NORTH DAKOTA LEGISLATIVE MANAGEMENT

Minutes of the

HEALTH SERVICES COMMITTEE

Thursday, April 24, 2014
Fargo City Commission Meeting Room, Fargo City Hall
200 Third Street North
Fargo, North Dakota

Senator Judy Lee, Chairman, called the meeting to order at 9:00 a.m.

Members present: Senators Judy Lee, Howard C. Anderson Jr., Robert Erbele, Joan Heckaman, Tim Mathern; Representatives Alan Fehr, Curt Hofstad, Rick Holman, Marvin E. Nelson

Members absent: Senator Oley Larsen; Representatives Dick Anderson, Jon Nelson

Others present: Carolyn C. Nelson, State Senator, Fargo
Peter F. Silbernagel, State Representative, Casselton
Alon Wieland, State Representative, West Fargo
See Appendix A for additional persons present.

It was moved by Senator Mathern, seconded by Representative Hofstad, and carried on a voice vote that the minutes of the January 8, 2014, meeting be approved as distributed.

DENTAL SERVICES STUDY

At the request of Chairman Lee, Dr. Colleen Brickle, Dean of Health Sciences, Normandale Community College, and Liaison, Metropolitan State Dental Programs, Minnesota State Colleges and Universities System, provided information (Appendix B) regarding program development, education, licensure, and certification of dental therapists (DTs). Dr. Brickle said the goal of the midlevel practitioner is to improve access by filling gaps where there are too few dentists. She said midlevel practitioners are not intended to replace or compete with dentists but rather to serve as part of a broader strategy to improve access. She said dentists are vital to the success of the dental therapy program and served on an advisory committee formed to develop the educational program. She said educators were also important to the development of the Minnesota State Colleges and Universities System (MnSCU) program for midlevel practitioners. She said the new program application developed for MnSCU was approved before legislation was proposed for the new midlevel practitioner and included information regarding standards; need for the program, both in communities and among the students; resources; collaborations; financial viability; and curriculum.

Dr. Brickle said in 2009 Minnesota approved legislation to establish two levels of mid-provider dental practitioner. She said the MnSCU program began the same year and is jointly administered by Normandale Community College in Bloomington, Minnesota, and Metropolitan State University in St. Paul, Minnesota. She said because the program begins with an experienced dental hygienist, MnSCU combined DT and advanced dental therapist (ADT) competencies into one curriculum. She said graduates are dual-licensed in dental hygiene and dental therapy. She said in 2013 the University of Minnesota (U of M) also combined DT and ADT into one program. She said DT/ADT students from both educational institutions are taught routine restorative and surgical procedures within a defined scope of practice to the same competencies as a dental student. She said they are trained with dental students and dental residents. She said in addition to dental courses, MnSCU ADT students take coursework in pharmacology and medical emergencies, epidemiology, health policy and leadership, cultural awareness, and managing patients with special needs (an emphasis in geriatric and pediatric dentistry). She said the program is transitioning from a part-time to a full-time curriculum eventually taking 16 months at a cost to the student of approximately $36,000. She said extended campus rotations provide opportunities for the DT/ADT students to serve varying population groups. She said the licensure examination includes laboratory requirements based on the scope of practice of a DT, but the patient-based clinical examination is based on the examination dental students must also take for licensure. She said DT/ADT students are held to the same evaluation standards as dental students. She said certification is through the Minnesota Board of Dentistry and requires casework, an examination, and an interview.

Dr. Brickle said the DT earns a baccalaureate degree and may provide preventative services, such as sealants, and health promotion education under general supervision and routine restorative and surgical procedures under indirect supervision as allowed in the collaborative management agreement. She said for a licensed DT to be credentialed as an ADT, the DT must practice under the indirect supervision of a dentist for 2,000 hours and pass a certification examination issued by the Minnesota Board of Dentistry. She said the ADT earns a master's level degree and may perform all of the same services as the DT under general supervision and additional services, including oral evaluation and assessment; formulation of an individualized treatment plan; extractions of permanent moderately to severely mobile teeth; and the ability to provide, dispense, and administer antibiotics, analgesics, and anti-inflammatories under general supervision (no dentist onsite) within the protocols of a collaborative management agreement between the dentist and ADT. She said working within the protocols of the collaborative management agreement, patients are referred to a dentist when services beyond the ADTs scope of practice are needed. She said the collaborative management agreement allows ADTs to work in schools, community centers, nursing homes, and other places where there are unmet needs and to refer more complex cases to a dentist. She said the ADT is allowed to practice outside of the dental office as allowed in the collaborative management agreement. She said the agreement is updated and renewed annually.

Dr. Brickle said a report entitled "Early Impact of Dental Therapists in Minnesota" was presented to the Minnesota Legislature in February 2014. She said 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.

