

Testimony
House Human Services Committee
Senate Bill 2030
March 18, 2013
North Dakota Department of Health

Good morning, Chairman Weisz and members of the Human Services Committee. My name is Kelly Nagel, and I am the public health liaison for the North Dakota Department of Health. I am here to provide background information on the local public health system and information on the proposed changes to NDCC 23-35.1 relating to Regional Public Health Networks as approved by the Interim Health Services Committee.

Background

North Dakota's public health system is decentralized with 28 independent local public health units working in partnership with the state health department. The 28 local public health units are organized into single or multi-county health districts, city/county health departments or city/county health districts. Seventy-five percent of the local health units serve single county, city or combined city/county jurisdictions, while the other 25 percent serve multi-county jurisdictions. The western part of the state consists of multi-county health districts, whereas the eastern part of the state consists mostly of single county health districts and departments. There are three city health departments in the state: Bismarck, Fargo and Grand Forks (map attached).

In this decentralized approach, the units are required to meet state standards and follow state laws and regulations, but they can exercise their own powers and have administrative authority to make decisions to meet their local needs, and therefore determine their own service area or jurisdiction.

According to the National Association of County and City Health Officials National Profile of Local Health Departments, 54 percent of North Dakota's local public health units serve a population of less than 10,000. These health units have an average of 3 FTE for all staff, 1.5 FTE being a nurse, and an average budget or expenditures of \$115,000. The profile survey also indicated that 34 percent of the total annual revenue sources for all North Dakota local public health units is from local government, 28 percent is federal pass through, 9 percent is state direct with only 5 percent from state aid, 1 percent is direct from Medicare and Medicaid, and 24 percent is from fees and other sources (funding pie chart attached). As a result of the various structures, and because funding sources and amounts differ for local

public health units, there is a wide variety in the levels of services they provide and in their capacity to provide comprehensive services.

Local public health units have a history of collaborating within a region. A regional infrastructure was established for emergency preparedness and response to amass the resources necessary to meet new public health challenges and to provide additional capacity throughout the state, especially in the smaller health units. A lead local public health unit has been identified for emergency preparedness and response in each of the eight regions of the state. Each of these units has employed a public health emergency response coordinator, a public information officer and an environmental health practitioner, all of whom provide services to the region. Funding for these efforts is provided through the federal emergency preparedness and response grant. The North Dakota Department of Health also remotely staffs seven epidemiologists who provide services to the regions regarding disease-related issues and five environmental health practitioners who inspect food and lodging facilities. The lead public health units also employ environmental health practitioners who provide general environmental health services within their region.

SB 2030 Changes to NDCC 23-35.1 Relating to Public Health Regional Networks

The North Dakota Association of City and County Health Officials (SACCHO) selected representatives to serve on a task force to develop recommendations for changes to NDCC 23-35.1 Regional Public Health Networks.

The general theme around the task force recommendations is to have the statute language more permissive than prescriptive. The recommendations align well with national research findings. The National Association of City and County Health Officials compilation of research findings relating to regionalization indicated the following abbreviated summary of benefits to regionalization and structural considerations:

Benefits:

- Two most commonly accepted reasons for regionalization are that it results in improved efficiency and economies of scale.
- Multi-county and regional local health departments provide a more comprehensive set of services than smaller departments.
- Allows health departments to pool resources to meet the demands of research and evidence based practices.

Structuring

- Experiences from regionalized health departments have revealed commonalities should be considered when deciding the geographic area of a region.
- Other considerations for a viable region should be based on:
 - Sound operational principles.
 - Ability to integrate.
 - Ability to provide equitable services and access.
 - Population demographics.
 - Availability of resources.

The establishment and requirements of the Regional Public Health Networks were modeled after the Regional Educational Association (REA). REAs receive student foundation aid funding or state aid for each participating school district, which has been the most valuable asset in allowing for about 90 percent of North Dakota's student population to be covered by an REA. There were changes made to the statute defining REAs in the 2011 legislation. The list of potential administrative functions and student services was removed as well as the required number of shared services and functions. Required services and functions were replaced with five key focus areas or core services.

Like the REAs, the original Regional Network Pilot Project conducted in 2010 by the Southeast Central local public health unit region (Jamestown area) also experienced difficulty in distinguishing between administrative functions and services. Therefore, the task force proposes to remove the lists and allow for flexibility, but yet some standardization, by requiring networks to create a work plan that includes activities around the core public health activities identified by a national steering committee for "Public Health in America." The core activities include: 1) Prevent epidemics and spread of disease; 2) Protect against environmental hazards; 3) Prevent injuries; 4) Promote health behaviors; 5) Respond to disasters; and 6) Assure the quality and accessibility of health services. Identified work plan activities should also meet the community needs or reflect a community health assessment. These requirements will assure that populations covered by regional health networks will be better protected and that their health needs are better met.

Another recommendation is to remove the requirement for the network to correspond to one of the emergency preparedness and response regions. The defined geographical boundaries prohibit health units with an existing working

relationship to form a network. For example, Cavalier County Public Health may work closely with Walsh County Public Health and have commonalities, but current statute would not allow the two to participate in the same network. The task force proposes that networks serve a minimum population of 15,000 or comprise at least three local public health units.

The final recommendation is to remove the requirement for the network to have a regional network health officer. The authority of the regional health officer is not clear with statute requiring that there also be a local health officer with specific authority and responsibilities for each local public health unit jurisdiction.

The original pilot project conducted in the Southeast Central region (Jamestown) in 2010 achieved successes that the Southeast local public health region (Fargo area) wanted to model and explore further. One of the things they are testing as part of a current pilot project is the effectiveness in a region with varying health units – a large city health unit jurisdiction and five smaller county health unit jurisdictions. The Southeast local public health region is currently undergoing a three-year regional network pilot project funded by the Bush Foundation. The collaborative is beginning year two of the project. Local public health units included in the southeast collaborative are the lead health unit, Fargo Cass Public Health; and the single county health units, Ransom County, Richland County, Sargent County, Steele County and Traill District.

The Southeast local public health region project is specifically focused on improving capabilities and capacity to provide more consistent environmental health services throughout the region; effectively implementing and utilizing electronic health records for population-based services; and preparing for National Public Health Accreditation.

Southeast local public health region partners believe that shared capacity in environmental health will be sustained by the adoption of ordinances throughout the region which will result in a requirement for additional inspections and fee collections. Accreditation can be achieved and sustained by sharing capacity to prepare for accreditation and through a joint application. The joint application option will save the six local public health units a total of \$63,600. Collaboratively preparing and applying for accreditation not only has financial and staff efficiencies, it has also made accreditation more realistic for smaller health units to apply. Finally, the electronic health records will result in staff efficiencies and better data collection and analysis, which will better position the collaborative for other funding sources.

This project will provide additional evidence that formal collaborations will strengthen local public health infrastructure, more efficiently use limited funding and staff, and provide more equitable access to quality public health services for people in all counties of North Dakota.

This concludes my testimony. I am happy to answer any questions you may have.