NORTH DAKOTA LEGISLATIVE MANAGEMENT

Minutes of the

HEALTH SERVICES COMMITTEE

Wednesday, July 27, 2016
Roughrider Room, State Capitol
Bismarck, North Dakota

Senator Judy Lee, Chairman, called the meeting to order at 8:00 a.m.

Members present: Senators Judy Lee, Howard C. Anderson Jr., Tyler Axness, Joan Heckaman, Dave Oehlke; Representatives Rich S. Becker, Alan Fehr, Dwight Kiefert, Gail Mooney, Gary Paur, Todd Porter, Karen M. Rohr, Jay Seibel, Marie Strinden

Member absent: Senator John M. Warner

Others present: Senator Ray Holmberg, Chairman, and Representative Kathy Hogan, Members, Legislative Management
See Appendix A for additional persons present.

It was moved by Representative Seibel, seconded by Representative Mooney, and carried on a voice vote that the minutes of the April 13, 2016, meeting be approved as distributed.

Chairman Lee distributed a copy of a National Conference of State Legislatures report entitled *Telehealth Policy Trends and Considerations.* A copy of the report is on file in the Legislative Council office.

DENTAL SERVICES STUDY

Chairman Lee welcomed Dr. Frank A. Catalanotto, Professor, Department of Community Dentistry and Behavioral Science, University of Florida College of Dentistry. Dr. Catalanotto provided information (Appendix B) regarding enhancing predoctoral dental education with a focus on public health, access to oral health care, health care disparities, and enhancing the oral health workforce, including information regarding 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. He said dental therapists are less expensive to educate because they focus on a limited set of routine dental procedures. He said dentists learn approximately 500 competencies, while a dental therapist is trained in approximately 50 to 60 skills, depending on the program. He said dental therapists are also less expensive to employ. He said of the 56 dental therapists that have graduated from the Minnesota programs, 20 are employed in private dental practices (urban and rural) and the remaining dental therapists are employed in nonprofit clinics, federally qualified health centers, and other similar facilities, including 15 in a federal Health Resources and Services Administration (HRSA) designated rural areas. He said additional infrastructure is not needed to employ dental therapists in the state, nor does the state need to establish an educational curriculum to train dental therapists. He said students can attend one of two programs in Minnesota, where the necessary regulations have already been established to license dental therapists and the Medicaid agency is able to reimburse dentists for services provided by the dental therapists they employ. He said North Dakota needs only to approve legislation to allow the licensure of advanced practice dental hygienists. He said giving dentists flexibility in supervision is critical, because many patients struggle to visit a dentist during traditional hours or are unable to visit the office because they are nonambulatory. He said allowing dentists to supervise dental therapists while not at the same location allows private practices to offer evening or weekend services for routine care. He said the dental therapist allows "hub-and-spoke" programs, in which a supervising dentist is located in a "hub" office while a dental therapist is providing care in settings like schools and nursing homes through a "spoke" system. He said telehealth technology is often used to share information with the supervising dentist. He reviewed 2015 Senate Bill No. 2354 [15.0848.01000], legislation considered, but not approved, by the 2015 Legislative Assembly. He said the bill included provisions that would have allowed supervising dentists to limit, through a collaborative management agreement, procedures performed by the dental therapist to those procedures the dentist deemed appropriate.

In response to a question from Representative Fehr, Dr. Catalanotto said in Alaska, dental therapists are only allowed to practice on tribal land. He said in Maine, Minnesota, and Vermont, they are allowed to practice anywhere in the state.

In response to a question from Chairman Lee, Dr. Catalanotto said while many dentists are currently in private practice, dental care is moving toward a system delivery model. He said dental therapists are part of a system approach to providing dental care.

Dr. Shawnda Schroeder, Assistant Professor, Center for Rural Health, University of North Dakota School of Medicine and Health Sciences, provided information (Appendix C) regarding the status of pediatric oral health and updated research on access to dental services in North Dakota, including long-term care facilities and the dental workforce. She said North Dakota has 55.36 dentists per 100,000 residents compared to the national average of 60.89. She said 32 percent of the counties in the state have no dentist and 15 percent have only one dentist. She said while 50 percent of the state's population lives in urban communities, over 60 percent of dental assistants, dental hygienists, and dentists practice in urban areas.

Dr. Schroeder said a 2015 survey of long-term care facilities identified oral health as a priority among participating facilities; however, many facilities had no overall system in place to meet the oral health needs of residents. She said 50 percent of long-term care facilities had a written plan of care for dental needs in place, but only three had been reviewed by a dental professional. She said data from the 2015-16 State Department of Health's Basic Screening Survey and the National Youth Risk Behavioral Surveillance System indicates American Indian and lower income youth in North Dakota are at a greater risk of tooth decay, rampant decay, need for treatment, and need for urgent treatment. She said the rate of untreated decay in the state is higher for American Indian (51 percent), and other minority children (41 percent) than for their Caucasian peers (24 percent). She said lower income and American Indian youth also report less frequent brushing, lack of oral health care supplies like a toothbrush, and more sugary drink consumption. She said fluoride varnish and dental sealants are effective methods to prevent decay. She said although a reimbursable service, fluoride varnish is not being applied to at-risk patients in the primary care setting. She said the sealant program is limited, requiring additional resources and workforce to meet the needs of all elementary school students in the state.