In response to a question from Representative Fehr, Dr. Brickle said the report presented to the Minnesota Legislature indicated there were some complaints filed against DTs, but none of the complaints have been directly related to patient safety issues.

Chairman Lee said she received the report (Appendix C) in an email and forwarded it to committee members earlier in the day.

In response to a question from Representative M. Nelson, Dr. Brickle said Indian Health Service has not yet used DTs in Minnesota.

In response to a question from Senator Mathern, Dr. Brickle said legislation was first introduced to increase the education and scope of practice of the dental hygienist to provide for an advanced dental hygiene practitioner; however, compromise led to the development of a dental therapy practitioner. She said the compromise was it led to two points of entry for individuals entering dental therapy programs--the dental assistant and the dental hygienist.

At the request of Chairman Lee, Ms. Sarah Wovcha, Executive Director, Children's Dental Services, Minnesota, provided information (Appendix D) regarding the role of DTs and their integration within community dental clinics. Ms. Wovcha said Children's Dental Services (CDS) is a private nonprofit organization delivering care to low-income individuals. She said CDS reviewed models in New Zealand, Canada, and England and was pleased with the clinical outcomes. She said CDS employs four ADTs and one DT. She said the collaborative management agreement formalizes the relationship between the dentist and the DT and limits the scope of practice of the DT to those services the dentist is comfortable having the DT perform. She said since December 2011, CDS DTs and ADTs have provided services to over 5,000 patients. She said two individuals have requested to see a dentist rather than a DT. She said there have been no complaints of poor quality work. She said professional liability insurance is available for ADTs and is substantially less than professional malpractice insurance for dentists. She said the average production of the dental team in 2011, prior to the addition of DTs, was $280.72 per hour compared to $326.76 per hour in 2013 (adjusted for fee increases). She said employing one ADT to provide restorative care to 1,500 low-income children and pregnant women results in $62,400 per year in savings compared to employing a dentist to see the same patients.

In response to a question from Chairman Lee, Ms. Wovcha said CDS is the primary school-based and Head Start-based provider of dental services in Minnesota. She said it serves approximately 32,000 children and pregnant women per year.

At the request of Chairman Lee, Dr. John T. Powers, Owner, Main Street Dental Care, Montevideo, Minnesota, and Adjunct Faculty, Rice Regional Dental Clinic, University of Minnesota, provided information (Appendix E) regarding the employment of DTs in rural private practices to increase access to care. Dr. Powers said the DT hired at Main Street Dental Care had been his dental assistant for 10 years. He said Rice Regional Dental Clinic is an outreach facility for senior dental students and DTs in their last six months of training, and in his role as adjunct faculty, he has had the opportunity to observe both DTs and dental students. He said, in his opinion, the DTs are as clinically competent as the dental students. He said patients were traveling four hours to five hours to see a dentist at the Rice Regional Dental Clinic because dentists in southwestern Minnesota were not accepting new medical assistance patients. In addition, he said, due to lack of dental care, patients were presenting with more severe dental issues. He said 60 to 70 percent of the DTs patients are on a state program.

At the request of Chairman Lee, Dr. Brad Anderson, General Dentist, Fargo, and Member, Academy of General Dentistry, provided information (Appendix F) regarding barriers to better oral health and options for improving the public's overall oral health. Dr. Anderson said in addition to the financial and provider distribution issues normally referenced, there are other factors that lead to systemic lack of care, including a lack of oral health literacy and psychological factors. He said the public remains largely unaware of the connection between oral health and overall health and well-being. He said the Academy of General Dentistry (AGD) suggests oral health stakeholders collaborate to:

- Develop a comprehensive oral health education component for public schools' health curriculums;
- Provide oral health examinations for one-year-olds to help facilitate early screenings; and
- Equip teachers and day care providers with creative educational tools on the importance of oral health.

Dr. Anderson said it is important the public understands the difference between the prevention model of oral health care versus the treatment mentality in traditional medical health care. He said health care delivery must consider cultural diversities that might affect patient perceptions. He suggested establishing patient navigators within communities to provide hands-on education about oral health and social services, including transportation, to convert health literacy into action. He said, however, using navigators to provide clinical services should be prohibited. He said with the influx of new dental schools, new dentists are seeking employment and established dentists are seeking patients. He said there is no shortage of dentists; however, uneven geographical distributions of dental practices may give the impression of a shortage. He said the AGD supports loan repayment programs that bring dentists to areas of the state that do not have practicing full-time dentists. He said some counties lack practice capacity and would be better served by mobile dental units, transportation services, community health clinics, and patient navigators. He said two tiers of care are created when nondentists serve the poor and dentists serve everyone else. He said relegating these alternative providers to underserved areas is also financially unsustainable. He said a 2005 American Dental Association study revealed that, when provided the opportunity to practice in underserved areas without the physical presence of dentists, alternative nondentist providers move to wealthier neighborhoods, driven by the inability to cover overhead costs.

