Testimony
Health Services Committee
Tuesday, January 10, 2012
North Dakota Department of Health

Good morning, Chairperson Lee and members of the Health 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 geographic coverage areas of health programs in the state, the effects of the Regional Network Pilot Project on consumers, any recommended legislation relating to the regionalization of public health services and options for a regional network to become self-sustaining.

Geographic Coverage Areas of Health Programs

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 majority of the multi-county jurisdictions reside in the western part of the state (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: therefore, they determine their own service area or jurisdiction.

North Dakota local public health units have a long history of providing personal and population-based health services to residents in their city and/or county jurisdictions. The local public health infrastructure represents the capacity and expertise necessary to carry out services and programs. Therefore, the health units function differently and offer an array of services. The top activities and services provided by local public health as indicated in the 2010 National Profile of Local Health Departments are child immunizations, adult immunizations, tobacco use prevention, high blood pressure screening, injury prevention screening, blood lead screening and EPSDT (the child health component of Medicaid).

A regional infrastructure has been developed to amass the resources necessary to meet new public health challenges. In 2002, when the Emergency Preparedness and Response program first began, the local public health unit administrators developed eight public health planning regions around the eight most populated

cities in the state (map attached). The health units whose jurisdiction covers the larger cities have been identified as the "lead" local public health unit (LPHU) in each region. Each employs 2.5 staff through funding provided by the Public Health Emergency Preparedness funding that is issued by the Centers for Disease Control and Prevention (CDC). These 2.5 employees assist with health and medical planning and preparedness activities with the stakeholders in their region. These planning regions do not have any "regional" responsibility, but rather a cooperative partnership for public health emergency planning and preparedness activities. The hospital preparedness planning regions are based on referral patterns into four largest cities with tertiary care centers. Geographic boundary lines do not exist. Hospitals have the freedom to identify where their affiliation is the strongest for participation in planning.

The Division of Disease Control has regional arrangements with local public health units regarding infectious and communicable disease surveillance and investigations. In this arrangement, the state is divided into eight field epidemiology areas. Each field epidemiologist has an office located in the lead LPHU for the region. The lead LPHU location corresponds to the EPR defined lead health units; however, the field epidemiologist coverage areas are not the same as the EPR regional geographic boundaries. Offices are located in these cities.

1) Fargo – covers Cass, Traill, Steele and Griggs Counties
2) Grand Forks – covers Grand Forks, Pembina, Cavalier, Walsh and Nelson Counties
3) Devils Lake – covers Ramsey, Towner, Rolette, Benson, Eddy, Pierce and Wells Counties
4) Minot – covers Ward, Bottineau, Sheridan, McLean and McHenry Counties
5) Williston – covers Williams, Mountrail, Divide, Burke, northern Ward, Renville and McKenzie Counties
6) Dickinson – covers Stark, western Morton, western Grant, Mercer, Golden Valley, Billings, Dunn, Bowman, Adams, Slope and Hettinger Counties
7) Bismarck – covers Burleigh, eastern Morton, eastern Grant, Oliver, Kidder, Emmons and Sioux Counties
8) Jamestown – covers Stutsman, Foster, Barnes, Richland, Ransom, Lamoure, Sargent, Logan, Dickey and McIntosh Counties

There are also contractual agreements with many of the local public health units for immunization, HIV, Ryan White, hepatitis and West Nile virus services, but again the geographical coverage area is not defined. The funding is typically appropriated to serve the health unit jurisdiction population.

The Community Health Section (CHS) is composed of five divisions: 1) Cancer Prevention and Control, 2) Chronic Disease, 3) Family Health, 4) Injury Prevention and Control, and 5) Nutrition and Physical Activity. The purpose of the CHS is to support individuals, families and communities by providing quality programs that protect and enhance the health and safety of all North Dakotans. Local public health units and other partners across the state provide many of these program services through contracts. Contracts are strategically entered into with those entities who allow for the best possible statewide coverage. While most of the entities have defined geographic service areas, for many of these contracts, there is no defined geographical coverage between health units and other providers. Rather the contract is between the state health department and the provider to expand services outside of their jurisdiction. In other words, the provider can choose their coverage area.

