The professional student exchange program (PSEP) provides access to professional programs not offered in the state in veterinary medicine, dentistry, and optometry. Since 2008, the number of applicants in the three professions available through PSEP has averaged 61 students per year and 37.8 percent of the applicants were in veterinary medicine, 38.6 percent were in dentistry, and 23.6 percent in optometry. During the 2013-14 school year, 20 new slots were funded, of which 10 were funded in veterinary medicine, 3 in optometry, and 7 in dentistry. Some slots were not filled, either because there were not enough applicants or because applicants were not eligible and the University System is reviewing the possibility of reallocating unused funding to provide additional slots in another profession.

The PSEP budget for the 2013-15 biennium is approximately \$4.5 million, of which \$3.8 million is from the general fund, \$465,307 is from the student loan trust fund, and \$186,532 is available from carryover. The carryover resulted from optometry and veterinary slots that were not filled for the 2012-13 school year.

The committee received information regarding funding per student provided for participants in PSEP. During the 2013-14 school year, PSEP is providing funding for 40 veterinary, 28 dentistry, and 26 optometry students. Within Western Interstate Commission for Higher Education (WICHE), veterinary students receive approximately \$30,600 per student, dentistry students receive \$23,900 per student, and optometry students receive \$16,400 per student. Non-WICHE students receive \$17,930 per student for dentistry students and from \$11,226 to \$26,059 per student for veterinary students.

## University System Report

The committee received a report from the University System regarding the results of a survey of the graduates of PSEP and a report on out-of-state programs in veterinary medicine, optometry, and dentistry. The professional student exchange program provided funding for 192 students from 1999 through 2010 and currently 94 students are participating in PSEP. A survey of PSEP alumni who graduated from professional studies in veterinary medicine, optometry, and dentistry from 2003 through 2013 was conducted in fall 2013. Of the 192 graduates, 159 were surveyed and 40 percent (63 graduates) responded. Surveys returned included 14 dental professionals, 20 veterinarian professionals, and 29 optometry professionals. Seventy-one percent of the dental professionals responding to the survey practice in North Dakota, while 45 percent of the veterinarians and 28 percent of the optometrists responding to the survey practice in the state.

Based on estimated tuition and fees for the 2013-14 school year, tuition support provided by PSEP ranged from 23.2 percent in the dentistry program at the University of Minnesota to 57.5 percent in the veterinary program at Kansas State University. Students attending the University of Minnesota in the veterinary and dentistry programs are subsidized at a lower rate than those attending WICHE and other schools.

Nationally the average student debt of veterinary graduates is \$162,113, the debt of dentistry graduates is over \$221,000, and the debt of optometry graduates ranges from \$150,000 to \$200,000. Based on the University System survey, most of the PSEP graduates in each profession reported debt as follows:

- Veterinary students' debt ranged from \$75,000 to \$150,000;
- Dentistry students' debt ranged from \$150,000 to \$250,000; and
- Optometry students' debt ranged from \$100,000 to \$150,000.

Nationally, the average starting salary of a veterinarian is \$48,674, while a dentist's starting salary ranges from \$145,240 to \$150,223 and an optometrist's starting salary ranges from \$65,000 to \$120,000.

It is anticipated the workforce needs of PSEP professions will grow over the next seven years due to an aging workforce, the needs of an aging population, and the Affordable Care Act. The state is experiencing distribution issues with all of the PSEP professions. Survey respondents indicated that rural areas of the state lack the volume needed to make a practice profitable. Respondents also expressed the desire for a diverse practice that allowed for specialization.

Based on data collected by WICHE, which includes both states with payback features and without payback features, the average return rate over a 10-year period was 68 percent. The return rate for states which employ a contractual payback feature is 85 percent, while the return rate of PSEP participants to North Dakota is 31 percent. University System survey data also indicated most of the PSEP graduates were licensed and practicing in the Midwest and Upper Midwest. Reasons for not returning, among respondents not practicing in North Dakota, included lack of job opportunities at the time of graduation, the financial strain of debt, family, and personal choice. Of the University System survey respondents, 71 percent indicated that, even if students were required to pay back the PSEP assistance if they did not return to the state to practice, they still would have applied for PSEP. The North Dakota PSEP previously included a payback feature and the return rate to North Dakota up to 1983 (when the repayment requirement was repealed) was 50 percent. The University System reported 5 of the 11 states that participate in the WICHE require more than one year to establish residency for the program. If a payback feature is implemented for those graduates of PSEP that do not return to the state, the residency requirement may not be as significant. North Dakota is one of four WICHE states that do not require a service payback as part of PSEP.

The committee learned eliminating PSEP support and converting the program to a loan forgiveness program would jeopardize the slots currently reserved for North Dakota applicants.