Mr. Ken Kompelien, Dean, Arts, Science and Business Division, North Dakota State College of Science, provided information (Appendix G) regarding an overview of the North Dakota State College of Science (NDSCS) dental programs and options to expand those programs.

Ms. Lucinda Hanekom, Associate Professor/Program Coordinator, Allied Dental Education, North Dakota State College of Science, provided information regarding the dental assisting program. She said the college offers two options, including a certificate and an associate in applied science. She said the only difference between the certificate and the associate degree is the number of general credit-hours. She said the college receives 48 applicants to 59 applicants for the dental assisting program which has a capacity of 20 students. She said 75 percent of the incoming fall class is from North Dakota.

Ms. Kathryn Dockter, Assistant Professor/Chair, Allied Dental Education, North Dakota State College of Science, provided information regarding the dental hygiene program. She said the 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. She said most of the students are from North Dakota cities with populations of less than 50,000. She said 15 of the 24 spring 2014 graduates are from North Dakota. She said a bachelor's degree in dental hygiene would require 30 to 35 additional credit-hours. She said the program has a bachelor's degree articulation agreement with Minnesota State University in Mankato.

Mr. Kompelien provided placement and average salary information for the dental assisting and dental hygiene programs. He said the college has placed 100 percent of the dental assisting graduates each year since 2010. He said placement rates for the dental hygiene program from 2010 to 2013 ranged from 91 percent in 2010 to

100 percent in 2011. He said 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.

Ms. Dockter provided information regarding the NDSCS Dental Clinic, including equipment, radiology, and patient demographics. She said the clinic serves mostly elderly, low-income, and Medicaid patients. In addition, she said, the clinic serves the local Head Start program and a Native American school. She said few clinic patients have dental insurance.

Ms. Dockter said the college looks forward to implementing expanded function modules. She said the college is patterning its expanded function programing after other states, and the clinic is suitable for use by multiple students as the expanded function programming is implemented. She said the college does not have a dental school and therefore would not be able to train DTs. She said the college could assist with rural rotations and help place DTs returning to the state.

Mr. Kompelien said the dental clinic at the college and the relationships the college has established with dental care providers in the state provide an opportunity for the college to assist in bridging the gap between the current dental assisting and dental hygiene programs and expanded function assistants and hygienists. He said the school could assist with appropriate clinical experiences and connections for DTs as the program develops.

In response to a question from Senator Mathern, Ms. Dockter said the bachelor's level dental hygienist degree offered in Mankato allows the graduate to teach in an associate level dental hygiene program as well are perform other duties related to public health. She said to offer a bachelor's level degree, NDSCS would need to partner with another university in the North Dakota University System. Mr. Kompelien said NDSCS has not pursued partnering with a university to offer a bachelor's degree.

In response to a question from Representative M. Nelson, Ms. Dockter said additional education related to the expanded function dental assistant and dental hygienist under consideration by the State Board of Dental Examiners would be outside of the college's current certificate or associate degree. Mr. Kompelien said NDSCS has experience in providing additional credentialing beyond certificates and associate degrees offered in other programs.

In response to a question from Representative M. Nelson, Dr. Brickle said an articulation agreement could provide for the transfer of an NDSCS graduate into the MnSCU dental therapy program.

Ms. Joyce Linnerud Fowler, Senior Executive, Housing and Assisted Living, Bethany Retirement Living, Fargo, provided information (Appendix H) regarding the cost and reimbursement of dental services provided to nursing home residents. She said federal regulations require skilled nursing facilities to provide, or obtain from an outside resource, routine and emergency dental services. She said routine services include an annual inspection of the oral cavity for signs of disease, diagnosis of dental disease, dental radiographs as needed, dental cleaning, fillings (new and repairs), minor dental plate adjustments, smoothing of broken teeth, and limited prosthodontics procedures (taking impressions for dentures and fitting dentures). She said Bethany Retirement Living has contracted with Apple Tree Dental to provide oral health services. She said Apple Tree Dental provides a dental hygienist to complete periodic oral health screenings which include preventative services and recommendations, such as improved oral care or dental care services that might be needed. She said additional dental services can be provided by Apple Tree Dental or the resident's primary dentist. She said fees cover oral care assessment and do not include professional dental services. She said dental services are billed separately by the dental care provider. She said contracting for oral health services allows Bethany Retirement Living to access onsite medical assistance dental care from Apple Tree Dental's mobile dental clinic. She said the contract is based on a per resident/per month fee and is currently $5.25 per resident per month. She said the annual cost is $7,308 per year for the 42nd Street campus and $10,836 per year for the University Drive campus. She said the Department of Human Services has taken the position that the contract fees are not an allowable expense when determining facility rates. She said although skilled nursing residents have priority, due to regulations, basic care residents can also receive services from Apple Tree Dental.