Ms. Brenda Weisz, Director, Accounting Division, State Department of Health, provided information (Appendix D) regarding an update on the dental loan repayment program and the number of participants in the program. She said the application deadline for the state dental loan repayment program is generally March of each year. She said applications are reviewed and prioritized by the department, in consultation with the North Dakota Dental Association, and presented to the Health Council for its approval. She said the current dental loan repayment program provides loan repayment up to $100,000 over 5 years and the number of loan repayment contracts issued each biennium is dependent upon funding. She said in April 2016, the Health Council approved eight applications based on the availability of funds; however, two dentists have decided to decline the contract because of the penalty section. She said if a dentist does not fulfill the contract, provisions of the loan repayment contract require full repayment of funds received and both dentists believed they could not commit to the full 5-year contract. She provided a summary of information regarding dentists participating in the loan repayment program from 2005 through 2016, including the dentists' original service location and current location, if no longer in the community served as part of the loan repayment program. She said of the 37 dentists participating the state's dental loan repayment program from 2005 through 2016, most are still in their original contract location. She said six dentists have either withdrawn from the program or live in communities other than the one they served as part of the loan repayment contract.

Ms. Weisz said the state oral health program provides services to children through a school-based fluoride varnish and sealant program (Seal!ND). She said schools with 45 percent or more of their students on the free or reduced-fee school lunch program are given priority for the program. She said funding for the Seal!ND program is provided primarily through an HRSA oral health workforce grant and partially through a federal Centers for Disease Control and Prevention (CDC) oral disease prevention program grant. She said the HRSA grant funds will be available to support the program through August 31, 2017, at which time the 3-year (approximately $435,000/year) grant cycle will end. She said the CDC grant funds will be available to support the program through August 31, 2018, at which time the 5-year (approximately $310,000/year) grant cycle ends. She said information on a new cycle of grant funds is generally not released until 4 to 6 months before each grant cycle ends. She said while federal funding was not received during the 2012-13 fiscal year, funding was restored in 2014.

In response to a question from Representative Fehr, Ms. Weisz said the medical loan repayment program penalty is prorated based on years served on the contract.

Dr. Katie Stewart, President-Elect, North Dakota Dental Association, provided information (Appendix E) regarding the effectiveness of case management services, including program and administrative costs, anticipated resources, information regarding a pilot project for the reimbursement of outreach services, and an update on Medicaid outreach efforts and a plan to provide emergency services at hospitals. She said payment delays related to the Department of Human Services' transition to the Medicaid management information system have challenged

the association's Medicaid outreach efforts. She said the North Dakota Dental Association (NDDA) will continue to work with providers to navigate administrative changes and facilitate the transition. She said stakeholders continue to work on a plan to reduce dental emergencies seen in hospital emergency rooms. She said a plan may be implemented by fall 2016. She said case management is key to reaching the population most at risk for oral disease. She said the NDDA favors a grant-funded case management pilot program and expanded sealant program. She provided information regarding case management codes recently approved nationally and said these codes enable the dentist to bill dental insurance for case management services that are evidence-based and save money. She said the age of the dental workforce in the state is trending lower and the dental loan repayment program has contributed to growth in new dentist licensees. She suggested the following strategies to reduce barriers to care in the state:

- Increase dental Medicaid payment rates, reduce administrative burdens, and increase dentist recruitment efforts;
- Maximize the current dental hygienist and dental assistant workforce through expanded training programs, community outreach, and case management to connect more high-risk patients to a dental home;
- Expand and support nonprofit safety-net clinics through public-private grant partnerships and dental loan repayment programs; and
- Engage with tribal communities to improve Indian Health Service dentistry, maximize prevention, reduce credentialing barriers, and facilitate contracting with the local dental community.

In response to a question from Chairman Lee, Dr. Stewart suggested the state gather more information from the dental therapy model implemented in Minnesota before implementing it in North Dakota. She suggested the NDDA strategies be implemented and the outcomes measured before implementing the dental therapy model.

Chairman Lee said that dental therapists would be available for those dentists that might want to expand their practice.

Mr. Rod St. Aubyn, North Dakota Dental Hygienists' Association, suggested the committee receive information regarding a comparison of the state's Medicaid dental payment rates to the payment rates in surrounding states. He also suggested the committee review the percentage of dentists and medical providers participating in Medicaid in North Dakota compared to participation in surrounding states. He said even though the expanded functions approved by the State Board of Dental Examiners require additional training and testing, they must still be performed under the direct supervision of a dentist. He said these limitations do not allow for an expansion of services outside of the dental office.

In response to a question from Senator Anderson, Mr. St. Aubyn said the shortage of dental providers is not limited to reservations. He said a mobile dental model using telehealth communications would be an ideal setting for a dental therapist. He said a dental therapist could refer the patient to a dental home.

In response to a question from Senator Anderson, Mr. St. Aubyn said outreach in schools by a dental hygienist must be based on a dentist's orders.

Representative Becker said he toured the University of Minnesota dental therapy program. He said 43 percent of the dental therapists in Minnesota are employed outside the twin cities area and the program would have slots available for North Dakota students if licensure were available in the state.

Chairman Lee suggested the committee receive information regarding a comparison of the state's Medicaid dental payment rates to the payment rates in surrounding states. She also suggested the committee review the percentage of dentists and medical providers participating in Medicaid in North Dakota compared to participation in surrounding states.

Senator Anderson suggested the committee receive information from the North Dakota Dental Hygienists' Association and the State Board of Dental Examiners regarding the ability of dental hygienists to perform outreach and refer patients to a dental home without a dentist on site and any legislative changes necessary to allow for such outreach and case management.

