2013 SENATE HUMAN SERVICES

SB 2030

2013 SENATE STANDING COMMITTEE MINUTES

Senate Human Services Committee
Red River Room, State Capitol

SB 2030
1/22/13
Job Number 17512

☐ Conference Committee

Committee Clerk Signature

Explanation or reason for introduction of bill/resolution:

Relating to regional public health network definitions, joint powers agreement review, annual plan, and receipt and use of moneys; and to provide an appropriation.

Minutes: Testimony attached.

Vice Chairman Larson opens the hearing on SB 2030.

Sheila Sandness, Senior Fiscal Analyst for the Legislative Council, introduces SB 2030 to the committee. See attached testimony #1.

Senator Anderson asks how many more regional health networks are anticipated as a result of this bill.

Ms. Sandness wasn't able to answer but suggested someone else might be able to.

Kelly Nagel testifies that it will cover everywhere in the state.

Sen. Larsen - asked for clarification about the funding.

Ms. Sandness explained that the 3 million she talked about in her testimony was what was included in the 2011/2013 biennium (grant funding for the local public health units). The 4 million is just for the networks, not the grants.

Kelly Nagel, public health liaison for the North Dakota Department of Health, provided neutral testimony on SB 2030. See attached testimony #2.
Testimony ends at 16:44

Senator Axness - asked for an explanation on the 24% funding that comes from fees and other sources. What are those fees and who is paying them?

Ms. Nagel responded that a lot of the local public health units charge donations for services. Other sources might be other 3rd party reimbursements.

Sen. Anderson stated that the original idea behind the pilot project was to see that these operations could be more efficient, both fiscally and in delivering services. He wondered if that was now just being replaced with ongoing funding from the state. He asked Ms. Nagel to comment.

Ms. Nagel said the justification for the $4 million is mostly for start-up funding to get the networks formed. Benefits include access to resources.

Sen. Larson - what is an epidemiologist?

Ms. Nagel said they are called field epidemiologists. They are disease related experts in the state that do disease surveillance and investigations.

Sen. Larson asked for some examples of what resources they are pooling.

Ms. Nagel used the SE collaborative as an example. They have pooled financial resources to obtain a consultant to help them do accreditation review and performance improvement issues. They have pooled resources to staff an environmental health practitioner or contractor to do policy scans and develop model policies. They also pool their expertise in electronic health records.

Sen. Larson asked her if the core activity she was discussing was going to be like the five areas of the REA.

Ms. Nagel said that was correct.

Discussion: Electronic records. Currently public health does not have the capability of being on the electronic health record system. Records do not follow from jurisdiction to jurisdiction unless the information is put into the state registry, like the immunization registry.
It is in state law that public health units provide services regardless of ability to pay. Public health is not clinical health care.

Ruth Bachmeier, Director at Fargo Cass Public Health, provided comments on the benefits of the regional public health network in the southeast corner of ND. See attachment #3. (Testimony ends at 28:00)

Ms. Bachmeier read testimony from **Wanda Kratochvil**, Administrator for Walsh County Health District in Grafton. See attached testimony # 4. (Testimony ends at 31:30)

Sen. Anderson wondered if there had been any effort on the part of the public health units to find an electronic public health system for everyone.

Ms. Bachmeier replied that across the state they are probably utilizing 4 or 5 different systems. It probably isn't so important they all have the same system but is more important that they can communicate with each other.

No further questions.

Keith Johnson, administrator for Custer Health - Mandan, testified on behalf of **Lisa Clute**, Executive Officer of First District Health Unit, who was not able to be present. See attachment #5.
He also commended the committee for work on this bill in the interim committee.

He pointed out that, in terms of funding, this will probably result in more funds accruing from the state to the local health units. They feel that is probably appropriate.

He also talked about the software programs. He pointed out that the health units were specifically excluded last session from meaningful use incentives in the health information exchange. They have to be part of it and will participate whether they are being paid for it or not.

He answered questions from the committee.

Sen. Anderson asked how this would help those in the western part of the state that already have a collaborative public health network since it seemed to him this was written to establish and fund new public health units.

Mr. Johnson replied that there are ample opportunities out west to cooperate such as providing environmental health services especially to the oil patch that cross boundaries. Another area is the school of nursing and interfacing with the regional educational association to market school health to the schools that want it. It will definitely benefit the east.

Sherry Adams, Executive Officer from Southwestern District Health Unit, gave input for the regional health network from a multicounty district health unit view. (Meter 43:00) She provided a packet of testimony and letters of support from health units that were not present. See attachment #6. Testimony ends at 47:18

Terry Traynor, Associations of Counties, testified in support and reported that their commissioners are very supportive.

Sen. Anderson asked if it would be his perception that probably no levies would go down in any of the counties because additional money was put in.

Mr. Traynor replied that the goal of this and some of the first indication is that there are efficiencies gained. He would not expect to see an immediate drop.

There was no further testimony in favor or in opposition.

The hearing closed but was re-opened for additional information from Sheldon Wolf.

Sheldon Wolf, Health Information Technology Division, provides further information.

He reported that they are working on the Health Information Network which would connect electronic health record systems between all the facilities within the state. Systems need

to be able to speak a common language to be able to connect it. They have received an appropriation - cooperative agreement from the federal government of 5.3 million dollars - that goes through 2014.
They have Phase I done which is a direct system - a security mail process.
They are working on Phase 2 which is query based services.

Discussion followed on putting information into the immunization registries. It is not mandatory right now but a bill is in the works on the House side.

Mr. Wolf spoke about the Regional Extension Center which helps facilities look at electronic health systems.

A citizen, who did not state his name, expressed his opinions and concerns about the cost.

Senator Anderson and **Sen. Lee** commented on his concerns.

The hearing on SB 2030 was closed.

2013 SENATE STANDING COMMITTEE MINUTES

Senate Human Services Committee
Red River Room, State Capitol

SB 2030
1/22/13
Job Number 17549

☐ Conference Committee

Committee Clerk Signature

Explanation or reason for introduction of bill/resolution:

Minutes:

Chairman Lee opened **SB 2030** for committee discussion.
She explained the background on the regional public health networks.

Senator Anderson moves Do Pass.

Senator Axness seconds.

Senator Anderson explained that he was concerned this would become an ongoing funding source for the public health units. However, this funding is intended to be startup and by putting this seed money in he looks forward to them saving enough to at least continue doing what they are currently doing and maybe add a little more.

Committee agrees that collaboration is an exciting thing. Without some incentive, they can't do it and this will provide that incentive.

Roll call vote 5-0-0. Carrier is **Sen. J. Lee**.

This bill was rereferred to Appropriations.

Date: 1/22/13
Roll Call Vote #: 1

2013 SENATE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. 2030

Senate Human Services Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☑ Do Pass ☐ Do Not Pass ☐ Amended ☐ Adopt Amendment

☑ Rerefer to Appropriations ☐ Reconsider

Motion Made By Sen. Anderson Seconded By Sen. Axness

Senators	Yes	No	Senator	Yes	No
Chariman Judy Lee	✓		Senator Tyler Axness	✓	
Vice Chairman Oley Larsen	✓				
Senator Dick Dever	✓				
Senator Howard Anderson, Jr.	✓				

Total (Yes) 5 No 0

Absent 0

Floor Assignment Sen. Lee

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

SB 2030: Human Services Committee (Sen. J. Lee, Chairman) recommends **DO PASS** and **BE REREFERRED** to the **Appropriations Committee** (5 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). SB 2030 was rereferred to the **Appropriations Committee**.

2013 SENATE APPROPRIATIONS

SB 2030

2013 SENATE STANDING COMMITTEE MINUTES

Senate Appropriations Committee
Harvest Room, State Capitol

SB 2030
01-31-2013
Job # 18046

☐ Conference Committee

Committee Clerk Signature

Explanation or reason for introduction of bill/resolution:

Relating to regional public health network definitions

Minutes: See attached testimony

Chairman Holmberg called the committee to order on Thursday, January 31, 2013 at 8:30 am in regards to SB 2030. Roll call was taken. All committee members were present except Senator Robinson. Laney Herauf from OMB and Sheila M. Sandness from Legislative Council were present.

Senator Judy Lee, District 13: (1.36) I am here to introduce SB 2030.which is the result of the work of the interim committee on health services. It discusses the importance of permitting joint powers agreements between and among public health units so that they can more effectively and efficiently deliver services at a time when they are especially challenged because of the growth in the west but everywhere. Two sessions ago we enabled them as a voluntary pilot project to do this and you will hear from the lead person on that. There will be others that can tell you the importance here. Public health is not individual clinical health. This is environmental health, vaccines and immunizations, things that affect the general public. Environmental health, we'll tell you a little more about that, Inspection of food facilities. We know there are mushrooming needs for those kinds of things. It was very successful. A lot of good response from that pilot project. The good news is, after some of the successes were seen there some other public health units who were a little bit apprehensive at the beginning about losing their autonomy realized that wasn't what this was about. The legislation is based on the REA's for schools, Representative Sanford helped with this, it is very much optional, it also permits the multi county districts to work with other districts. But I encourage you to move this forward. Two years ago it was left out of the budget and I didn't know what wasn't in the budget so we ended putting it back for study and review and the recommendation of the health services committee is that we enable these public health units to continue their work. (4.46)

Chairman Holmberg This bill will be assigned to the subcommittee of the Department of Health consisting of Senator Kilzer, Senator Grindberg and Senator Mathern.