In response to a question from Senator Mathern, Ms. Fowler said the cost would be eligible for reimbursement if the provider were employed by the nursing home. She said most facilities contract for the service because Apple Tree Dental has the expertise necessary to perform the assessments and it would be difficult to employ a professional to provide this service.

At the request of Chairman Lee, Dr. Michael Helgeson, Chief Executive Officer, Apple Tree Dental, provided information (Appendix I) regarding dental access and services provided to skilled nursing home residents. Dr. Helgeson said Apple Tree Dental is a not-for-profit organization serving adults with disabilities, long-term care

residents, and low-income children and their families in urban and rural communities. He said Apple Tree Dental provides clinical student rotations for dental students, dental residents, DTs, dental hygienists, dental assistants, nurses, and CNAs. He said in 1997 funding from the Dakota Medical Foundation helped purchase mobile equipment and establish a center in Hawley, Minnesota. He said in 2013 North Dakota Medicaid made up 12 percent of the value of services provided at the Hawley Center. He said services provided in nursing facilities include oral health education for patients and staff, preventative care, dental screenings, and triage and care coordination. He said the critical access dental provider program approved in Minnesota has been an important policy change and has allowed the growth of safety net programs in the state. He said the program brings supplemental resources to the practices serving the greatest numbers of individual with challenges to access.

At the request of Chairman Lee, Dr. Brent L. Holman, Executive Director, North Dakota Dental Association, provided information (Appendix J) regarding a service model that 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. Dr. Holman said the services would be provided in preschools, elementary schools, medical settings, or long-term care facilities. He said dental professionals would identify high-risk patients and link them to a dental home. He said case management has been shown to reduce barriers to care for Medicaid recipients. He said the services provided by Apple Tree Dental could be considered case management services. He said case management would include educating individuals, identifying their barriers to care, and following up to remove barriers and link the patient to a dental home. He said the proposed model would depend on reimbursement for outreach services provided by collaborative dental offices. He said regulatory infrastructure necessary for this model was recently approved by the North Dakota State Board of Dental Examiners. He said the model would be studied by the American Academy of Pediatric Dentistry. He said grant funding is available as part of a pilot project for the reimbursement of outreach services and administrative costs of the study. He said if the model proves to be successful, Medicaid and other third-party reimbursement sources will be able to make evidence-based decisions regarding reimbursement for these outreach services. He said the proposed model addresses three issues related to dental care access--prevention, workforce, and funding.

Ms. Jan Anderson, Title I Coordinator and Homeless Liaison, Fargo Public Schools, provided information (Appendix K) regarding access to dental care for children in poverty. She said most individuals living in poverty find it difficult to navigate the system to access care and pay for the services. She said unlike most middle class and wealthy households, they tend to be more reactive than proactive when it comes to dental care. She said access to preventative services for children will help them learn the importance of dental health care.

In response to a question from Chairman Lee, Ms. Anderson said Fargo Public Schools refer students for treatment but do not provide dental services.

Mr. Tyler Winter, President, North Dakota Dental Assistants Association, expressed opposition (Appendix L) to legislation to establish DTs in North Dakota. He said current professionals are not utilized to the extent possible. He said the North Dakota State Board of Dental Examiners recently approved expanding the scope of practice of registered dental assistants and dental hygienists to provide for expanded function dental auxiliaries (EFDAs). He said EFDAs complete supplementary education to qualify to perform additional procedures. He said the state should adopt the EFDA model before creating a DT program. He provided a copy of a *Journal of Dental Education* article entitled "Dental Therapists in General Dental Practices: An Economic Evaluation." He said the article concluded, based on the economic analysis outlined, the potential impact of DTs on access disparities in private general practices would be negligible. He said the analysis also found that DTs would have a negative impact on most dentists' hours of work, gross income, and net income. He said the article concluded that a DT may assist in accessing services in some isolated areas where a full-time dental practice cannot be fully utilized and that DTs may be employed by dentists who want to reduce their work hours or by dental practices that employ associate dentists.

In response to a question from Chairman Lee, Mr. Winter said the EFDA will increase the number of patients that could be seen at one time.

Chairman Lee expressed concern regarding the ability of the EFDA to improve access when there appears to be a shortage of dental assistants.

Dr. Robert C. Lauf, President, North Dakota State Board of Dental Examiners, said a dentist already has a working relationship with an EFDA and the increased function will provide for efficiencies. He said existing staff would not have to leave the community for training. He said investments should be made in the existing workforce that is already living and working in the area and less likely to leave.