DEATH INVESTIGATION AND FORENSIC PATHOLOGY CENTER STUDY

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 F) regarding the department's recommendations relating to the development of a system approach to death investigation, a regional death investigation system framework, and statewide standards for death investigation. He said establishing

autopsy services in two locations, Grand Forks and Bismarck, has served the state well; however, there is a need to stabilize adequate funding for the Grand Forks location. He said in spite of outreach and training, many cases that should be reported are not being forwarded to county coroners or the state's forensic pathologists. He said changes are needed to the process of coroner reporting to align the state's system with more modern systems while maintaining local responsiveness. He said a regional system of trained death investigators, receiving reports directly from first responders and reporting directly to forensic pathologists, would enhance the state's death investigation system. He said additional capacity is needed at the Bismarck facility and the Grand Forks facility is in need of enhancements. He said the state does not have a level III biohazard facility. He said the western edge of the state is outside of the national recommendation of a mortuary within a 2-hour drive and would benefit from a stronger system of death investigation. He said recommendations for improvement to service expectations include:

- A strategy for accreditation of all facilities;
- Regional expansion of certified death investigators;
- Educational and training programs for all within the medicolegal death investigation system;
- Timely reporting and analysis of cases for public health, public safety, legislative needs, and workforce safety; and
- Services and interactions that are respectful, timely, and of service during time of stress and need.

In response to a question from Representative Rohr, Dr. Koponen said death investigation systems should be designed based on distance and resources.

In response to a question from Chairman Lee, Dr. Koponen said death investigators are usually contracted part-time on an as-needed basis to serve an area or county.

Chairman Lee suggested the committee receive additional information regarding the funding required to implement the recommendations of the Department of Pathology, including information regarding the cost of incremental implementation.

In response to a question from Representative Fehr, Dr. Koponen said the nearest level III biohazard facility is in Albuquerque, New Mexico.

In response to a question from Representative Becker, Dr. Koponen said the Grand Forks facility has some efficiencies due to its relationship with the School of Medicine and Health Sciences. He said autopsies performed for hospitals and under contracts with certain Minnesota counties supplement the facility's funding.

Dr. Mary Ann Sens, Professor and Chair, Department of Pathology, University of North Dakota School of Medicine and Health Sciences, provided information (Appendix G) via prerecorded electronic media regarding the state's death investigation system. She said the Bismarck facility serves 32 counties with 51 percent of the state's population and the Grand Forks facility serves 21 counties with 49 percent of the state's population. She said the Bismarck facility has 1 forensic pathologist providing service 5 days per week, while the Grand Forks facility has 4 forensic pathologists (1.8 full-time equivalent positions) and provides services 7 days per week. She said 258 autopsies were performed in Bismarck while the Grand Forks facility performed 228 autopsies. She said the biennial appropriation for the Bismarck facility is approximately $1.5 million and the biennial budget for the Grand Forks facility is approximately $1.6 million, of which the state provides $640,000. She said death investigation and reporting statewide is an issue. She said measures should be taken to ensure every case is reported and reviewed. She said infrastructure should be reviewed and service standards set for the entire state, including accreditation and certification.

Dr. William Massello, State Forensic Examiner, State Department of Health, provided information (Appendix H) regarding the responsibilities of the State Forensic Examiner and recommendations relating to the development of a system approach to death investigation, a regional death investigation system framework, and statewide standards for death investigation. He said North Dakota is one of eight states that have a hybrid system of death investigation which consists of county coroners and a state forensic examiner. He said 28 of the 53 counties have medically trained coroners and the remaining 25 nonmedically trained coroners are usually a sheriff or funeral director. He said functions of the State Forensic Examiner's office include performing medicolegal autopsies; consulting with local officials on cases; and providing education to local coroners, law enforcement, and medical and mortuary personnel. He said the objectives of a medicolegal autopsy include identifying the deceased, determining cause and manner of death, determining and documenting injuries, conforming to legal requirements, providing information to investigators, and answering questions of public health interest. He said deaths under certain reportable circumstances identified in North Dakota Century Code Section 11-19.1-01, are required to be

reported to the coroner or law enforcement. He said these deaths must be reported whether they occur in a hospital, at a home, or elsewhere. He said reporting by medical personnel has been a challenge, but the state's vital record's electronic death certificate program has been updated to prompt those entering the information to report the death to the local coroner or the forensic examiner when anything other than a natural death is reported. He said in 2015, 75 percent of the cases in which the forensic examiner was notified, resulted in a forensic autopsy, compared to 64 percent in 2012.

In response to a question from Representative Fehr, Dr. Massello said overdose deaths are always referred for autopsy.

In response to a question from Representative Seibel, Dr. Massello said the electronic death certificate system has been operational for approximately 2 months. He said deaths reported to the coroner appear to be handled properly; however, he expressed concern regarding the investigation of deaths that are not reported to the coroner.

In response to a question from Chairman Lee, Dr. Massello said coroners are trained and currently investigate deaths. He said the best training for investigators is the experience gained on the job. He said areas of the state that do not have a coroner with medical training also may not have the number of cases necessary to maintain the skills of a salaried regional death investigator. He said a regional death investigator would spend a considerable amount of time traveling and may still receive a limited amount of death investigation experience. He said currently the department consults with the local coroner and video connections allow the department to view the scene in real time. He said emergency medical technicians could be trained in death investigation and in determining under which circumstances it would be appropriate to consult with the State Forensic Examiner.

In response to a question from Representative Hogan, Dr. Massello said every child death is reviewed by a child fatality review committee.