Robin Iszler, Administrator at Central Valley Health District testified in favor of SB 2030 and provided Testimony attached # 1. She stated she would testify about the history and highlights of the SE Central Regional PH network pilot that was funded in 2009 and her testimony shares about the importance of the Computer based time recording system(TIMS) for standardized employee time reporting and the computerized billing system which her district and the partners share. The partners are City County Health District-Valley City, Wells County District Health Unit - Fessenden and LaMoure County District Health Unit-LaMoure. She is asking for the support of this committee for SB 2030. (11.08)

Vice Chairman Bowman: Do you see this budget growing every biennium? Is this going to be an ongoing appropriation and is it going to grow very fast. You talk about saving some money with technology and all I;ve seen is our technology has cost us a tremendous amount of money but If it helps all of the health units and provides better service and savings to the people I am for that.

Robin Iszler: commented she wasn't sure if they would need to ask for more funds or just be able to continue on with the services they provide. (13.02)

Senator Kilzer asked for a breakdown of the $4M to the subcommittee. He was asked if he meant the health districts and he told her no, he is more interested in the services.

Robin Iszler: Every public health department has needs so I don't know if we can give exactly what these dollars would buy. The health departments have said they are interested in increased environmental health services. For example, Central Valley in Jamestown, we have two people that provide 8 counties with services and it's very limited now so I would have to figure out how much money I would need out of this $4M to increase services to the counties. Also there's some talk with the school nursing, that is a need in our communities and that is one of the areas that has been looked at is how they can expand and share some resources for school nurses so usually we would put together our plan and budgets with our partners and come back to the Health Department and give this budget and they would allot this $4M to the locals.

Senator Kilzer: Already there are a lot of grants that come through the state Health Department to all the 29 units around the state, this is $4M more, why is not a different amount. I want to see what the services are in addition to all the grants that come through the Health Department.

Robin Iszler: Probably our request is based on the population amount but let me visit with our partners and see if we can provide that information for you.(16.02)

Theresa Will, Director at City-County Health District (CCHD) in Valley City. Testified in favor of SB 2030 and provided Testimony attached # 2. Her testimony states the services that her agency provides for the citizens of Barnes County. She asked for support from this committee in passing of this bill because it will help public health gain a better capacity to improve health in our communities. (20:21)

Senator Wanzek: Both you and Robin talked a little about the billing system and collaboration and we're hoping that this collaboration saves enough money to give us a return on that $4M investment By collaborating you've gotten one billing system you all can use and spread the cost over all these public health units. Is that the type of savings we are talking about?

Theresa Will: Yes. We were able purchase this system as a group and it has to be purchased for each health unit. (21.37)

Vice Chairman Bowman: As a county commissioner, you said you saved over $6,000 so did you reduce your budget the next year or did you keep that to use for something else.

Theresa Will stated they were able to operate with a decreased mill levy>

Murray G. Sagsveen appeared in his own personal capacity in support of SB 2030. He stated he was the state health officer in 1998 and 2000 and supported the local health units then and as the state flood coordinator in 1997 in Grand Forks and 2011 in Minot he worked very closely with the local health units. He stated he wanted to commend the local health units and the legislature for the job they have done regarding this matter and asks that they support SB 2030. (24.43)

Senator Krebsbach: I've had opportunity to visit the 1st District Health Unit in Minot and have listened to what they have gone through with all the additional work they've had to do and I would like to have Lisa Clute come and share in the area of environmental issues and vaccines.

Lisa Clute, Executive Officer of 1st District Health Unit testified in favor of SB 2030. She said they are in a unique position in Minot and the Souris valley, a double whammy of the flood and oil boom impact. Some are the very similar issues that Williston and Dickinson are dealing with in there are a few things we would love to collaborate with in the western part of the state and this bill would give us the funding and the opportunity to do that.

1. Environmental health
2. Labs
3. Language barriers
4. Legal services.

She concluded her testimony by asking for the support of the committee on SB 2030. (30.07)

Testimony # 3 -Final Evalutation Report: Southeast Regional Public Health Network Pilot Project by Mona P. Close, MS. RN CPHQ. was submitted to the committee but no oral testimony was given.

Chairman Holmberg: This is not in the governor's budget. He was told that is true. The hearing was closed on SB 2030.

2013 SENATE STANDING COMMITTEE MINUTES

Senate Appropriations Committee
Harvest Room, State Capitol

SB 2030 subcommittee
February 4, 2013
Job # 18255

☐ Conference Committee

Committee Clerk Signature Rose Laning

Explanation or reason for introduction of bill/resolution:

Relating to regional public health network definitions.

Minutes: Testimony # 1

Senator Kilzer opened the subcommittee hearing on SB 2030. **Senator Grindberg** and **Senator Mathern** were present.

Legislative Council - Sheila M. Sandness
OMB - Laney Herauf & Sheila Peterson

Senator Kilzer wants to focus on what the $4M will be used for and how it would fit in with additional appropriations. Also whether it was in the governor's budget and why it's an orphan out here. Any statements that weren't presented to the full committee?

Lisa Clute, Executive Director, 1st Distrct Health: This came out of interim committee. Testimony attached # 1 - SB 2030 - Regional Public Health Networks
She recommended that there would be a committee that has 6-7 people that distribute the plans.

(3:50) **Tammy Dillman, Finance Director, Central Valley Health District**
She's filling in for Robin Islzer who is at a meeting today. I was a project coordinator for the pilot group for the five counties that did the SE Central Regional Network pilot. In addition to the sample schedule, the difference there is that investing in America's Health National Report suggested the $6/capita for prevention services. This funding would be helpful and it's in line with the work that local public health currently does in addressing community health needs.

Senator Kilzer would really like to know what the difference would be if we didn't fund this at all. Which services would my cousins get? Bring it down to people. Would they get vaccinations that they wouldn't otherwise get? Would they get treatment for communicable diseases? Would they get screenings? Would they have nurses coming to the school once a week or once a month? Put it right down the care and things that directly affect people.

Lisa Clute: We can work to give you more detail to each one of these, but the problem is - in the NW part of the state, what we would utilize these dollars for is going to be immunization, environmental health capacity because that's where our problems are right now.

Senator Kilzer: In the pilot area, it was Jamestown & Valley City, but that is completely different. How can you take that pilot project and apply it to the NW because the demographics and changes are different. $275,000 pilot project and expand it to a $4M project for the whole state.

Tammy Dillman: The communities are different, but some of the needs aren't that different. The bullets on the sheet are needs. The proposed amendments have identified some key activities for these networks to address. The work plans that the networks address will be directly linked and have to demonstrate how your work plan will address the needs in your community. The pilot group had to select three administrative functions and three services to address in the work plan. At that time we didn't have a community assessment that was completed, but we do now.

Lisa Clute: The one thing this will ensure is that you have environmental health services for the entire state and currently that is not happening.

Senator Kilzer asked what the three people requested for environmental health would do. Lisa answered (9:23) - inspections, sewer licensing, hotels, swimming pools, etc.

(13:47) Senator Mathern asked if more people get sick when there is a lack of services.

Keith Johnson, Chief Administrator, Custer Health - Currently the lakes in Kidder County (which are being developed) have no upfront input on onsite water and sewer. In August, you can walk across the algae on a lot of the lakes. In Rolette County, they are having the same problem. They are underserved to the point that they don't realize the service can be provided.

Senator Kilzer would you anticipate the $4M as a one-time investment for this coordination that is going on; would it be a repeating request or would it be rolled into the Health Dept. budget. It comes from an interim committee, but it's an orphan bill because it's separate from the Health budget and was obviously not in the executive budget.

Keith Johnson: Looked at history of REAs and we anticipate that this would be up and running in two biennium.

Senator Kilzer commented that they are all professionals. Do they really need this much money to coordinate with other administrators of public health units?

Discussed how public health has grown and expanded over the years. **Keith Johnson** said the bill addresses 15,000 people and **Tammy Dillman** said it mentions community needs.

Lisa Clute said some units are over 15,000 people and the intent of the bill to is to make sure they have core public health services out there. The interim committee liked coordinating administration and putting more boots on the ground. They also talked a lot about environmental health.

Discussed the size of the health districts and the staffing needed.

Tammy Dillman said its based on community need and the amendments in the bill have provided that.

Senator Grinberg: (asked of Arvy) - This has been talked about for a while. If we pass this bill, what will it look like five years from now? What value would it add to citizens?

Arvy Smith: This was optional request #22. Many of our requests were funded in the governor's budget, but this one wasn't. A study 6-8 years ago is how we came up with the original networking requirements.

Discussed the networking and gaps in service and consolidated efforts.

(37:47) **Senator Kilzer**: Where can I read about the REAs?

Kelly Nagel, ND Public Health Liaison, ND Dept. of Health - I have a power point that they have provided to me and it's also in statute how they structure- a minimum population.

Senator Grinberg: It's in the Career and Vocational Department with Wayne Kutzer.

Lisa Clute: This is Senator Judy Lee's brain child. She could answer questions.

Sheila M. Sandness: In HB 1013 will answer questions of how the REAs are funded. It's in the DPI budget.

Theresa Will, Administrator at Kidder County Health in Valley City - We were part of the study. We've gained some great efficiency that we continue to use with the billing systems and such. We've since completed our community health assessment and the needs that are community has identified is huge and we don't have the resources to address those needs such as obesity and chronic disease prevention, increasing access to mental health and substance abuse prevention as well as violence.