In response to a question from Senator Heckaman, Dr. Lauf said funding and education are key to Medicaid access. He said case management and the dental home model will provide an opportunity to educate the patient and the family, provide routine preventative care, and allow the patient to be seen when there is a need for services. He said adequate funding is needed to provide these services.

Ms. Rita Sommers, Executive Director, North Dakota State Board of Dental Examiners, said there are currently 435 dentists, 747 dental hygienists, and 653 dental assistants licensed in the state. She said the board has also made it easier for dentists to volunteer their services. She said the board has not been asked to consider expanding the functions of dental hygienists and dental assistants. She said the board decided to rewrite administrative rules to make them clear and to study the expanded functions.

In response to a question from Senator Anderson, Ms. Sommers said legislation is not necessary at this time because the board is able to make changes to administrative rules.

Ms. Rachelle Gustafson, President Elect, North Dakota Dental Hygienists' Association, expressed support (Appendix M) for the EFDA. She said the association supports the expanded functions approved by the North Dakota State Board of Dental Examiners, but it is uncertain how these changes will improve access to dental care. She said because the new functions must be performed under direct or indirect supervision of a dentist, access will remain limited in areas of the state where there are a limited number of dentists to provide the supervision. She expressed concern regarding a board proposal to allow dental assistants to perform limited teeth cleaning. She said the limited service may be confused with a more comprehensive cleaning and result in an increase of periodontal disease. She said dental hygienists are qualified to provide comprehensive cleaning services. She said a shortage of dental assistants in the state has led to dental hygienists taking positions where they are performing the duties of dental assistants. She said in these cases, dental hygienists are not being utilized to their fullest potential. She said the association supports efforts to serve those with limited access to dental care and the expanded education of the current dental workforce.

In response to a question from Representative M. Nelson, Ms. Gustafson said the North Dakota Dental Hygienists' Association did not request the expanded function changes proposed by the North Dakota State Board of Dental Examiners.

Ms. Leah Hildebrandt, Dental Therapy Graduate, University of Minnesota School of Dentistry, said DTs train with dental students. She said DTs are trained to perform needs assessments in rural communities. She said EFDAs are valuable, but DTs are able to perform more services freeing more of the dentist's time to perform complex procedures. She said because dental therapy is not nationally recognized, DTs are unable to practice in the federal Indian Health Service.

Ms. Patricia Patrón, Chief Executive Officer, Family HealthCare, Fargo, provided information (Appendix N) regarding community health centers in the state. She said Family HealthCare is one of four safety net dental clinics in the state. She said patients are served regardless of ability to pay, and services are billed on a sliding fee scale. She said many of the extractions performed at the clinic could be avoided if the individual had received timely access to education and preventative care. She said the clinic is only able to perform basic procedures and must refer patients for additional services, such as crowns, partials, and dentures. She said providers are unable to perform to their full scope of practice, resulting in high turnover rates. She said barriers to dental access include the:

- Lack of dental providers willing to accept patients covered by Medicaid, leaving these patients to seek services at a limited number of nonprofit, safety net clinics and in emergency rooms;
- Lack of dental providers in rural areas of the state and willingness to practice in a safety net clinic;
- High cost of dental insurance which makes coverage too expensive for many individuals and families and is not considered an essential benefit under the Affordable Care Act;
- Lack of dental coverage by Medicare; and
- Distance low-income and uninsured patients must travel to reach a safety net clinic.

Ms. Patrón said the state public health dentist loan repayment program has helped the clinic recruit dentists, but there is only one grant awarded each biennium and some dentists leave for private practice if loan repayment is not granted or has ended and debt still exists. She said two other safety net clinics also qualify for this loan repayment program. She said the clinic uses innovative techniques to improve access to dental services. She said the clinic received a grant from the National Network of Oral Health Access in 2013 to integrate dental assessments into the medical practice of the clinic. She said medical personnel were trained to perform a full oral assessment for

children who were age 5 at the time of their well child immunizations, including fluoride varnish, oral health education, and supplies.

Dr. Paul Tronsgard, President Elect, North Dakota Dental Association, not in attendance, submitted written testimony (Appendix O) in opposition of a new category of dental provider.

Chairman Lee thanked Ms. Patrón, who is leaving the Family HealthCare Center, for her service to the community.

The committee recessed for lunch at 12:30 p.m., reconvened at 1:15 p.m., and conducted a tour of the Family HealthCare Center.