The following programs have services that extend beyond the local public health unit or county jurisdictions: (1) Domestic Violence and Rape Crisis Program is a statewide program with activities provided through 21 local programs (map attached); 2) Women's Way is a statewide program with activities provided through the lead EPR regional public health units; 3) Women, Infants and Children (WIC) is a statewide program with services being provided through 17 LPHUs, four hospitals, two tribes and one nonprofit; and 4) Family Planning is a statewide program with activities being provided through six local public health units, one nonprofit, one community action agency, one university system and many satellite clinics (map attached).

North Dakota Department of Human Services provides direct care services through the North Dakota State Hospital, Developmental Center, eight regional human service centers, eight regional child support enforcement units, and county social service offices (map attached). Each of the regional human service centers are located in the eight largest populated cities similar to the EPR regional lead health units. However, the counties within the Human Services regions are slightly different. The only two regions that align with the EPR regions are the southwest region and the southeast region. The counties that may be impacted by the differences are Mountrail, Pierce, McLean, Sheridan and Griggs.

<u>Regional Network Pilot Project Effects and Legislative Recommendations</u>
The health outcomes or impact to the pilot project community members is unknown. The pilot project was only 12 months in duration, which was not adequate to plan shared services and functions, implement activities and evaluate for long-term health outcomes. Administrative efficiencies were noted in the

network. The small health units in the network implemented an electronic billing system which generated reimbursable revenue, but the impact on the clients was not measured. It can be assumed that a more efficient billing system is also more convenient to the clients in that the health unit bills the insurer directly rather than providing a receipt for the client to submit. Other impacts as related to the shared public health services also were not measured, but again we can assume that extending the family planning clinic hours would have allowed for better access to the outlying county clients. The establishment of a local Sexual Assault Response Team also may have increased the availability of sexual assault resources and created collaboration among local health-care providers and law enforcement officers, which also could be assumed to improve access to consumers. Finally, a chronic disease management program with standardized screening and educational protocols most likely allowed for improved client identification of chronic disease and self-management. As mentioned in previous testimony, public health needs to do better at measuring and monitoring program and service performance and the pilot project clearly demonstrated opportunities for improvement.

The North Dakota Association of City and County Health Officials (SACCHO) selected representatives to serve on a task force to develop recommendations for amendments to CC 23-35.1 Regional Public Health Networks. Task force members include a representative of the North Dakota Department of Health, Bev Voller, Emmons County Public Health; Paula Flanders, Bismarck Burleigh Public Health; Barb Frydenlund, Rolette County Public Health, Robin Iszler, Central Valley Health District; Julie Barker, Ransom County Public Health; Keith Johnson, Custer District Health; Tami Dillman, SACCHO Executive Director; and Kelly Nagel, North Dakota Department of Health. The task force had one meeting on January 3, 2012. The National Association of City and County Health Officials' (NACCHO) compilation of research findings relating to regionalization was presented. Regionalization was defined to have various formations that include networking, coordinating, standardization and centralization. The findings indicated benefits to regionalization, structural considerations and funding formula considerations.

Here is an abbreviated summary of the NACCHO findings:

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.

- Regionalization allows health departments to pool resources to meet the demands of research and evidence based practices.

Structuring

- Experiences from regionalized health departments have revealed that commonalities should be considered when deciding the geographic area of a region.
- Other considerations for a viable region are:
  - Sound operational principles
  - Ability to integrate
  - Providing equitable services and access
  - Population demographics
  - Resource availability

Funding Formulas

- Funding formulas are the most widely used way to allocate funding for regional formations. Formulas typically include a minimum base funding guaranteed to all recipients.
- State mandated services may be associated with state funded allocations.

<u>Recommended Legislation Relating to Regionalization of Public Health Services</u>
The general theme around the task force recommendations is to have the statute language more permissive than prescriptive. The recommendations align well with the research findings.

The establishment and requirements of the Regional Public Health Networks were modeled after the Regional Educational Association (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 Regional Network Pilot Project 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.

Another recommendation is to remove the requirement for the network to correspond to one of the EPR 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 LPHU jurisdiction.

Sustainability of Regional Networks

As noted in the pilot project evaluation report, expanding and sharing services is not feasible without fiscal support. In addition, there was a large amount of effort from Central Valley Health District, the administrative health unit, invested in the regional network pilot operations. Through cost savings, increased revenue and administrative financial assistance from the state, networks should be sustainable In addition, it should be expected that participating local public health units will contribute funding to the network for expanded or additional services. Keith Johnson, Custer District Health, is here representing SACCHO. He will expand on the funding recommendations and on sustainability.

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