Keith Johnson: We do not intend to provide all the answers to all these issues, but through collaboration, we get to work with community partners to help make these issues addressable.

Senator Kilzer said it's important to work with clinics, hospitals and other organizations and not take on the world. When he hears of gaps, he wants to know they are truly gaps. He's not a proponent of every school having a school nurse. There are parental and family issues that are not the school's responsibility.
They will meet again early next week.

2013 SENATE STANDING COMMITTEE MINUTES

Senate Appropriations Committee
Harvest Room, State Capitol

SB 2030 subcommittee
February 12, 2013
Job # 18803

☐ Conference Committee

Committee Clerk Signature Rose Laning

Explanation or reason for introduction of bill/resolution:

Relating to regional public health network definitions.

Minutes: Testimony # 1

Legislative Council - Sheila M. Sandness
OMB - Laney Herauf

Senator Kilzer: Opened the hearing on SB 2030. (**Senator Mathern** is present, and **Senator Grindberg** is in Washington, DC.

Keith Johnson, Custer Health: See testimony attached # 1 for recommended Amendments to SB 2030 Regional Public Health Networks. (Proceeded to explain the amendments, how bill would be enacted, and what the results would be, specifying the accountability of the act)

(4:38) Senator Kilzer: You're representing the Health Department to make these changes, and the obvious question is why weren't they made early on?

Keith Johnson: We took what the interim committee had put out and right now it is just the process of amending what the interim committee has done. I cannot really answer for the interim committee. We are trying to build the accountability provisions in so that you are at peace with it.

Senator Kilzer: Is Sheila at peace with it?

Sheila M. Sandness, Legislative Council: I have not had time to review this, but there doesn't seem to be anything in here that would be a problem.

Senator Kilzer: It doesn't seem make any substance, but it does clarify.

Arvy Smith, Department of Health: Keith is representing local public health, not the Health Department. We did work together on these. If you recall at the last meeting, I had some concerns about how the money was going to be distributed and so we set out to clarify that and found a couple of other things in the process.

Senator Mathern: I think is a work in progress. I would say that the interim committee probably just didn't have time to get the work done in the interim. I see these as a friendly amendment to the interim committee work. I do question the wording on the second to the last paragraph, "a distribution formula may be used", I think that is a little bit vague. I wonder if that isn't too much delegation of authority without clarification of what that distribution formula is. Is it based on population, or on geographies, etc? This could be a matter of some conflict. If Legislative Council drafts this, would they have more specific language?

Arvy Smith: At the last meeting a formula was presented to you and so it gave the appearance that this money would be distributed based on a formula. It is not. It needs to be on the merits of the network and the plan that they are going to put together. That is what we were after. The reason I added that comment was because I was reflecting back to what happened in reality when we dealt with the EMS situation. We looked for gook plans and we were going to approve those plans but we got request for $7million, when we only had $3 million to spend, and so in that situation, we needed to apply a formula. We most likely wouldn't provide a formula here, but it depends on how much money is allotted and whatever formula would be used would be approved by this. That is why that group of three locals and three health department people would approve whatever formula that was if we were to use one. We were trying to say that it may be used but it may not be used or distributed on formula.

Senator Mathern: What is a formula to you?

Arvy Smith: Often funding, it may be a base plus, it may be something based on population, where we take money and say it is prorated out based on the population of each local public health unit, or whatever the situation might be. Sometimes we do a base plus population where everybody gets $6000 and the rest is prorated based on population.

Senator Mathern: Just a minute ago you said something about the quality of proposal…

Arvy Smith: That would be the first criteria to look at. We would look at the quality of proposals coming in.

Senator Mathern: Is that part of a formula?

Arvy Smith: Not really. I didn't envision it to be. They have to do an assessment of the network that they are forming and that would determine what the needs are in that network. Then we would be looking at the quality of how their proposal met the needs of their network. I don't see that as a formula.

Senator Mathern: That to me doesn't leave room for that. The wording doesn't say quality of proposal.

Arvy Smith: That was intended to be approved regional public health, approved work plan and budget. That would be their proposal. That is what that was intended to mean if that is not clear, it might be something to re-word.

(Senator Mathern, Arvy Smith, and Keith Johnson Discussed formula distribution)

(13:17)**Lisa Clute, First District Health, Minot, North Dakota:** We modeled this after an immunization task force that we set up for a public health unit. We had 3 locals and 3 state people and that worked great. It has some precedence in how we've administered the money. They could collaborate and submit a plan.

Senator Mathern: I am not disputing the fact that we should do this, I want to make sure that it is not a situation where the health officer can say that the formula is this and the local folks can say the formula is something else. If you feel comfortable with this, I am.

Keith Johnson: We want this to be accountable about as much as anyone. Whatever language that we can put in there to make it so.

Senator Mathern: I suggest that we have Legislative Council draft these amendments and we could bring it to committee.

Senator Kilzer: I am fine with that. In a practical matter, the vaccination program for the last 6-8 years has been on an up and down course. The feds used to fund it, now they give hardly anything. There have been some independent bills the last few sessions that kind of stood to be the distributers; what's happening in the future?

Arvy Smith: The last time we were able to do all the vaccinations with just the federal vaccine was in 2003-2004. At that point there were some new vaccines that were quite expensive so then we had to get other effort involved there. The federal government supplies all the vaccines for VFC so if you are uninsured, underinsured Medicaid, Native American, and Alaska Native - all those are still provided. That is at least 1/3 of the population in North Dakota. There was a second federal source of vaccine and that is called Section 317. In that states were allowed to use what the needed for special projects. Last session it was decided that local public health units would be able to do universal vaccines. That would mean that all the vaccines would be provided for free. It was calculated that we get about $2 million a biennium from section 317 plus $1.5 million general fund and that all goes to public health for universal vaccine in the current biennium. As of this October, the federal government said the 317 can no longer be used for insured people. We have enough for the current biennium to fill that gap, but as we move into next biennium, we're asking for $1 million general fund to replace what we lost with the federal vaccine.

Senator Kilzer: That would take care of all the needs?

Arvy Smith: Yes, at local public health units.

Senator Kilzer: Would local public health units bill the insured?

Arvy Smith: No, they would use the general fund money to vaccinate the kids. There is a $1.5 million in our base plus the $1 million being added.

Keith Johnson: We don't bill for the vaccine, but we do bill for the administration of the vaccine. Medicaid is billed for the administration of those on Medicaid.

Senator Kilzer: Are all public health units doing this?

Arvy Smith: Except for about 5.

Senator Kilzer: What happens in those areas?

Arvy Smith: They bill insurance for the vaccine.

Senator Kilzer: Last time we talked about gaps in service and things like that, is that something that we can go into a bit deeper?

(22:14)Keith Johnson: I think you can say pretty fairly that environmental health statewide is going to be bolstered. In areas where there currently is little or none, it is going to be present and in areas where there is a present environmental health program, there is a need for strengthening especially in the patch. That is one thing I can reliably say is definitely going to be needed. We have some real needs with chronic disease that I think are going to result in programs from community health assessments. Community health assessments statewide are starting to coalesce around the same issues. They are not necessarily issues that we have treated very well in the past. We have got needs with chronic disease. Diabetes management and obesity are some examples.

Senator Kilzer: Are there documents from the time when Murry Sagsveen travelled the state that describe the needs and goals of these units? Does every unit have its own goals?

Keith Johnson: Every unit is autonomous. We are only recently getting to the point where an accredited unit is going to deliver a uniform set of services based on community needs. In 1999 when we put everything under a local public health unit, it did not necessarily stipulate that every public health unit had to provide full service. That is the way it resulted. We have a lot of single nurse counties and we have a wide variety of health units with wide variety of health services. So there are no documents that I am aware of.

Lisa Clute: There was a document in the early 90's. Now that would have to be gotten from each local public health unit.

Senator Kilzer: I am wondering how relevant that would even be at this point.

Keith Johnson: I can put the word out to the administrators and ask about it.

Kelly Nagel, State Health Department: There was resistance at that time for consolidation. This has nothing to do with consolidation. This is retaining their autonomy. This is collaboration and so all local public health units are fully onboard with this concept. If you go back to the consolidation/regionalization concept, you'll get resistance.

Senator Kilzer: We shouldn't be looking back too much, we should be looking forward.

Senator Mathern: When these amendments are drafted, I don't know if there will be two sections here. The funding appropriated and section and the add section 5 section. If there are two sections of the bill, I would add the words "to the approved regional public health networks" in Section 5 so we don't have two appropriation processes going on here. That way it will be the same as the one before.

Keith Johnson: I would love to give you a list of services that will be added as a result of this bill, but I think I would be irresponsible to do it. It may tie us into doing things that aren't necessary and we want to make sure that the things that we do put into place are necessary. It is going to vary across the state. As you know, public health is not an easily quantifiable set of objectives or services and in fact that is only one of the ten core areas for us. I sense your frustration with getting some concrete language that says that this is what is going to benefit the people of North Dakota as a result of this bill, but at the same time, I think if we did do that, we would be doing the effort a disservice. If we could bill language in here to make sure that we are accountable for results, I think then we have a success.

(31:00)Senator Kilzer: Asked an unrelated question that lasted the rest of the time. Closed the sub-committee discussion.

2013 SENATE STANDING COMMITTEE MINUTES

Senate Appropriations Committee
Harvest Room, State Capitol

SB 2030 subcommittee
February 19, 2013
Job # 19159

☐ Conference Committee

Committee Clerk Signature Rosella M. Daning

Explanation or reason for introduction of bill/resolution:

Relating to regional public health network definitions.