AUTOPSY STUDY

The committee returned to the Fargo City Commission meeting room, and at the request of Chairman Lee, Mr. Terry Traynor, Assistant Director, North Dakota Association of Counties, provided information (Appendix P) regarding autopsy costs incurred by the counties and the potential impact on counties and autopsy services of changes in the responsibility for the cost of autopsies. Mr. Traynor said prior to the creation of the State Forensic Examiner's office in 1995, counties were responsible for death investigations. He said 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. He said the cost of local coroners and transportation of the bodies for autopsy provides for a balance and should remain with the county. He said the North Dakota Association of Counties surveyed counties to gather information related to arrangements for county coroner and cost. He said 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.

Mr. Traynor said 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. He said 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. He said 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. He said Grand Forks County has budgeted $11,000 for autopsy fees during calendar year 2014.

In response to a question from Representative Fehr, Mr. Traynor said the appointed coroner is to determine the cause of death, and if there is a question, it is the coroner's duty to consult with the State Forensic Examiner or to refer the body for examination by the State Forensic Examiner.

In response to a question from Senator Mathern, Mr. Traynor said entering the 2013 legislative session, counties were comfortable with the arrangement. He said counties understand the shared responsibility acts as both an incentive and a disincentive to refer cases. He said the issue was raised because cases referred to the State Forensic Examiner were anticipated to exceed the capacity of the office during the 2013-15 biennium. He said the State Department of Health sought to increase funding for additional resources for the State Forensic Examiner's office. He said if counties were required to pay for autopsies, there would be more of a disincentive to refer cases. He said counties are judicious in their requests because they incur coroner and transportation costs.

At the request of Chairman Lee, Dr. John Baird, Coroner, Cass County, provided information (Appendix Q) regarding the current and optimal provision of medicolegal death investigation services in the state; current and unmet needs, obstacles, and practices within the medicolegal death investigation system; and state, county, and family responsibilities for the cost of autopsies, including transportation, and the potential impact on counties and autopsy services of changes in the responsibility for the cost of autopsies. Dr. Baird said in North Dakota, coroners are appointed by each county commission and the State Forensic Examiner provides expert consultation. He said 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. He said 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. He said 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. He said 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. He said the State Forensic Examiner assumes jurisdiction over a dead body when requested to do so by a coroner or state's attorney. He said the workload of the State Forensic Examiner's office has continued to increase, and the Legislative Assembly provided funding for the State Department of Health to contract with the University of North

Dakota School of Medicine and Health Sciences Department of Pathology to provide forensic consultations and autopsies for the eastern part of the state. He said the contract has been in place since September 2013. He said three forensic pathologists at the School of Medicine perform autopsies at a morgue facility recently constructed in Grand Forks.

Dr. Baird provided information regarding the deaths handled by the Cass County Coroner's office. He said the office, located in the courthouse, includes two deputy coroners and handles an average of 23 cases per month. He said an average of 60 autopsies are performed per year for Cass County. He said the coroner's office works closely with local funeral homes and the F-M Ambulance Service to coordinate care of the deceased individuals and transportation as needed. He said recently the Cass County Commission authorized a new coroner's office and county morgue which will be part of the building the city of Fargo purchased and is remodeling for Fargo Cass Public Health. He said the Fargo Police Department will have a substation in the building adjacent to the coroner's office.

Dr. Baird said professional medicolegal death investigation requires adequate resources and well-trained personnel. He said it is difficult to find a physician with an interest in this field, especially when compensation is relatively minimal. He said deputy coroners in Cass County are trained and certified by the American Board of Medicolegal Death Investigators, attend continuing education courses, and manage a sufficient caseload to maintain their skills. He said in addition to qualified personnel, adequate equipment and facilities are also a necessity. He said the county relies heavily on local funeral homes for assistance in the handling and storage of deceased bodies. He said if a body requires examination in more detail or toxicology specimens, these procedures must be done in the funeral home's preparation rooms. He said the new county morgue will provide professional space and address concerns regarding the chain of custody of decedents. He said because autopsies are not done in the county, arranging appropriate transportation to Bismarck and now to Grand Forks has been an issue at times. He said the timing of autopsies can impact organ and tissue donation and funeral arrangements.

Dr. Baird said there are some national norms for the overall cost of death investigation in a jurisdiction, but there is no set standard in North Dakota for the cost of a coroner's office and other investigation costs. He said some counties pay the coroner by case, while others budget for annual contracts for services and salaries. He said other costs include transportation, toxicology, supplies, and other expenses of the office. He said the 2014 Cass County budget for the coroner's office is $189,856. He said the expense for autopsies done by the State Forensic Examiner or designee are covered by the budget of the State Department of Health. He said an informal survey of transportation costs paid by the counties showed rates vary widely, but generally the further the distance the greater the cost. He said Cass County currently pays funeral homes $450 round trip to drive a body to Bismarck and $225 round trip to Grand Forks. He said Cass County has realized transportation cost-savings because it is able to refer bodies to Grand Forks instead of Bismarck. He said if a coroner decides an autopsy is not necessary, the family is free to make arrangements for an autopsy to be done and is responsible for the cost.