Mr. Corey Sayler, Office Administrator, State Forensic Examiner's office, State Department of Health, provided information (Appendix I) regarding an update on the contract with the University of North Dakota (UND) and the availability of hospital discharge data. He said 235 coroner cases were accepted for autopsy from January through June 2016. He said 118 (50 percent) were accepted by the State Forensic Examiner's office in Bismarck and 117 (50 percent) were accepted by Department of Pathology at UND. He said the contract with UND continues to alleviate the pressures of an increased forensic caseload. He said the State Department of Health believes the current system of county coroners works well for the state. He said in 2014 a working group outlined recommendations to improve the current system which focused on continuing education in death investigation for local coroners and law enforcement officials. He said the death investigation workgroup continues to meet and will convene in August 2016 to identify areas for improvement. He said the State Department of Health recently entered into a data use agreement with the Minnesota Hospital Association, which receives hospital discharge data from North Dakota facilities. He said health care related data may assist the committee in its discussion of the impact of opioid use and abuse in the state and trends in drug use and abuse. He said through this agreement, the department will receive hospital discharge data for 16 North Dakota facilities in an electronic format. He said the State Department of Health will receive discharge data from 2010 through 2015 and plans to continue receiving the data annually in the future.

In response to a question from Chairman Lee, Ms. Tracy Miller, State Epidemiologist, State Department of Health, said the data will include discharge information from the six larger hospitals in the state. She said the department estimates the data will include approximately 95 percent of the hospital discharge data available in the state.

Mr. Rick Tonder, Facilities Planning Director, North Dakota University System, provided information regarding the feasibility of acquiring the Forensic Pathology Center building by UND, including estimated acquisition cost and additional ongoing operating costs related to acquisition. He said the building was built for its purpose by a private developer that retains ownership and the university leases the building. He said a federal grant and local funding provided funding for the facility's equipment.

Chairman Lee suggested the committee receive additional information regarding the terms of the lease, including rental costs.

STUDY OF EMPLOYMENT RESTRICTIONS IN PUBLIC ASSISTANCE PROGRAMS

Ms. Michele Gee, Policy Director, Child Care Assistance, Department of Human Services, provided information (Appendix J) regarding a Department of Human Services review of child care subsidies and recommendations regarding gradual reductions in benefits to mitigate the "cliff effect" on participants when work hours are increased. She said due to the Governor's budget allotment, and effective April 1, 2016, the department revised the child care

sliding fee schedule from 85 percent of state median income to 60 percent of state median income and increased family's monthly copayments. She said families eligible for temporary assistance for needy families are not subject to the sliding fee schedule and were not affected by the change. She said the child care assistance program caseload decreased from 2,049 in April 2016 to 1,549 in June 2016. She said new provisions in the federal Child Care and Development Block Grant Act of 2014 and proposed federal regulations for the block grant include "family friendly" eligibility policies that are likely to address the "cliff effect." She said the department anticipates the proposed federal regulations will be final in September 2016. She said the proposed eligibility policies include:

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

In response to a question from Representative Hogan, Ms. Gee said work search is not an eligible activity unless the individual was working and eligible and then becomes unemployed. Subsequently, via email, she said new child care assistance program provisions will allow for at least 3 months of job and housing search for homeless individuals at the time of application and during review and certification. She said the department anticipates implementing this change in October 2016.

OTHER COMMITTEE RESPONSIBILITIES

At the request of Chairman Lee, Ms. Jane Myers, Diabetes Program Director, State Department of Health, distributed a report entitled *Diabetes in North Dakota 2016* (Appendix K) by the Department of Human Services, State Department of Health, Indian Affairs Commission, and Public Employees Retirement System on their collaboration to identify goals and benchmarks while also developing individual agency plans to reduce the incidence of diabetes in the state, improve diabetes care, and control complications associated with diabetes. She said information regarding goals and strategies contained in the report were provided by the departments at the committee's last meeting.

Chairman Lee suggested committee members review the report and contact the Legislative Council if additional information is needed.

At the request of Chairman Lee, Ms. Jeanne Prom, Executive Director, Center for Tobacco Prevention and Control Policy, provided a report (Appendix L) regarding grant expenditures, the granting process, and reporting requirements of a grant provided by the Comprehensive Tobacco Control Advisory Committee to the State Department of Health. She said the 2015 Legislative Assembly, in House Bill No. 1024, provided for a grant from the Comprehensive Tobacco Control Advisory Committee to the State Department of Health to replace CDC grant funds that had been reduced. She said the $500,000 grant was provided for the period beginning July 24, 2015, and ending June 30, 2016. She said the advisory committee and the department implemented a plan that meets CDC *Best Practices for Comprehensive Tobacco Control Programs - 2014*. She said the plan was to enhance the reach of the NDQuits program. She said the department reported quarterly to the advisory committee, completed the grant project, and billed quarterly for the entire $500,000 contract.

Mr. Neil Charvat, Director, Tobacco Prevention and Control Program, State Department of Health, provided a report (Appendix M) regarding grant expenditures, the granting process, and reporting requirements of a grant provided by the Tobacco Prevention and Control Executive Committee to the State Department of Health. He said the department was notified in March 2015 that funding for tobacco prevention and control activities provided by the CDC would be reduced by approximately $500,000 for the 2015-17 biennium. He said because promotion of NDQuits is included in both the department and the advisory committee's work plan activities, the department used the funds to support advertising for NDQuits, the state's phone- and web-based quit services. He said the advisory committee provided a media plan that would meet its requirements for CDC *Best Practices for Comprehensive Tobacco Control Programs - 2014* and the department contracted with Odney Advertising to implement the media plan.