Minutes: Testimony # 1

Legislative Council - Becky J. Keller
OMB - Laney Herauf & Joe Morrissette

Senator Kilzer: Opened the subcommittee hearing on SB 2030. **Senator Grindberg** and **Senator Mathern** were present.

Senator Kilzer: Asked for comments from committee members.

Senator Mathern: See attachment #1 for **amendment 13.0034.03001**. (Explained the amendments proposed)

(2:23) Senator Kilzer: This would take authority away from whom and give it to whom?

Senator Mathern: I don't see it as taking away the authority. It basically clarifies that the state public health officer would get some input in terms for how these decisions would be made and that input would be from a committee of three local public health representatives appointed by the association of health officials and three representatives that were appointed by the state health officer; essentially though the state health officer would have the final say.

Senator Kilzer: When did we have this discussion?

Senator Mathern: In one of our previous subcommittee meetings. I viewed it as needing to be done relating to the fact that the interim committee had a bill coming forward but not time to attend to some of the details in the bill as to how they would be carried out. These amendments are just to attend to those details and they don't change the interim committee bill in any substantial format.

Senator Kilzer: Did the policy committee take this up at all because that is where you would think it would come from?

Senator Mathern: Yes.

Lisa Clute, Executive Officer, First District Health Unit: We talked to Senator Judy Lee and she said she was fine with it and that it doesn't change the intent.

Senator Mathern: Did they see these amendments or did you express these concerns to the policy committee?

Lisa Clute: These were not concerns at the policy committee. As I understand it, when the health department looked at them and they were concerned about the distribution process, so they were the ones that brought forward these amendments and suggestions and we agreed with them.

Senator Kilzer: It would be my preference that if this bill makes it past crossover that it will go to the policy committee in the House and that might be a better place to have a thorough review of how the application and the distribution of the funds is carried out. What are the thoughts of the other committee members?

Senator Grindberg: I have mixed messages on this piece of legislation. Part of me says that this is something that we need to do. It should have been sorted out in the interim committee or in the policy committee. Maybe we're maybe not ready for this yet. There has to be a lot of work done before it goes into law.

Senator Mathern: There is a lot of work to do and we can do a piece of it now. That is what these amendments are. These are amendments coming from the parties that have to make this work, and they have come to this agreement and we are a step in the process to help get it done.

Senator Mathern: Moved the amendment.

Lack of second - amendment is not adopted.

(8:48)Senator Mathern: It's still a good bill and I think we should send it out. I think it is important that we do everything we can to support the individual health districts cooperate with each other. I think there is a better quality of service that happens because of it.

Senator Grindberg: With what you just said, wouldn't that continue to prevail if this bill is defeated?

Senator Mathern: It really doesn't. What we learned with a couple of pilot projects we had, was wherein we did this kind of thing and some of these smaller units combined with some of the bigger units and so the people in the region got a higher level of service because of that working together process. Some units might not have this service and another unit might have more services and by working together they basically got that higher level to every public health unit in that region. It was this process that made it happen so I don't think it will happen without this bill. They just don't have the overhead to actually work together and elevate their services. They just sort of hunker down and do their own thing

with the limited amount of resources they have but then the citizens miss out on some things.

Senator Kilzer: I have a different take on it. I feel that people who are in public health, just like people who are in education, that should be the qualification of the people who are administering the various health units. That they work with the other neighboring units. To me it's like schools; we hand out money from the legislature because schools have rapidly increasing enrollment. We also have handed out money in schools that have a declining enrollment and then we hand out money to schools when they combine. To me a good superintendent is one who can make the adjustments without additional money. This item didn't make the executive budget. I think there are better ways to spend the money, so I'm going to support a do not pass on this bill.

Senator Mathern: When you brought up the schools, it is a very appropriate comparison and what we have done in schools is funded regional educational networks. That really is what this is. That superintendent that has reduced funding or something dramatic has happened, they might have to change the services that are available or the personnel may need to be changed. The regional education network can make up those differences by using a staff person from the regional center for a service verses duplicating it in his own school district. We fund that regional network for schools. This is essentially using that model in the public health sector.

Senator Kilzer: Then why would they need extra money to come to that decision?

Senator Mathern: I suppose it is because there is the freedom to not be putting out fires every day.

Senator Kilzer: Money doesn't buy freedom. I feel that there are needs - computer needs, vaccine needs over and above what we are funding. This is administrative and it's nice, but I prefer OARs to be directed toward people. In another bill, we're increasing the colorectal screening and re-screening, and I think making it applicable to more people directly and this bill does not do that in a very direct way.

Senator Mathern: Maybe it has not clearly enunciated then. People will get services here in these local public health units. Those are direct services and individuals benefit from it.

Senator Grindberg: Moved Do Not Pass.

Senator Kilzer: Seconded.

Senator Mathern: Voted against.

The subcommittee recommendation to the full committee will be Do Not Pass.

2013 SENATE STANDING COMMITTEE MINUTES

Senate Appropriations Committee
Harvest Room, State Capitol

SB 2030
02-20-2013
Job # 19222

☐ Conference Committee

Committee Clerk Signature Alice Delzer

Explanation or reason for introduction of bill/resolution:

A BILL relating o regional public health network definitions. (Do Pass.)

Minutes:

Chairman Holmberg called the committee to order on Wednesday, February 20, 2013. All committee members were present.

Brady Larson -Legislative Council
Joe Morrissette-OMB

2030 job # 19222

(0:00:50) **Senator Krebsbach** 2030 is the one about 4M for regional public health, comes from interim health services. There was a study of the public health units Jamestown, Valley City area, for $275,000 and this grew to this bill to cover the whole state. A do not pass on 2030

Senator Krebsbach moved a do not pass. 2nd by Vice Chairman Grindberg .

(0:01:33) **Senator Mathern** I hope you resist this motion. We had an interim study that reviewed the pilot project if you get 3 or 5 public health districts to work together, that project was out the Jamestown the south west. A sharing of the expertise of those districts that had more staff with those that had fewer staff, and a coordination of services, when there is a larger group. Creating regional networks. This is what is happening in public health, the success of the pilot projects suggest we do this around the state. It funds regional networks around the state. I ask for a do pass.

(0:3:29) Senator Kilzer: this was an OAR optional request. The governor did not have it in his budget. Your committee felt that money could be spent otherwise, even in the pilot project; a lot of that money was used for computers. Recommends a Do Not Pass.

(0:04:14) Senator Krebsbach this was the funding bill for the 17 areas did not have registration for the septic units the funding for that was included in this bill. Is it true?

(0:04:54) Senator Mather I could comment on that. Senator Krebsbach question about septic systems is a good example of what happens in the districts. What are the rules that have all the rules and procedures, I suspect that is one of the ways this could be used. Versus one district doing it well and one not doing anything.

(0:05:59) Chairman Holmberg . Call the roll on a DO NOT PASS.

A Roll Call vote was taken. Yea: 6 Nay: 7; Absent: 0. Motion failed.

Senator Mathern moved a do pass . 2nd by Senator Warner.

Chairman Holmberg: Call the roll on a DO PASS on SB 2030.

A Roll Call vote was taken. Yea: 8; Nay: 5; Absent: 0.

Senator Mathern will carry the bill.

The hearing was closed on SB 2030.

Date: 2-20-13

Roll Call Vote # 1

2013 SENATE STANDING COMMITTEE
ROLL CALL VOTES

BILL/RESOLUTION NO. 2030

Senate Appropriations Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken DNP

Motion Made By Kilzer Seconded By Grindberg

Senators	Yes	No	Senator	Yes	No
Chariman Ray Holmberg	✓		Senator Tim Mathern		✓
Co-Vice Chairman Bill Bowman		✓	Senator David O'Connell		✓
Co-Vice Chair Tony Grindberg	✓		Senator Larry Robinson		✓
Senator Ralph Kilzer	✓		Senator John Warner		✓
Senator Karen Krebsbach		✓			
Senator Robert Erbele		✓			
Senator Terry Wanzek	✓				
Senator Ron Carlisle	✓				
Senator Gary Lee	✓				

Total (Yes) 6 No 7

Absent

Floor Assignment

If the vote is on an amendment, briefly indicate intent:

failed

Date: 2-20-13

Roll Call Vote # 2

2013 SENATE STANDING COMMITTEE
ROLL CALL VOTES

BILL/RESOLUTION NO. 2030

Senate Appropriations Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken Do Pass

Motion Made By Mathern Seconded By Warner

Senators	Yes	No	Senator	Yes	No
Chariman Ray Holmberg		✓	Senator Tim Mathern	✓	
Co-Vice Chairman Bill Bowman	✓		Senator David O'Connell	✓	
Co-Vice Chair Tony Grindberg		✓	Senator Larry Robinson	✓	
Senator Ralph Kilzer		✓	Senator John Warner	✓	
Senator Karen Krebsbach	✓				
Senator Robert Erbele	✓				
Senator Terry Wanzek	✓				
Senator Ron Carlisle		✓			
Senator Gary Lee		✓			

Total (Yes) 8 No 5

Absent 0

Floor Assignment Mathern

If the vote is on an amendment, briefly indicate intent:

7

REPORT OF STANDING COMMITTEE

SB 2030: Appropriations Committee (Sen. Holmberg, Chairman) recommends **DO PASS** (8 YEAS, 5 NAYS, 0 ABSENT AND NOT VOTING). SB 2030 was placed on the Eleventh order on the calendar.