Dr. Baird said medicolegal investigations of deaths have improved in North Dakota, and close working relationships with law enforcement, state's attorneys, funeral homes, and partners have brought together many talents. He said the current arrangement of cost-sharing by the counties and the state for the different portions of the overall system allows professional and appropriate investigations to be done. He said citizens deserve a professional death investigation system, and it is important for the state to continue to cover the cost of autopsies. He said if an autopsy is not done and a murder is missed because of the inability of counties to pay for the costs involved, the system will have failed.

In response to a question from Senator Anderson, Dr. Baird said the State Forensic Examiner has not had time to perform autopsies at the request of the family when the coroner has decided an autopsy is not necessary. He said that the service could be provided by the forensic pathologists at the School of Medicine.

In response to a question from Senator Mathern, Dr. Baird said not all counties have a trained death investigator, and he is concerned that not all deaths that warrant review are investigated.

In response to a question from Chairman Lee, Dr. Baird said the population of the state is not large enough to warrant a large forensic examiner's office, but there are needs that are complicated by distance and lack of physicians in rural areas. He said some of the challenges can be overcome by coordination and a good working relationship between coroners that are adequately trained and the forensic pathologists in Bismarck and Grand Forks.

Chairman Lee suggested the counties and the State Forensic Examiner's office collaborate to find ways to improve the medicolegal death investigation system in the state.

At the request of Chairman Lee, Dr. Mark Koponen, Associate Professor and Assistant Medical Examiner, Department of Pathology, University of North Dakota School of Medicine and Health Sciences, provided information (Appendix R) regarding statewide standards for death investigation and expectations for achieving national standards for death investigation. Dr. Koponen said there is a need for a comprehensive statewide system of death investigation that meets national standards. He said 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. He provided information (Appendix S) regarding travel times to autopsy facilities in Bismarck and Grand Forks. He said the goal is less than 120 minutes. He said the School of Medicine performs autopsies for families and charges a fee for the service. He said the School of Medicine also performs death investigations for eight counties in northwest Minnesota. He said a regional system could cross state boundaries. He said pathologists at the medical school are also licensed in Minnesota and South Dakota.

In response to a question from Chairman Lee, Dr. Koponen said 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.

In response to a question from Senator Mathern, Dr. Koponen said family practice residents at the School of Medicine in Minot are also trained to be coroners.

Chairman Lee suggested the committee receive additional information at a future meeting from Dr. Mary Ann Sens, Chair, Department of Pathology, University of North Dakota School of Medicine and Health Sciences, regarding recommendations for a death investigation system.

Mr. Kirby Kruger, Section Chief, Medical Services Section, State Department of Health, said the department supports a system approach to death investigation. He said an increase in the number of autopsies at the State Forensic Examiner's office led to the department contracting with the School of Medicine to perform autopsies in the eastern part of the state during the 2013-15 biennium. He said the contract provides the School of Medicine will serve 13 counties in eastern North Dakota starting September 1, 2013, through June 30, 2015. He said beginning July 1, 2014, seven additional counties will be served by the School of Medicine through June 30, 2015. He said the contract has resulted in 29 fewer autopsies being performed by the State Forensic Examiner during the first quarter of 2014. He said the department may request legislation to allow the State Forensic Examiner to change a cause or manner of death under certain circumstances.

In response to a question from Senator Mathern, Mr. Kruger said the State Department of Health would be willing to work with stakeholders to develop recommendations for a system approach to death investigation.

In response to a question from Senator Anderson, Mr. Kruger said it is the responsibility of the coroner to contact the State Forensic Examiner; however, there are instances in which the State Forensic Examiner should have been notified but was not. He said underreporting of disease is always a concern. He said mandated laboratory reporting has been beneficial; however, as laboratories began reporting, some physicians have become complacent.

Chairman Lee suggested a task force meet to discuss the framework of a regional death investigation system. Mr. Kruger said a task force or committee would be appropriate.

OTHER COMMITTEE RESPONSIBILITIES

Dr. Ken Grafton, Vice President for Agricultural Affairs, North Dakota State University, said the university has two programs related to veterinary activity. He said 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. He said the laboratory provides information to veterinarians, owners, and livestock producers regarding injury or death of animals and livestock.