In response to a question from Representative Mooney, Mr. Charvat said from January through March 2016, compared to the same period last year, telephone enrollments in NDQuits increased 100 percent, while web enrollments increased 13 percent.

REPORTS OF BEHAVIORAL HEALTH-RELATED BOARDS

Dr. Margo Adams Larsen, President, State Board of Psychologist Examiners, provided information (Appendix N) regarding a report (Appendix O), pursuant to 2015 House Bill No. 1048, regarding a plan for the administration and implementation of licensing and reciprocity standards for licensees, including a standard for issuance of licenses to qualified applicants in a timely manner and an evaluation of whether regional, national, or international licensing and reciprocity standards are adequate for licensure in the state. She also provided information regarding internship programs and postgraduate supervision requirements of the various behavioral health-related professions including information regarding requirements to be accepted into an internship or postgraduate program; requirements to become a mentor or supervisor in the programs; and reimbursement for interns, postgraduate professionals under supervision, and mentors or supervising professionals. She said she is presenting the report for the North Dakota Board of Addiction Counseling Examiners, North Dakota Board of Counselor Examiners, North Dakota Board of Social Work Examiners, North Dakota Marriage and Family Therapy Licensure Board, North Dakota State Board of Psychologist Examiners, and the North Dakota Board of Medicine. She said the boards agree that, for professional mobility, North Dakota should match national standards and minimal statutory changes would be needed to align state standards with national occupation specific standards. She said there are no consistent international standards, but the number of applicants is small. She said workforce-related issues are not due to regulatory barriers or board inefficiencies. She said the boards have no authority over employment standards or insurance reimbursement requirements. She said the boards collaborated to advance the following recommendations:

- Require North Dakota employers and insurance carriers to use North Dakota occupational licensing standards when setting employee requirements;
- Maintain autonomous boards with North Dakota standards mapped to national occupational standards;
- Adopt an expedited licensure model for mobility and portability of licensure;
- Appropriate funds to the Governor's office to expand operational efficiencies for smaller boards;
- Appropriate funds to the Governor's office for the designated purpose of annual meetings of all regulatory board chairs and board managers;
- Require background checks for all new issue licenses;
- Standardize continuing education reporting and renewal processes;
- Develop a mechanism to share disciplinary action between North Dakota boards and the public;
- Develop consistent telepractice laws and rules across all behavioral health boards; and
- Provide for consistency in statutory language for all licensing professions by using model language to promote consistent format, mechanism, procedures, and issuance of licenses.

In response to a question from Senator Oehlke, Dr. Adams Larsen said health insurance companies are not consistent with regard to the professional requirements for providers credentialed in their networks.

In response to a question from Representative Hogan, Dr. Adams Larsen said because North Dakota is a rural state, those practicing in rural areas are often not able to consult with colleagues locally, so the desire is to place more highly qualified and experienced professionals in these areas.

Representative Hogan said some professionals have found that national standards are often lower than what is required in North Dakota.

In response to a question from Representative Mooney, Dr. Adams Larsen said five of the six boards included in the report are aspiring to develop national standards. She said some states and jurisdictions have lower standards than what are proposed for national standards, while other jurisdictions may have higher standards.

In response to a question from Representative Fehr regarding psychology programs that allow for some internship hours required for licensure to be earned under the supervision of professionals outside of psychology, Dr. Adams Larsen said the collaborating boards did not discuss the matter.

Ms. Heidi Nieuwsma, Board Chair, North Dakota Board of Social Work Examiners, said licensed independent clinical social workers were allowed licensure hours under the supervision of other professionals, but that was changed to allow only another licensed independent clinical social worker to provide the supervision.

In response to a question from Representative Fehr, Ms. Nieuwsma said social workers bring a different perspective to the client than other behavioral health professionals. She said she would consult with the board regarding the purpose of the change.

Representative Fehr said the cross training that happens when a candidate is supervised by another behavioral health professional outside of their profession is valuable.

Chairman Lee said while the report contains valuable information, there are still barriers to moving between behavioral health professions. She said individuals are required to start over when moving from one behavioral health profession to another. She said the boards should involve representatives of higher education and assist with the development of curriculum that would expose students to the other professions.

Chairman Lee said the Legislative Assembly would welcome the boards' recommendations with regard to changes that would encourage mobility, including the adoption of national standards.

Senator Anderson suggested the boards raise dues to allow them to carry out their work.

In response to a question from Representative Fehr, Mr. Duane Houdek, Executive Secretary, State Board of Medicine, said medical boards collaborate with the residency programs. He said if the residency program provides training for an international medical graduate, the State Board of Medicine will accept their training.

In response to a question from Representative Fehr, Dr. Adams Larsen said the boards did consider what functions could be combined. She said some office and operational functions, as well as continuing education, might be combined to save money, but the funding each board has available varies substantially.

In response to a question from Representative Hogan, Dr. Adams Larsen said there are overlapping scopes of practice within the behavioral health professions. She said mobility is made easier if there is a national consensus with regard to regulation.

Chairman Lee invited Representative Fehr to provide information (Appendix P) regarding interstate medical licensure compacts. Representative Fehr said the interstate medical licensure compact makes it easier for physicians to gain licensure in multiple states. He said compact legislation has been enacted in many of the midwestern states surrounding North Dakota. He said there is concern with the State Board of Medicine regarding the requirement to accept anyone who qualifies under the compact, the collection of fees, and that the Federation of State Medical Boards has not yet completed rules for how the compact will be operated.