2013 HOUSE HUMAN SERVICES

SB 2030

2013 HOUSE STANDING COMMITTEE MINUTES

House Human Services Committee
Fort Union Room, State Capitol

SB 2030
March 18, 2013
Job 20024

☐ Conference Committee

Lynell Thueson

Explanation or reason for introduction of bill/resolution:

A BILL relating to regional public health network definitions, joint powers agreement review, annual plan, and receipt and use of moneys; and to provide an appropriation.

Minutes: *Testimony #1, 2, 3, 4, and 5*

Chairman Weisz opened the hearing on SB 2030

01:52 Kelly Nagel, **Public Health liaison** for the **ND Dept. of Health**: provided background information on the local public health system and on the proposed changes to Century Code 23-35.1. (See Testimony **#1**) Listed benefits of the National Association of City and County Health Officials.

7:08 Senator Lee, **District 13**, **West Fargo**: introduced and supported the bill. This was researched two sessions ago. This is an important project and was designed for schools. Multi-county units find this advantageous to collaborate with other county units. This is a voluntary and flexible project. There would be more consistent services throughout the state. Once it is up and working there should not be any significant additional expenses. I ask for a favorable consideration.

11:12 Kelly Nagel resumed her testimony.

16:58 Representative Porter: What was the appropriation level last time and what this money is going to buy?

Nagel: There was no funding last session, but the session before there was $275,000 appropriated for the pilot project. The $4 million appropriation and how it will be spent will vary according to each network because it is voluntary. There is testimony from different regions of the state.

19:11 Representative Porter: So none of the $4 million dollars does not stay inside the Health Department and no FTE's required inside the Health Department in order to do this?

Nagel: That is correct.

19:32 Representative Porter: There are 17 counties that don't have environmental health services. If they choose to collaborate then are they mandated to do those core components so then they would have to have an environmental health section to that side of the Public Health responsibilities?

Nagel: I'm not sure where that information from Natural Resources came from.

20:48 Representative Porter: The bill has two FTEs for the Health Department to take over the septic side of things for the environmental health on 25 and over occupancy and then it pushes the other component of 25 and less back to the locals, has an entire certification program and an education component in it for the contractors, but in that testimony it was stated that there are 17 counties that don't have current environmental health services.

Nagel: There are 17 that don't employ environmental health.

22:03 Representative Porter: Those two FTEs are for inspections of those larger systems.

Nagel: I thought the one bill was for a statewide program and the other for bigger systems.

23:08 Representative Porter: There are three different bills dealing with the same issue.

Nagel: This bill is not directly related to environmental health.

23:49 Chairman Weisz: It could have an effect on that component. Money was to be used not to provide services, but for putting together that network.

Nagel: That is correct.

25:14 Chairman Weisz: I got the impression the $4 million could be used for services not just the cost of bringing the network together and the network up and running.

Nagel: Correct.

26:19 Ruth Bachmeier, **Director at Fargo Cass Public Health**: in support of the bill. Testimony read by Kelly Nagel. (See Testimony **#2**) Together we are using quality improvement methods and tools to try and determine best outcomes. Shared highlights of the first year of their collaborative and lessons learned through the experience.

29:30 Robin Iszlaer, **Administrator at Central Valley Health District, Jamestown**: testified in support of the bill. (See Testimony **#3**) Explained the history and highlights of their SE Central Public Health network project. This bill will allow for improvements to local public health departments in ND by encouraging regional shared services.

34:08 Representative Fehr: Are you aware of the problems of the REA's?

Iszlaer: Not familiar completely with their problems.

34:56 Theresa Will, **Director at City-County Health District, Valley City**: Read by Robin Iszlaer. (See Testimony **#4**) This bill will help local public health of all types/sizes gain a better capacity to improve health in our communities.

Handed in testimony in support:

From several health unit directors in ND: (See Testimony **#5**)

Chairman Weisz closed the hearing on SB 2030.

2013 HOUSE STANDING COMMITTEE MINUTES

House Human Services Committee
Fort Union Room, State Capitol

SB 2030
March 27, 2013
Job #20558

☐ Conference Committee

Committee Clerk Signature Vicky Crabtree

Explanation or reason for introduction of bill/resolution:

Relating to region public health network definitions.

Minutes:

Chairman Weisz: Let's take up 2030. I will give you my opinion of the odds in appropriation which are zero. I support the regional public health network. We fought hard to get the pilot project back in 2009 and get some funding. I don't have with the language. The problem is the $4 million is not really in there for the purpose of implementing the regional health network.

Rep. Porter: I agree that the core activities and the policy language need to stay so I move we amend out Section 5 of the bill.

Chairman Weisz: Take out everything (inaudible) money for implementation or not?

Rep. Porter: It just removes the $4 million. The public health entities have their mil levies to work with to implement the policies that are there. The pilots we funded in the past, a lot of those software programs and billing stuff is available to them now. I think they are ready to go on their own.

Rep. Laning: Second.

Rep. Oversen: I resist this motion. Giving them the freedom to do something, but not backing it up, it is not going to go very far. The locals may have the ability to do that, but unless it is coming from statewide broad approach to allow them to work together, this is not going to accomplish anything.

Rep. Fehr: If some units are working toward creating a network. If they put together a plan couldn't they come back in 2 years and say this is money we have come up with and this is what we want to do, opposed to pulling the money out now?

Chairman Weisz: In the pilot project, the money, $275,000 was a carrot for you to develop a regional public health network. They did in Stutsman County and three other counties.

The money wasn't available for just funding their services. This bill is only funding public health services. I don't support the $4 million and I don't know what Appropriations will do. I don't have a problem giving them some money to give them some incentive to get the public health units to work together. They saved an equivalent of one FTE in the pilot project.

Rep. Mooney: Isn't there a limitation in statute to just how many mils can be levied for the district health units? We can't just levy more. Correct?

Chairman Weisz: I believe that is correct. I think it is a 5 mil.

Rep. Porter: I would think one of the purposes of created a regional public health network is to group your resources together and save money. The mil levies out there should go down because of the efficiencies of the regional public health unit. The language in Section 5 is for the Dept. of Health to help establish, administer and operate regional public health networks in the state. We did the pilot projects to show that it works.

Rep. Silbernagel: We received testimony from Ruth Bachmeier from Fargo/Cass Public Health and they are involved in a 3 year grant funded by the Busch Foundation and it includes Cass, Ransom, Richland, Sargent, Steele and Trail Counties. This would be a second area to resource in addition to the project funded by the state.

Rep. Fehr: I'm going to support the motion. There were several comments in reference to modeling after the REAs and there are significant problems with the REAs. Taking the appropriation out eliminates the issues I have with it.

VOICE VOTE: MOTION CARRIED

Chairman Weisz: This one will be in conference at this point.

Rep. Fehr: I move a Do Pass as Amended.

Rep. Laning: Second.

Rep. Porter: We have the Health Dept. budget on our side right now. I think a conversation with Rep. Pollert would be in order in regards to that. That might take the need for a conference committee on this bill out and just pass policy and have them look at if they want implementation grants inside of that budget or not.

ROLL CALL VOTE: 10 y 3 no 0 absent

Bill Carrier: Rep. Porter

13.0034.03002
Title.04000

Adopted by the Human Services Committee

March 27, 2013

VR
3/27/13

PROPOSED AMENDMENTS TO SENATE BILL NO. 2030

Page 1, line 3, remove "; and to"

Page 1, line 4, remove "provide an appropriation"

Page 4, remove lines 30 and 31

Page 5, remove lines 1 through 3

Renumber accordingly

Date: 3-27-13
Roll Call Vote #: 1

2013 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. 2030

House Human Services Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☒ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By Rep. PORTER Seconded By Rep. Laning

Representatives	Yes	No	Representatives	Yes	No
CHAIRMAN WEISZ			REP. MOONEY		
VICE-CHAIRMAN HOFSTAD			REP. MUSCHA		
REP. ANDERSON			REP. OVERSEN		
REP. DAMSCHEN					
REP. FEHR					
REP. KIEFERT					
REP. LANING					
REP. LOOYSEN					
REP. PORTER					
REP. SILBERNAGEL					

Total (Yes) _____ No _____

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

amend out section 5 of the bill
remove the $4 million

Voice Vote
MOTION Carried

Date: 3-27-13
Roll Call Vote #: 2

2013 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. 2030

House Human Services Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☒ Do Pass ☐ Do Not Pass ☒ Amended ☐ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By Rep. Fehr Seconded By Rep. Laning

Representatives	Yes	No	Representatives	Yes	No
CHAIRMAN WEISZ	✓		REP. MOONEY		✓
VICE-CHAIRMAN HOFSTAD	✓		REP. MUSCHA		✓
REP. ANDERSON	✓		REP. OVERSEN		✓
REP. DAMSCHEN	✓				
REP. FEHR	✓				
REP. KIEFERT	✓				
REP. LANING	✓				
REP. LOOYSEN	✓				
REP. PORTER	✓				
REP. SILBERNAGEL	✓				

Total (Yes) 10 No 3

Absent 0

Floor Assignment Rep. Porter

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

SB 2030: Human Services Committee (Rep. Weisz, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (10 YEAS, 3 NAYS, 0 ABSENT AND NOT VOTING). SB 2030 was placed on the Sixth order on the calendar.