The University System recommended the following considerations for the University System, professional state associations, and the Legislative Assembly:

- Improve the PSEP application process and communication;
- Develop a reliable reporting system to determine future workforce needs and encourage professional associations to develop comprehensive mentoring and recruiting plans for students throughout their education;
- Consider PSEP eligibility guidelines to lower the possibility of an out-of-state student establishing minimal residency parameters for purpose of gaining access to PSEP funding, and

- Consider PSEP service payback structure options. If a service payback program is deployed, the University System anticipates collaborating with the Bank of North Dakota to administer the program. If a payback feature were implemented, considerations should include:
  - Administrative costs and burden;
  - Loan terms and conditions;
  - Creating or increasing rural or underserved incentives;
  - Job availability in the state;
  - Startup assistance available to new graduates;
  - Affordability of living and working in rural and underserved areas;
  - Use of funding repaid by nonreturning students to further promote educational incentives;
  - Funding estimated to be paid back;
  - Life choices of students after graduation;
  - Justification of a payback feature for all programs;
  - Equity among all professional programs receiving state support;
  - Effects of the Affordable Care Act on dental and optometry practices.

### **Other Information and Testimony**

The committee received additional information and testimony relating to professional programs from representatives of the North Dakota Dental Association, North Dakota Optometric Association, North Dakota Veterinary Medical Association, NDSU, North Dakota Veterinary Technician Association, and the North Dakota Stockmen's Association, including:

- The distribution of dentists in the state and the appropriate number of dentists in a population. Nationally, the ratio is one dentist per 1,612 residents and in North Dakota the ratio of dentists to population is approximately one dentist per 1,750 residents. This ratio compares favorably with South Dakota (1:1,890) and Iowa (1:1,825) but not with Minnesota (1:1,630). North Dakota's growing economy has brought more dentists to the state to practice and the number of licenses issued by the State Board of Dental Examiners has been steadily increasing. The favorable ratio of dentists to population seems to indicate the state does not have a shortage of dentists but rather a misdistribution of dentists around the state.
- The distribution of optometrists in the state, the appropriate number of optometrists in a population, and whether there is a shortage of optometrists in the state. There are 175 practicing optometrists in the state. Of the 150 members of the North Dakota Optometric Association, 59 percent are in private practice (100 percent ownership), 24 percent are employed by a hospital or ophthalmology clinic, and 17 percent are practicing independently but lease space and equipment from a corporate entity. There is currently no shortage of optometrists in the state, but 30 percent of the North Dakota Optometric Association membership is likely to retire in the next 10 years.
- National standards for the number of veterinarians and the distribution of veterinarians in the state. The North Dakota Veterinary Medical Association does not believe there is a shortage of veterinarians in the state. Areas of the state, particularly the western counties, struggle to keep a full-time veterinarian available because animal numbers are low. Shortages of food animal veterinarians are due primarily to the high cost of education, physically demanding work, long hours, and lower pay relative to small animal veterinary work. In addition, federal programs and the increased complexity of pharmaceuticals and biological product use requiring veterinarian supervision have expanded the role of veterinarians in food animal operations in recent years. Federal programs, such as the United States Department of Agriculture's Animal and Plant Health Inspection Service's animal disease traceability program, now require additional processes at every stage in the production cycle, further increasing the demand for veterinary services. In 2013 the American Veterinary Medical Association suggested an adequate number of veterinarians was 32.15 per 100,000 in population, or approximately 225 veterinarians for a population of 700,000. There are 250 practicing veterinarians in the state.
- The veterinary technology program, the ability of veterinary technicians to practice at the top of their scope of practice and the potential for an expanded role for veterinary technicians--especially in the area of large food animal services. North Dakota State University has two programs related to veterinary activity. The veterinary technology program is a four-year academic program to train veterinary technicians for industry and the Veterinary Diagnostic Laboratory is a service laboratory in the Agricultural Experiment Station in Fargo. The laboratory provides information to veterinarians, owners, and livestock producers regarding injury or death of

animals and livestock. Up to 28 students are accepted into the veterinary technology program each year and the services veterinary technicians are allowed to perform are identified in Section 43-29-12.1. Most services require the direct supervision and control of a licensed veterinarian. Technology may make it possible to provide appropriate supervision for some duties.

- The direct cost of educating other health care professionals in the state. During the 2013-14 school year the cost of educating a pharmacy student at the College of Pharmacy, NDSU, is \$20,811, of which \$11,262, or 54 percent is provided from the general fund with the remainder provided by tuition and grants. The direct cost per student at the School of Medicine for the same year is \$82,796, of which \$56,870, or 69 percent is provided from the general fund. General fund support for students enrolled in other health sciences degree programs is approximately 52 percent.

### **Committee Considerations**

The committee considered but did not recommend a bill draft relating to the repayment of tuition assistance provided through professional student exchange programs if the participant does not return to the state to practice.

### **OTHER INFORMATION RECEIVED**

#### **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*. In January 2014 agencies completed a survey of their prevention and treatment programs for risk-associated behavior for the 2011-13 biennium and budgeted information on the 2013-15 biennium. Agencies reported a total of \$148.4 million is budgeted for risk-associated programs during the 2013-15 biennium, \$26.2 million more than the \$122.2 million spent during the 2011-13 biennium. Expenditures from the general fund are anticipated to increase \$10.7 million from the 2011-13 biennium total of \$53.3 million to an estimated \$64 million during the 2013-15 biennium.