Mr. Houdek said the State Board of Medicine has been monitoring interstate medical licensure compact legislation. He anticipates North Dakota will receive more licensees than it will export and questions remain regarding who will pay the fees and whether or not there will be an independent commission that would require funding. He said telemedicine, health care networks and the regionalization of health care providers has required physicians from other locations to be licensed in the state. He said the State Board of Medicine currently licenses more physicians that live outside the state (2,108) than live within the state (1,859). He said a compact that allows for local input and control will serve the state better than national standards.

Ms. Courtney Koebele, Executive Director, North Dakota Medical Association, provided information (Appendix Q) regarding the interstate medical licensure compact. She said the association supports the interstate medical licensure compact. She said each state in the compact will receive equal representation on the commission.

In response to a question from Representative Fehr, Ms. Koebele said if North Dakota signs onto the compact, representatives from the state will participate in making the rules.

Mr. Colmon Elridge, The Council of State Governments National Center for Interstate Compacts, provided information (Appendix R) regarding the expansion of compacts related to health care professional licensure, the use of interstate health care licensure compacts for behavioral health professionals, and whether interstate licensure compacts might be part of a solution to the state's behavioral health-related workforce issues. He said The Council of State Governments National Center for Interstate Compacts has facilitated collaborative agreements between state governments, federal agencies, and the private sector regarding a variety of issues. He said

initiatives in license portability and reciprocity have resulted in compacts for the licensure of physicians, nurses, emergency medical services personnel, psychology, and physical therapy. He said the process does not replace the licensure process of each state, but rather serves as a mechanism for practitioners in good standing to have an expedited and, in most cases, less expensive avenue to multistate licensure. He said the process has been especially helpful for military spouses practicing in a health care discipline. He said the interstate compact and telehealth are tools available to close the gap of quality and affordable access for those living areas in which there is a shortage of mental health service providers.

Dr. Julijana Nevland, Vice Chair, Board of Addiction Counseling Examiners, provided a report (Appendix S) on the evaluation of the initial licensure coursework requirements and clinical training requirements in Section 43-45-04 and a comparison of initial licensure coursework requirements and clinical training requirements of neighboring states. She said two board members were assigned to review current laws and rules related to the licensure of addiction counselors. She provided a summary of recent changes made by the board, including the addition of a new training consortium, regular review of licensure requirements, streamlined applications, flexible consortium training start dates, and collaboration to allow for a national certification in addiction counseling. She said the board is also proposing changes related to tiered licensure levels, academic requirements, clinical training, and reciprocity. She said the board consulted a Substance Abuse and Mental Health Services Administration document regarding scopes of practice and provided a copy of the information (Appendix T) regarding scopes of practice and "career ladder" for substance use disorder counseling. She said the board is proposing a four-tier system of certification. She said the "career ladder" would allow the board to give out-of-state professionals credentialing while they complete their academic and clinical training requirements. She said the board is also proposing to remove certain academic requirements, the completion of which is implied by other coursework. She said with regard to clinical training, the board reviewed requirements in surrounding states (Appendix U) and is proposing a reduction in clinical training hours. She said there is value in the consortium, but the board is also proposing an individualized training plan at the universities, if a consortium is not possible for an individual. She said the board is also proposing changes to reciprocity rules, including plans to prorate clinical hours for reciprocity. She said there is no restriction with regard to payment for those individuals completing their internship and they may be paid, but often it is a matter of funding. She said in the case of a hardship, the board can approve training on a part-time basis.

In response to a question from Chairman Lee, Dr. Nevland said the individualized training plan at a university is the final consideration for those individuals for which a consortium is not available.

In response to a question from Representative Fehr, Dr. Nevland said training supervision must be by a licensed addiction counselor registered as a supervisor with the board.

In response to a question from Chairman Lee, Dr. Nevland said recovery coaches are not currently regulated. She said the board will discuss a scope of practice and supervision requirements for recovery coaches at its October meeting.

In response to a question from Representative Rohr, Dr. Nevland said consortiums are only in North Dakota.

Dr. Nevland presented recommended legislative changes (Appendix V) to the definition of addiction counseling for the committee's consideration.

Dr. Rebecca Pitkin, Executive Director, Education Standards and Practices Board, provided information (Appendix W) regarding the board's role in the licensure of counselors, social workers, and psychologists providing services in schools. She said the Education Standards and Practices Board is the licensing agency for counselors and psychologists providing services in schools. She said both licenses fall into the "restricted license" category, indicating a specialization rather than a regular professional education core. She said applicants are required to complete the application form, submit transcripts, fees, a background check, and align with other teacher licensure procedures. She said a K-12 restricted licensure for counselors requires professional education coursework in educational psychology, instructional planning, methods, and assessment; classroom management; and school-based field experience or practicum and a master's degree, either in counseling or counseling with an emphasis in school counseling. She said licensure may also be granted to individuals with a bachelor's degree through an alternative access licensure which includes a plan of study. She said a school psychologist must obtain a specialist degree in school psychology or achieve school psychologist national certification to apply for a license. She said the Education Standards and Practices Board does not license social workers. She said social workers are licensed by an external board and credentialed by the Department of Public Instruction.

In response to a question from Representative Hogan, Dr. Pitkin said finding professionals experienced in childhood trauma is difficult.