Page 1, line 3, remove "; and to"

Page 1, line 4, remove "provide an appropriation"

Page 4, remove lines 30 and 31

Page 5, remove lines 1 through 3

Renumber accordingly

2013 CONFERENCE COMMITTEE

SB 2030

2013 SENATE STANDING COMMITTEE MINUTES

Senate Human Services Committee
Red River Room, State Capitol

SB 2030
4/10/13
21074

☒ Conference Committee

Committee Clerk Signature

Explanation or reason for introduction of bill/resolution:

Relating to regional public health network definitions, joint power agreement review, annual plan, and receipt and us of moneys; and to provide an appropriation.

Minutes:

Sen. J. Lee, Sen. Anderson, Sen. Dever are present.
Rep. Porter, Rep. Looysen, Rep. Oversen are present.

Senator J. Lee opens the conference committee for SB 2030

Senator J. lee asks for clarification on the amendments that were made to SB 2030.

Senator J. Lee discusses testimony in Senate Human Services committee hearings.

Keith Johnson is recognized administrator for Custer health which is a regional unit, shares with the committee the cost efficiencies and public health. **Mr. Johnson** also discusses the cost of providing services within the counties. **Senator J Lee**. Discusses how much work public health units are and funding the public health units. **Mr. Johnson** shares with the committee about environmental health needs, in addition to other needs of the regional health units. **Senator Anderson** discusses that the funding is not for additional services, and discusses the funding in SB 2030. **Senator J. Lee** shares that we are not looking at expanding services and offering the services in a timely matter.
Senator Dever discusses that this is optional, asks if the money in a onetime spending, and how was the amount determined. **Senator J. lee** asks how many regional PHU's would establish with the original bill. **Senator J. Lee** asks about the program in Jamestown.
Representative Overson asks for clarifications on units that are close to the 5 mill limit. .
Representative Porter asks what stops a county from using the general funds dollars. **Senator J Lee** discusses about not having the units restructure. **Reprehensive Porter** Inquires about revenue are generated from fees.

Senator J. Lee closes the conference committee.

2013 SENATE STANDING COMMITTEE MINUTES

Senate Human Services Committee
Red River Room, State Capitol

SB 2030
4/12/13
21129

☒ Conference Committee

Committee Clerk Signature

Explanation or reason for introduction of bill/resolution:

Relating to regional public health network definitions, joint power agreement review, annual plan, and receipt and us of moneys; and to provide an appropriation.

Minutes:

Sen. Dever , Sen. J lee is absent, , Sen. Anderson are present

Rep. Porte,r Rep. Looysen, Rep. Overson are present.

Sen. Dever opens the conference committee.

Sen. Dever discusses were the SB 2030 stands at the time of the conference Committee.

The Committee discusses that there is no new information at this time and will adjourn and reschedule.

Sen. Dever closes the Conference Committee SB 2030

2013 SENATE STANDING COMMITTEE MINUTES

Senate Human Services Committee
Red River Room, State Capitol

SB 2030
4/16/13
21180

☒ Conference Committee

Committee Clerk Signature

Explanation or reason for introduction of bill/resolution:

Relating to regional public health network definitions, joint power agreement review, annual plan, and receipt and us of moneys; and to provide an appropriation.

Minutes:

You may make reference to "attached testimony."

Sen. J. Lee opens the conference committee SB 2030

Sen. J. Lee discusses the information from Brenda Stallman, Director at Trail District Health Unit. Attachment #1

Rep. Porter discusses funding for health units.
Sen. J. Lee asks for clarification on how they would establish the region.

Sen. J. Lee discusses about adding more units and funding.

There is discussion about the units and funding.

Sen. Anderson discusses the information from Brenda Stallman

Keith Johnson from Custer Health is recognized, discusses the language of establishment of environmental heal services.

There is a discussion about funding for the project(s).

Rep. Oversen shares her concerns with the language of establishment.

There is discussion on adding Planning language.

Rep. Porter discusses proposed amendment .03004 #2.

Sen. J. Lee discusses funding and the tribal health units.

Sen. J lee discusses about moving forward with SB 2030

Sen. J. Lee closes the conference committee SB 2030

2013 SENATE STANDING COMMITTEE MINUTES

Senate Human Services Committee
Red River Room, State Capitol

SB 2030
4/17/13
21214

☒ Conference Committee

Committee Clerk Signature

Explanation or reason for introduction of bill/resolution:

Relating to regional public health network definitions, joint power agreement review, annual plan, and receipt and us of moneys; and to provide an appropriation.

Minutes:

Sen. J Lee, Sen. Dever, Sen. Anderson are present.
Rep. Porter, Rep. Looysen, Rep. Oversen are present.

Sen. J. Lee opens the conference committee for SB 2030

There is a discussion on the funding for SB 2030.

Rep. Porter asks about the tribal component amendment.

There is a discussion about the tribal health amendment.

Sen. J. Lee talks about the funding and public health units and the services they provide.

Rep. Oversen states that she is favor of the raising the funding to 1 million.

Sen. J Lee closes the conference committee for SB 2030

2013 SENATE STANDING COMMITTEE MINUTES

Senate Human Services Committee
Red River Room, State Capitol

SB 2030
4/18/13
21278

☒ Conference Committee

Committee Clerk Signature

Explanation or reason for introduction of bill/resolution:

Relating to regional public health network definitions, joint power agreement review, annual plan, and receipt and us of moneys; and to provide an appropriation.

Minutes:

Sen. J. Lee, Sen. Dever, Sen. Anderson are present.
Rep. Weiz (sitting in for Rep. Porter) Rep. Looysen, Rep. Oversen are present.

Sen. J. Lee opens the conference committee SB 2030

Sen. J. Lee discusses were the committee left off.

There is a discussion on the funding within SB 2030.

There is a discussion on the program in Jamestown, ND.

Sen. J. Lee closes the conference committee SB 2030.

2013 SENATE STANDING COMMITTEE MINUTES

Senate Human Services Committee
Red River Room, State Capitol

SB 2030
4/19/13
21338

☒ Conference Committee

Committee Clerk Signature

Explanation or reason for introduction of bill/resolution:

Relating to regional public health network definitions, joint power agreement review, annual plan, and receipt and us of moneys; and to provide an appropriation.

Minutes:

You may make reference to "attached testimony."

Sen. J. Lee , Sen. Dever, Sen. Anderson are present
Rep. Porter, Rep. Looysen, Rep. Oversen are present

Sen. J. Lee opens the conference committee for SB 2030

Rep. Porter explains amendments .03005

There is a discussion on the amendment(s).

Rep. Porter motions for the House to recede from House amendments and amend as follows

Rep. Looysen seconds

6 yes
0 no
0 absent

Motion passes.

Sen. J lee closes the conference committee for SB 2030

13.0034.05000

FISCAL NOTE
Requested by Legislative Council
04/22/2013

Amendment to: SB 2030

1 A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2011-2013 Biennium		2013-2015 Biennium		2015-2017 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues						
Expenditures			$700,000			
Appropriations			$700,000			

1 B. **County, city, school district and township fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

	2011-2013 Biennium	2013-2015 Biennium	2015-2017 Biennium
Counties			
Cities			
School Districts			
Townships			

2 A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

The Bill defines regional public health networks, sets guidelines for joint powers agreements, and creates tribal public health units. The amendment includes grant funding to regional public health networks to include tribal public health units.

B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

Section 13 of the Bill includes an appropriation to the Department of Health for grants to regional public health networks to include tribal public health units. The Bill does not have a fiscal impact on the Department of Health nor on the Local Public Health Units regarding the administration of the regional public health networks as FTE positions exist to provide for the administration of the grants.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*

A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

The bill provides $700,000 in the grants line item for the planning or establishment of regional networks, which include tribal public health units.

C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation is also included in the executive budget or relates to a continuing appropriation.*

No appropriation is needed as funding is included within this bill.

Name: Brenda M. Weisz

Agency: Department of Health

Telephone: 328-4542

Date Prepared: 04/23/2013

FISCAL NOTE
Requested by Legislative Council
03/27/2013

Amendment to: SB 2030

1 A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2011-2013 Biennium		2013-2015 Biennium		2015-2017 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues						
Expenditures						
Appropriations						

1 B. **County, city, school district and township fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

	2011-2013 Biennium	2013-2015 Biennium	2015-2017 Biennium
Counties			
Cities			
School Districts			
Townships			

2 A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

The Bill defines regional public health networks and sets guidelines for joint powers agreements. The amendment removes proposed grant funding to regional public health networks.

B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

The Bill does not have a fiscal impact on the Department of Health nor on the Local Public Health Units as the Bill establishes definitions and guidelines for regional public health networks. The Bill provides permissive language and guidance for regional networks, not a mandatory requirement to establish such networks.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*

A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation is also included in the executive budget or relates to a continuing appropriation.*

Name: Brenda M. Weisz
Agency: Department of Health
Telephone: 328-4542
Date Prepared: 03/28/2013

13.0034.03006
Title.05000

Adopted by the Conference Committee

April 19, 2013

VR
4/20/13
1 of 6

PROPOSED AMENDMENTS TO SENATE BILL NO. 2030

That the House recede from its amendments as printed on page 939 of the Senate Journal and page 1086 of the House Journal and that Senate Bill No. 2030 be amended as follows:

Page 1, line 1, after "Act" insert "to create and enact a new section to chapter 23-35 of the North Dakota Century Code, relating to tribal health districts;"

Page 1, line 1, after "reenact" insert "section 23-35-01, subsection 2 of section 23-35-03, subsection 1 of section 23-35-04,"

Page 1, line 1, after "sections" insert "23-35-06, 23-35-07, 23-35-08,"

Page 1, line 2, after "to" insert "health districts,"

Page 1, line 3, after the semicolon insert "to provide a report to the legislative management;"

Page 1, after line 5, insert:

"**SECTION 1. AMENDMENT.** Section 23-35-01 of the North Dakota Century Code is amended and reenacted as follows:

23-35-01. Definitions.