Dr. Grafton introduced Dr. Neil Dyer, Professor and Director, Veterinary Diagnostic Laboratory, North Dakota State University, to provide information (Appendix T) regarding the veterinary technology program at North Dakota State University; services veterinary technicians are allowed to perform; existing regulations, standards and certifications, including state and national requirements, and the processes to amend requirements; and whether veterinary technicians could play a larger role in meeting the veterinary needs of the state. Dr. Dyer said he advises students regarding careers in veterinary medicine, teaches in the veterinary technology program, and serves as the President of the North Dakota Veterinary Medical Association. He said the veterinary technology program at North Dakota State University is accredited by the American Veterinary Medical Association and is the first program in the country to offer a minor in large animal veterinary technology. He said up to 28 students are

accepted into the program each year. He said services veterinary technicians are allowed to perform are identified in North Dakota Century Code Section 43-29-12.1. He said most services require the direct supervision and control of a licensed veterinarian. He said Section 43-29-13(8) provides any veterinary technician or other employee of a licensed veterinarian performing duties under the direction and supervision of the veterinarian responsible for the technician's or other employee's performance is not considered to be engaging in the practice of veterinary medicine and therefore excepted from Chapter 43-29. He said this subsection allows a veterinarian to train any other employee to perform veterinary technician duties and may also allow for the expanded role of veterinary technicians in veterinary practices.

In response to a question from Chairman Lee, Dr. Dyer said most clinics hire trained and licensed veterinary technicians.

In response to a question from Senator Mathern, Dr. Dyer said it is possible for veterinary technicians to play a larger role in providing veterinary services; however, there should be input from the North Dakota Veterinary Medical Association and the North Dakota Veterinary Technician Association. He said Alaska, Indiana, and Texas have recently allowed technicians to work remotely under a veterinarian's supervision or have expanded their roles in the practice. He said expanding the services that can be provided by a veterinary technician under the direction of a veterinarian will do little to provide services in areas of the state that are currently underserved because they lack the animal density to support a veterinarian. He said technology may make it possible to provide supervision in those areas.

Senator Mathern suggested the committee receive information from the North Dakota Veterinary Technician Association regarding an expanded role for veterinary technicians. Chairman Lee suggested the committee also receive information regarding veterinary technicians' ability to practice at the top of their scope of practice and the potential for an expanded role for veterinary technicians in the area of large food animal services.

Senator Erbele said there is no shortage of veterinarians, but rather there is a distribution problem. He said veterinarians are more likely to settle in larger cities and serve small animals. He said large animal practices are often remote and less profitable. He said the large food animal practice could be an area for more veterinary technician involvement.

Senator Anderson said maybe there should be a focus put on providing benefits to professionals who return to the state rather than providing assistance while they attend college out of state.

Chairman Lee suggested the committee receive information from the North Dakota Stockmen's Association regarding the need for large food animal veterinary services.

At the request of Chairman Lee, the Legislative Council staff presented a memorandum entitled *Survey of Agency Alcohol, Drug, Tobacco, and Risk-Associated Behavior Prevention and Treatment Programs*. 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.

Chairman Lee said funding is fragmented, and agencies could be more efficient if they worked together to coordinate services.

COMMITTEE DISCUSSION AND STAFF DIRECTIVES

Senator Mathern suggested the committee receive additional information regarding the North Dakota Dental Association's proposal for a case management pilot project.

Senator Mathern suggested the committee receive information from the State Department of Health regarding the reintroduction of basic dental health prevention services in schools, including the cost and resources available to provide the services.

Representative Hofstad suggested the committee explore collaboration with Indian Health Service for dental health services on the reservation. Chairman Lee suggested the committee also receive information from a representative of the Indian Affairs Commission.

Representative Holman said the committee should explore ways to provide incentives to dentists and hygienists to practice in the underserved areas of the state.

Senator Mathern said the Apple Tree Dental model appears effective. He suggested the committee receive additional information regarding the area of the state with the most Medicaid eligibles.

In response to a question from Chairman Lee, Senator Anderson said there were six qualified candidates presented to the Health Council for three available awards through the dental loan repayment program. He said the program could benefit more communities if funding was available for more eligible candidates. He suggested the committee receive information regarding limitations on the number of dentists funded per nonprofit organization each biennium.

Chairman Lee suggested the committee receive information from the State Department of Health regarding limits on the number of dentists funded per facility during the biennium and the potential for expanding the dental loan repayment program, including cost and eligible candidates.

Chairman Lee said she received several emails in support of a midlevel dental provider, including an email from Ms. Kathy M. Lituri, Chair, Oral Health Section, American Public Health Association. She provided a copy (Appendix U) of the email for the committee.

Senator Anderson suggested the committee receive information from the Department of Human Services regarding those individuals that lost dental coverage when the state expanded Medicaid.

Chairman Lee said the next committee meeting will tentatively be scheduled in July 2014.

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

No further business appearing, Chairman Lee adjourned the meeting at 4:21 p.m.

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Sheila M. Sandness
Senior Fiscal Analyst

ATTACH:21