Dr. Richard M. Rothaus, Interim Vice Chancellor, Academic and Student Affairs, North Dakota University System, provided information (Appendix X) regarding the number of internships available each year to behavioral health-related students and graduates, including funding sources, role of universities in arranging internships, and number of behavioral health graduates each year. He provided a summary report (Appendix Y) of graduates and recent internship placements in behavioral health academic programs in the North Dakota University System. He said the percent of social work interns placed in the state ranged from 40 percent for interns with an associate's degree from the North Dakota State College of Science to 93 percent for interns with a bachelor's degree from Minot State University. He said the UND placed 45 percent of its master's degree social work interns in the state. He said challenges included lack of providers and funding to supervise interns. He said master's level counseling and counselor education programs at UND and North Dakota State University (NDSU) placed 77 percent and 95 percent of their interns in the state, respectively. He said 17 percent of the counseling psychology (PhD) interns from UND are placed in the state. He said there is a lack of internship sites for counseling interns and national competition for the only 3 accredited counseling psychology (PhD) internships available in the state. He said the couple and family therapy and human development and family therapy programs at NDSU report placing 90 percent and 80 percent of their interns in the state, respectively. He said bachelor's degree psychology programs in the University System placed from 55 percent to 95 percent of their interns in the state. He said although the campuses report that all of their students are eventually placed in internships both in and out of state, they report licensed addiction counselor internships are nearing maximum capacity. He said well qualified interns are generally hired by the agencies providing the internships, leaving the western region of the state at a disadvantage because that region of the state has few internship opportunities.

Chairman Lee said the major challenge to behavioral health services in the state is workforce. She suggested the University System and various behavioral health boards collaborate to streamline curriculum and develop solutions to make it easier for professionals to move from one behavioral health profession to another.

Dr. Rothaus said it is appropriate for the University System to review its academic role in preparing behavioral health professionals, how it relates to the disciplinary role of the boards, and commonalities that exist between the behavioral health professions.

Dr. Patricia Moulton, Executive Director, North Dakota Center for Nursing, provided information (Appendix Z) regarding the nursing workforce in the state, including information regarding a behavioral health nursing workforce capacity policy brief (Appendix AA), nursing faculty recruitment and retention policy brief (Appendix BB), and an advanced practice registered nurse preceptor policy brief (Appendix CC). She said the policy briefs result from collaboration with nursing associations, nursing education programs, state government, regulators, and other stakeholders. She said the behavioral health policy brief outlines ways the nursing community can assist with the state's behavioral health shortages. She said stakeholders recommend increasing funding for the health professional loan repayment program and adjustments to the program to remove the matching funds requirement and add registered nurses and licensed practical nurses to the those eligible for loan repayment. She said other recommended changes include adding advanced practice registered nurses to those authorized to order detoxification holds. She said increasing the number of nurses in the state will require increasing the capacity of the state's nursing education programs and an adequate supply of faculty and preceptors. She said stakeholders are recommending a new nursing faculty loan forgiveness program for public, private, and tribal nursing education program faculty to obtain master's and doctorate degrees while serving as faculty and an income tax credit of $1,000 for each clinical rotation of at least 160 hours for advanced practice registered nurses that serve as a preceptor for advanced practice registered nurse students.

Ms. Stacie Olson, Clinical Assistant Professor, College of Nursing, University of North Dakota, provided information (Appendix DD) regarding loan forgiveness programs for nursing faculty. She said she benefited from a student loan forgiveness program while obtaining a doctorate degree. She said because she worked as a full-time nurse educator, the program forgave a portion of her student loans each year up to 4 years. She said funding for these programs is competitive and not always available. She said the program is needed to increase faculty in the psychiatric mental health nurse practitioner program. She said UND is including more mental health content in their current family nurse practitioner program curriculum and is considering a continuing education program regarding the assessment and management of care for the mentally ill for family nurse practitioners currently in practice. She said provider shortages and demands for productivity make it difficult for preceptors to mentor students. She said a tax incentive could ease the burden for nurse practitioner preceptors.

Ms. Jackie Bleess Toppen, Vice President of Communications, North Dakota Nurses Association, provided information (Appendix EE) regarding recommendations to increase the number of behavioral health nurses in the state. She said there is a critical shortage of nurses. She said of the 13,000 registered nurses in the state, 3 percent are working in behavioral health, yet behavioral health nurses make up the largest portion of the professional workforce for acute inpatient psychiatric services. She said the North Dakota Nurses Association

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

Dr. Carla Gross, College and University Nursing Education Administrators, provided information (Appendix FF) regarding recommendations to increase nursing professionals in the state. She said there are more applicants for the state's nursing programs than slots available. She said there have been efforts to assure that all applicant slots are filled in each nursing program across the state, including advising applicants that are not admitted, of openings in other programs as well as alternative plans to obtain a nursing degree. She said one of the barriers to expanding nursing programs is the lack of qualified faculty. She said other advance degree career options are often considered more attractive and lucrative. She said the state's nursing programs have faculty positions they have been unable to fill or have filled with unqualified faculty working toward a master's degree. She said there has been success with the "grow your own" model in which programs encourage students and nurses who express an interest in teaching to pursue a master's degree and once they are hired as faculty members, they are encouraged to pursue doctoral education. She said this path requires additional time, added workload, and tuition costs. She said a faculty loan forgiveness program and higher salaries will help to encourage and reward these efforts. She said the biggest challenge is obtaining preceptors for students. She said reasons include increased productivity expectations of health care organizations and an increase in regional and online programs which has increased the demand for preceptors. She said reimbursement by health care organizations for hours physicians serve as preceptor for medical students makes them less likely to serve as a preceptor for advanced practice nurses which provides no compensation. She said health care systems and independent practitioners across the country are now seeking financial compensation for preceptor services, increasing the costs of a nursing education. She said College and University Nursing Education Administrators supports the income tax credit for preceptors, financial reimbursement to preceptors in the state's advanced practice registered nurse programs, and a loan repayment program for advanced practice registered nurses that graduate and stay in the state to work.