As used in this chapter, unless the context otherwise requires:

1. "Board of health" means a district, county, ~~or~~ city, or tribal board of health.
2. "Department" means the state department of health.
3. "Governing body" means, as applicable, a city commission, city council, board of county commissioners, ~~or~~ joint board of county commissioners, or tribal council.
4. "Health district" means an entity formed under section 23-35-04 or 23-35-05.
5. "Joint board of county commissioners" means the boards of county commissioners of two or more counties acting together in joint session.
6. "Local health officer" means the health officer of a public health unit.
7. "Public health department" means a city ~~or~~, county, or tribal health department formed under this chapter.
8. "Public health unit" means the local organization formed under this chapter to provide public health services in a city, county, or designated multicounty or city-county area, or Indian reservation. The term includes a city public health department, county public health department, tribal health department, and a health district.

SECTION 2. A new section to chapter 23-35 of the North Dakota Century Code is created and enacted as follows:

Tribal health units.

An Indian nation that occupies a reservation the external boundaries of which border more than four counties may form a health district or public health department as provided in this chapter. A tribal public health unit and bordering public health units shall collaborate regarding the provision of public health services. If an individual who is not an enrolled member of an Indian tribe of the Indian reservation that forms a tribal public health unit is a party to a civil action in which the tribal public health unit is also a party, that individual may bring the action in or move the action to tribal court or district court.

SECTION 3. AMENDMENT. Subsection 2 of section 23-35-03 of the North Dakota Century Code is amended and reenacted as follows:

2. A city's ~~or~~, county's, or tribe's governing body may establish a public health unit by creating and appointing a board of health, which in the case of a city, may be composed of the city's governing body, or in the case of a tribe, may be composed of the tribal council or governing body. A board of health must have at least five members.

   a. In the case of a board of health created by a joint board of county commissioners, each county in the health district must have at least one representative on the board; each county of over fifteen thousand population must have an additional representative for each fifteen thousand population or major fraction of that number; and in a health district of fewer than five counties, each county must have at least one representative on the district board of health, and the additional representatives selected to constitute the minimum five-member board must be equitably apportioned among the counties on a population basis.

   b. In the case of a joint city-county health district composed of only one county and having at least one city over fifteen thousand population, each city having a population over fifteen thousand must have a representative on the district board of health for each fifteen thousand population or major fraction of that number, and the remaining population of the county, exclusive of the populations of cities with more than fifteen thousand each, must have a representative on the district board of health for each fifteen thousand population or major fraction of that number, or at least one member if the remaining population is less than fifteen thousand.

SECTION 4. AMENDMENT. Subsection 1 of section 23-35-04 of the North Dakota Century Code is amended and reenacted as follows:

1. Upon the adoption of a resolution, the governing body may form a single county, multicounty, ~~or a~~ city-county, or tribal health district.

SECTION 5. AMENDMENT. Section 23-35-06 of the North Dakota Century Code is amended and reenacted as follows:

23-35-06. Health districts - Dissolution - Withdrawal.

1. ~~If~~Except for a tribal health district, if a health district has been in operation for two years, the district may be dissolved as provided for under this

section. If a petition is filed with the county auditor of each county of a health district which is signed by qualified electors of that county equal to ten percent or more of the votes cast in that county at the last general election, an election on the question of dissolution must be presented to the qualified electors in each county in the district at the next election held in each county in the district. If a majority of the votes cast on the question in a majority of the counties favor dissolution, the health district is dissolved on the second January first following the election. If a majority of the votes cast on the question in a majority of the counties are against dissolution, no other election on this issue may be held for two years.

2. If a health district has been in operation for two years, any county may withdraw from the district as provided under this section. If a petition is filed with the withdrawing county's auditor which is signed by qualified electors of the county equal to ten percent or more of the votes cast in that county at the last general election, an election on the question of withdrawal must be presented to the qualified electors in the county at the next election in the county. If a majority of the votes cast on the question favor withdrawing from the district, the county is withdrawn from the district on the second January first following the election. If a majority of the votes cast on the question are against withdrawal, no other election on this issue may be held for two years.

3. A tribal health district may be dissolved by the tribal council or governing body at any time.

SECTION 6. AMENDMENT. Section 23-35-07 of the North Dakota Century Code is amended and reenacted as follows:

23-35-07. Health district funds.

1. ~~A~~Except for a tribal health district, a district board of health shall prepare a budget for the next fiscal year at the time at which and in the manner in which a county budget is adopted and shall submit this budget to the joint board of county commissioners for approval. The amount budgeted and approved must be prorated in health districts composed of more than one county among the various counties in the health district according to the taxable valuation of the respective counties in the health district. For the purpose of this section, "prorated" means that each member county's contribution must be based on an equalized mill levy throughout the district, except as otherwise permitted under subsection 3 of section 23-35-05. Within ten days after approval by the joint board of county commissioners, the district board of health shall certify the budget to the respective county auditors and the budget must be included in the levies of the counties. The budget may not exceed the amount that can be raised by a levy of five mills on the taxable valuation, subject to public hearing in each county in the health district at least fifteen days before an action taken by the joint board of county commissioners. Action taken by the joint board of county commissioners must be based on the record, including comments received at the public hearing. A levy under this section is not subject to the limitation on the county tax levy for general and special county purposes. The amount derived by a levy under this section must be placed in the health district fund. The health district fund must be deposited with and disbursed by the treasurer of the district board of health. Each

county in a health district quarterly shall remit and make settlements with the treasurer. Any funds remaining in the fund at the end of any fiscal year may be carried over to the next fiscal year.

2. ~~The~~Except for a tribal health district, the district board of health, or the president and secretary of the board when authorized or delegated by the board, shall audit all claims against the health district fund. The treasurer shall pay all claims from the health district fund. The district board of health shall approve or ratify all claims at the board's quarterly meetings.

SECTION 7. AMENDMENT. Section 23-35-08 of the North Dakota Century Code is amended and reenacted as follows:

23-35-08. Boards of health - Powers and duties.

Except when in conflict with a local ordinance or a civil service rule within a board of health's jurisdiction, or a tribal code, ordinance, or policy, each board of health:

1. Shall keep records and make reports required by the department.

2. Shall prepare and submit a public health unit budget.

3. Shall audit, allow, and certify for payment expenses incurred by a board of health in carrying into effect this chapter.

4. May accept and receive any contribution offered to aid in the work of the board of health or public health unit.

5. May make rules regarding any nuisance, source of filth, and any cause of sickness which are necessary for public health and safety.

6. May establish by rule a schedule of reasonable fees that may be charged for services rendered. Services may not be withheld due to an inability to pay any fees established under this subsection. If a tribal board of health establishes fees for services rendered, the fees may not exceed the highest corresponding fee of any of the public health units that border the tribal public health unit.

7. May make rules in a health district or county public health department, as the case may be, and in the case of a city public health department may recommend to the city's governing body ordinances for the protection of public health and safety.

8. May adopt confinement, decontamination, and sanitary measures in compliance with chapter 23-07.6 which are necessary when an infectious or contagious disease exists.

9. May make and enforce an order in a local matter if an emergency exists.

10. May inquire into any nuisance, source of filth, or cause of sickness.

11. Except in the case of an emergency, may conduct a search or seize material located on private property to ascertain the condition of the

property as the condition relates to public health and safety as authorized by an administrative search warrant issued under chapter 29-29.1.

12. May abate or remove any nuisance, source of filth, or cause of sickness when necessary to protect the public health and safety.

13. May supervise any matter relating to preservation of life and health of individuals, including the supervision of any water supply and sewage system.

14. May isolate, kill, or remove any animal affected with a contagious or infectious disease if the animal poses a material risk to human health and safety.

15. Shall appoint a local health officer.

16. May employ any person necessary to effectuate board rules and this chapter.

17. If a public health unit is served by a part-time local health officer, the board of health may appoint an executive director. An executive director is subject to removal for cause by the board of health. The board of health may assign to the executive director the duties of the local health officer, and the executive director shall perform these duties under the direction of the local health officer.

18. May contract with any person to provide the services necessary to carry out the purposes of the board of health.

19. Shall designate the location of a local health officer's office and shall furnish the office with necessary equipment.

20. May provide for personnel the board of health considers necessary.

21. Shall set the salary of the local health officer, the executive director, and any assistant local health officer and shall set the compensation of any other public health unit personnel.

22. Shall pay for necessary travel of the local health officer, the local health officer's assistants, and other personnel in the manner and to the extent determined by the board."

Page 4, remove lines 30 and 31

Page 5, replace lines 1 through 3 with:

"SECTION 12. STATE DEPARTMENT OF HEALTH REPORTS TO THE LEGISLATIVE MANAGEMENT - TRIBAL PUBLIC HEALTH UNIT PILOT PROJECT. During the 2013-14 interim, the state department of health shall report semiannually to the legislative management on the status of the tribal public health unit pilot project, including services provided, resources available, expenditures, and the future sustainability of the pilot project.

