Testimony
To the
Senate Appropriations -Human Services Division
on
HB 1004

Good morning, Chairman Dever and members of the committee. I am Lisa Clute, Executive Officer of First District Health Unit. First District provides local public health services to Bottineau, Burke, McHenry, McLean, Renville, Sheridan and Ward counties.

I am in support of the additional $2,750,000 state aid to local public health in the Governor's budget and increased funding for workforce and data systems. State aid funding is one of the few streams of funding local public health units receive that is flexible to address the unique needs of the communities we serve Traditionally; most of the public health funding is disease-specific with a narrow focus and does not provide support for ongoing infrastructure and specific community needs.

Local public health is continually assessing their community needs in regards to the community's ability to have healthy people in healthy communities. In the geographic area First District Health Unit serves, there are a wide range of needs that vary depending on access to health care (including mental health), emergency response times, varied economic and housing situations and leading causes of death.

Local public health units work with numerous community partners to address community needs. Partners include private health care providers, educators, clergy, local governments, UND family practice residents, emergency responders, parents, aging services, long term care facilities, etc. We need to be creative about addressing community needs and often use a multi-agency approach. That is why state aid is so important. We need flexible funding to support our community collaborative efforts and to address concerns specific to the populations we serve. Our local community health needs continue to grow and become more complex, and increases in state aid funding is needed to ensure a strong local public health system.

I have listened to the state health budget presentations and appreciate the work that they do. I want to provide additional information regarding the local health responses to some of the situations your committee has discussed.

- Tuberculosis – we have provided daily observed medication, facilitated quarantine orders, and arranged housing and provided food for those in quarantine for TB. Local public health performs case management for positive TB cases in our communities.
- Community engagement – we have worked with community coalitions and partners, and conducted focus groups to identify community needs and develop strategic plans that are unique to the subject communities. One of our strategies was to purchase a mobile clinic unit that will allow us to go into rural and hard to reach populations and provide immunizations, wellness checks, syringe services, and better respond to public health environmental health and emergency events. We will partner with North Central Human Services to provide mental health services to communities that do not have accessible services now.

- Immunizations – throughout the COVID vaccine distribution we facilitated calls with 28 health care providers every Tuesday to move vaccine across providers and assure that priority groups in each community had access. We have a very good working relationship with health care providers and were able to operate mass vaccination clinics to protect the public.

  We provided 25 monkey pox vaccinations. We did 3 presentations to high-risk populations. Information included an explanation of the disease, how to prevent the spread of monkey pox and when to seek vaccinations.

Local public health units are addressing significant workforce issues. By the end of 2023, 21 of the 28 local health administrators will have resigned within the last 3 years. There are a variety of reasons for the high turnover. Some are (or have) retired, some have left for other jobs, and some have elected to do an earlier than planned retirement due to the stressful and ever-changing working environments. First District Health Unit is in the process of recruiting for my position. They need all the tools available to recruit qualified applicants. This is not unique to public health administrators. We struggle recruiting nurses and environmental health practitioners also. The workforce challenges are nationwide.

In addition, data systems are a challenge for local public health units because of the increased cost and the need to maintain local data in all of the programs and services we provide. Throughout the pandemic we were repeatedly asked for data at the local level. We relied on the state health department to give us case information in our service areas because the local public health departments did not have direct access this data which is reported to the state health department. This process was not efficient, and we did not receive local information in a timely manner. It is also important that we have local data on such programs as environmental health, nutrition and services that we provide specifically to our communities.

The COVID-19 pandemic emphasized the critical importance of a robust public health system and revealed the weaknesses in current public health infrastructure due to chronic underfunding. For the first time, the federal government has allocated funds to support critical public health infrastructure needs through the Strengthening U.S. Public Health Infrastructure, Workforce and Data Systems Grant. A requirement for this funding was that a minimum of 40% be allocated directly to local public health departments so jurisdictions could address their most pressing needs.

The North Dakota Department of Health and Human Services applied for this funding and developed a plan to distribute funds to local public health departments in North Dakota. The total award to NDDHHS is $8,929,580 which is one-time funding to be spent over 5 years. Of this

total grant award, $2,544,000 will be distributed directly to local public health departments to be used to meet the needs in their communities. This is just 28% of the total award, not the required 40%. The remaining 12% is being utilized at the state level to provide indirect support through state funded positions, training, and resources.

The National Association of City and County health officials have indicated that these dollars are better utilized at the local level and have advocated to get unrestricted funds to local public health departments. Nationally, this federal funding for local public health departments is a step in right direction, yet we are still cut short at the local level from the state of North Dakota. Other states have been allocated the entire 40% and some even more than that to meet the needs in their communities. Although I appreciate the State's efforts in applying for the grant funding, I would ask this committee to consider reallocating at least 12% of the funds the state received from the Strengthening U.S. Public Health Infrastructure, Workforce and Data Systems Grant to the local public health units to meet the minimum requirement of 40% to local public health. This will assist us in meeting the needs in our communities and keep the boots on the ground workforce staffed with qualified people. It will also assist us with improving our data systems at the local level.

Each Health Unit throughout the State develops services, activities and responses based on the resources available, and specific community needs. Local public health units appreciate your support. It allows us the ability to develop creative, efficient and effective strategies appropriate for our jurisdictions.

I would be happy to answer any questions.