In response to a question from Representative Becker, Dr. Gross said the nursing shortage is nationwide.

In response to a question from Chairman Lee, Dr. Gross said the bigger hospitals in the state have many student nurses completing clinical training. She said smaller, rural facilities are unable to provide the group clinical training done by the larger facilities, but may provide options for preceptorships or summer internships.

Ms. Jenna Herman, State Representative, American Association of Nurse Practitioners, provided testimony (Appendix GG) supporting of the recommendations included in the North Dakota Center for Nursing's policy briefs. She said the University of Mary has provided various incentives for preceptors. She said the tax incentive would attract additional qualified preceptors and ease the burden on current advanced practice registered nurse preceptors.

Dr. Lisa Peterson, Clinical Director, Department of Corrections and Rehabilitation, and Ms. Pamela Sagness, Behavioral Health Division Director, Department of Human Services, provided information (Appendix HH) regarding behavioral health needs in the criminal justice system. Dr. Peterson said the Department of Corrections and Rehabilitation is collaborating with the Department of Human Services and several jail administrators to improve access to behavioral health care for those in the criminal justice system. She said the stakeholder group has also presented their recommendations to the interim Incarceration Issues Committee and the interim Human Services Committee.

Ms. Sagness said the behavioral health system must focus on disease management. She said addiction and mental health must be managed just as any other chronic disease. She said the full continuum of care must be supported including promotion, prevention, treatment, and recovery. She said this includes sober living environments which are less expensive and will make available more primary treatment beds. She said the state should use best practices and only implement effective services.

Dr. Peterson said for diversion and re-entry strategies to be successful, they need to be supported by a full continuum of care. She said the capacity to effectively treat those that need to be incarcerated must be improved in order to reduce recidivism and contain the cost of the corrections system in the long term. She said the proposal is not to add resources to the corrections system, but rather to the behavioral health care system in order to prevent entry into the corrections system. She said diversion or alternatives to incarceration is not for individuals that have perpetrated violent or serious offenses, but rather for those that are in the corrections system because of gaps in behavioral health services. She said some of the initiatives supported by the stakeholder group include sober living environments, supported employment services, and peer support, such as recovery coaches.

Ms. Tammy Zachmeier, Utilization Review Administrator, Medical Services Division, Department of Human Services, provided information (Appendix II) regarding a comparison of the referral requirements for Medicaid reimbursement of the various behavioral health professions, including information regarding the length of time services may be reimbursed for various behavioral health professionals. She said no referral is needed for the services of licensed psychologists, licensed independent clinical social workers, licensed marriage and family therapists, and licensed professional clinical counselors. She said service is limited to 40 visits per year; however, limits can be exceeded, based on medical necessity, if the provider receives prior authorization from the department. She said rehabilitative services in the state plan require the referral of a licensed practitioner of the healing arts. She said services to families in crisis and at risk of disruption are limited to no more than 6 months of services (per occurrence) unless approval is received from the department.

In response to a question from Representative Hogan, Ms. Zachmeier said adding eligibility for individuals at risk of entering a corrections facility would require a change to the state plan.

In response to a question from Chairman Lee, Mr. Eric Elkins, Medical Services Assistant Director, Department of Human Services, said legislation is not required for the department to suspend, rather than terminate, Medicaid coverage when an individual is incarcerated. He said there may be issues to address in the department's system capabilities.

Chairman Lee suggested the Department of Human Services explore the suspension of Medicaid coverage while incarcerated.

At the request of Chairman Lee, the testimony of Ms. Sarah Wallace, Crisis Counselor, Killdeer, was distributed. She provided information (Appendix JJ) regarding the licensure requirements of a licensed clinical mental health counselor in Vermont compared to a licensed professional clinical counselor in North Dakota and her experience seeking licensure when moving to North Dakota from Vermont.

It was moved by Representative Mooney, seconded by Representative Seibel, and carried on a voice vote that the committee request the Legislative Council to prepare bill drafts to provide for an income tax credit for advanced practice registered nurse preceptors, remove the matching funds requirement for behavioral health professionals in the loan repayment program, and establish a loan forgiveness program for nursing faculty.

It was moved by Representative Rohr, seconded by Representative Becker, and carried on a voice vote that the committee request the Legislative Council to prepare a bill draft to amend the dental loan repayment program to provide for a prorated payback of loan repayment funds in the case of a breach of the loan repayment contract by the dentist.

It was moved by Representative Fehr, seconded by Representative Mooney, and carried on a voice vote that the committee request the Legislative Council to prepare a bill draft to provide the supervisory requirements of the various behavioral health professional boards reporting to the committee allow the primary supervision of behavioral health professionals by someone in their profession, but also allow other behavioral health professionals outside of their respective professions to provide additional supervision to meet the requirements for licensure.

Chairman Lee suggested the committee receive a copy of The Council of State Governments interstate compact for psychologists.

Chairman Lee announced the next meeting, anticipated to be September 21, 2016, will be the committee's last meeting of the interim.

It was moved by Representative Fehr, seconded by Representative Strinden, and carried on a voice vote that the meeting be adjourned. No further business appearing, Chairman Lee adjourned the meeting at 4:22 p.m.

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Sheila M. Sandness
Senior Fiscal Analyst

ATTACH:36