SECTION 13. APPROPRIATION. There is appropriated out of any moneys in the general fund in the state treasury, not otherwise appropriated, the sum of $700,000, or

so much of the sum as may be necessary, to the state department of health for the purposes of planning or establishing, or both, a regional public health network, for the biennium beginning July 1, 2013, and ending June 30, 2015. The department may not spend more than $250,000 for each regional public health network."

Renumber accordingly

Date_____

Roll Call Vote #_____

2013 SENATE CONFERENCE COMMITTEE
ROLL CALL VOTES

BILL/RESOLUTION NO. 2030 as (re) engrossed

Senate Human Services Committee

Action Taken

- ☐ SENATE accede to House Amendments
- ☐ SENATE accede to House Amendments and further amend
- ☐ HOUSE recede from House amendments
- ☐ HOUSE recede from House amendments and amend as follows
- ☐ **Unable to agree**, recommends that the committee be discharged and a new committee be appointed

Motion Made by: _____ Seconded by: _____

Senators	4/10	4/12	4/16	Yes	No	Representatives	4/10	4/12	4/16	Yes	No
Sen. J. Lee	✓		✓			Rep. Porter	✓	✓	✓		
Sen. Anderson	✓	✓	✓			Rep. Looysen	✓	✓	✓		
Sen. Dever	✓	✓	✓			Rep. Oversen	✓	✓	✓		
Total Senate Vote						Total Rep. Vote					

Vote Count Yes: _____ No: _____ Absent: _____

Senate Carrier _____ House Carrier _____

LC Number _____ . _____ of amendment

LC Number _____ . _____ of engrossment

Date 4-19-13

Roll Call Vote # 1

2013 SENATE CONFERENCE COMMITTEE
ROLL CALL VOTES

BILL/RESOLUTION NO. 2030 as (re) engrossed

Senate Human Services Committee

Action Taken

- ☐ SENATE accede to House Amendments
- ☐ SENATE accede to House Amendments and further amend
- ☐ HOUSE recede from House amendments
- ☒ HOUSE recede from House amendments and amend as follows
- ☐ **Unable to agree**, recommends that the committee be discharged and a new committee be appointed

Motion Made by: Rep Porter Seconded by: Rep Looysen

Senators	4/17	4/18	4/19	Yes	No	Representatives	4/17	4/18	4/19	Yes	No
Sen. J. Lee	✓	✓	✓	X		Rep. Porter	✓	✓	✓	X	
Sen. Anderson	✓	✓	✓	X		Rep. Looysen	✓	✓	✓	X	
Sen. Dever	✓	✓	✓	X		Rep. Oversen	✓	✓	✓	X	
						Rep. Weisz		✓			
Total Senate Vote				3		Total Rep. Vote				3	

Vote Count Yes: 6 No: — Absent: —

Senate Carrier Sen J Lee House Carrier Rep Porter

LC Number 13.0034 . 03006 of amendment

LC Number _____ . _____ of engrossment

REPORT OF CONFERENCE COMMITTEE

SB 2030: Your conference committee (Sens. J. Lee, Anderson, Dever and Reps. Porter, Looysen, Oversen) recommends that the **HOUSE RECEDE** from the House amendments as printed on SJ page 939, adopt amendments as follows, and place SB 2030 on the Seventh order:

That the House recede from its amendments as printed on page 939 of the Senate Journal and page 1086 of the House Journal and that Senate Bill No. 2030 be amended as follows:

Page 1, line 1, after "Act" insert "to create and enact a new section to chapter 23-35 of the North Dakota Century Code, relating to tribal health districts;"

Page 1, line 1, after "reenact" insert "section 23-35-01, subsection 2 of section 23-35-03, subsection 1 of section 23-35-04,"

Page 1, line 1, after "sections" insert "23-35-06, 23-35-07, 23-35-08,"

Page 1, line 2, after "to" insert "health districts,"

Page 1, line 3, after the semicolon insert "to provide a report to the legislative management;"

Page 1, after line 5, insert:

"**SECTION 1. AMENDMENT.** Section 23-35-01 of the North Dakota Century Code is amended and reenacted as follows:

23-35-01. Definitions.

As used in this chapter, unless the context otherwise requires:

1. "Board of health" means a district, county, ~~or~~ city, or tribal board of health.
2. "Department" means the state department of health.
3. "Governing body" means, as applicable, a city commission, city council, board of county commissioners, ~~or~~ joint board of county commissioners, or tribal council.
4. "Health district" means an entity formed under section 23-35-04 or 23-35-05.
5. "Joint board of county commissioners" means the boards of county commissioners of two or more counties acting together in joint session.
6. "Local health officer" means the health officer of a public health unit.
7. "Public health department" means a city ~~or~~, county, or tribal health department formed under this chapter.
8. "Public health unit" means the local organization formed under this chapter to provide public health services in a city, county, or designated multicounty or city-county area, or Indian reservation. The term includes a city public health department, county public health department, tribal health department, and a health district.

SECTION 2. A new section to chapter 23-35 of the North Dakota Century Code is created and enacted as follows:

Tribal health units.

An Indian nation that occupies a reservation the external boundaries of which border more than four counties may form a health district or public health department as provided in this chapter. A tribal public health unit and bordering public health units shall collaborate regarding the provision of public health services. If an individual who is not an enrolled member of an Indian tribe of the Indian reservation that forms a tribal public health unit is a party to a civil action in which the tribal public health unit is also a party, that individual may bring the action in or move the action to tribal court or district court.

SECTION 3. AMENDMENT. Subsection 2 of section 23-35-03 of the North Dakota Century Code is amended and reenacted as follows:

2. A city's ~~or~~, county's, or tribe's governing body may establish a public health unit by creating and appointing a board of health, which in the case of a city, may be composed of the city's governing body, or in the case of a tribe, may be composed of the tribal council or governing body. A board of health must have at least five members.

   a. In the case of a board of health created by a joint board of county commissioners, each county in the health district must have at least one representative on the board; each county of over fifteen thousand population must have an additional representative for each fifteen thousand population or major fraction of that number; and in a health district of fewer than five counties, each county must have at least one representative on the district board of health, and the additional representatives selected to constitute the minimum five-member board must be equitably apportioned among the counties on a population basis.

   b. In the case of a joint city-county health district composed of only one county and having at least one city over fifteen thousand population, each city having a population over fifteen thousand must have a representative on the district board of health for each fifteen thousand population or major fraction of that number, and the remaining population of the county, exclusive of the populations of cities with more than fifteen thousand each, must have a representative on the district board of health for each fifteen thousand population or major fraction of that number, or at least one member if the remaining population is less than fifteen thousand.

SECTION 4. AMENDMENT. Subsection 1 of section 23-35-04 of the North Dakota Century Code is amended and reenacted as follows:

1. Upon the adoption of a resolution, the governing body may form a single county, multicounty, ~~or a~~ city-county, or tribal health district.

SECTION 5. AMENDMENT. Section 23-35-06 of the North Dakota Century Code is amended and reenacted as follows:

23-35-06. Health districts - Dissolution - Withdrawal.

1. ~~If~~Except for a tribal health district, if a health district has been in operation for two years, the district may be dissolved as provided for under this section. If a petition is filed with the county auditor of each county of a health district which is signed by qualified electors of that county equal to ten percent or more of the votes cast in that county at the last general election, an election on the question of dissolution must be presented to the qualified electors in each county in the district at the next election held in each county in the district. If a majority of the votes cast on the

question in a majority of the counties favor dissolution, the health district is dissolved on the second January first following the election. If a majority of the votes cast on the question in a majority of the counties are against dissolution, no other election on this issue may be held for two years.

2. If a health district has been in operation for two years, any county may withdraw from the district as provided under this section. If a petition is filed with the withdrawing county's auditor which is signed by qualified electors of the county equal to ten percent or more of the votes cast in that county at the last general election, an election on the question of withdrawal must be presented to the qualified electors in the county at the next election in the county. If a majority of the votes cast on the question favor withdrawing from the district, the county is withdrawn from the district on the second January first following the election. If a majority of the votes cast on the question are against withdrawal, no other election on this issue may be held for two years.

3. A tribal health district may be dissolved by the tribal council or governing body at any time.

SECTION 6. AMENDMENT. Section 23-35-07 of the North Dakota Century Code is amended and reenacted as follows:

23-35-07. Health district funds.

1. ~~A~~Except for a tribal health district, a district board of health shall prepare a budget for the next fiscal year at the time at which and in the manner in which a county budget is adopted and shall submit this budget to the joint board of county commissioners for approval. The amount budgeted and approved must be prorated in health districts composed of more than one county among the various counties in the health district according to the taxable valuation of the respective counties in the health district. For the purpose of this section, "prorated" means that each member county's contribution must be based on an equalized mill levy throughout the district, except as otherwise permitted under subsection 3 of section 23-35-05. Within ten days after approval by the joint board of county commissioners, the district board of health shall certify the budget to the respective county auditors and the budget must be included in the levies of the counties. The budget may not exceed the amount that can be raised by a levy of five mills on the taxable valuation, subject to public hearing in each county in the health district at least fifteen days before an action taken by the joint board of county commissioners. Action taken by the joint board of county commissioners must be based on the record, including comments received at the public hearing. A levy under this section is not subject to the limitation on the county tax levy for general and special county purposes. The amount derived by a levy under this section must be placed in the health district fund. The health district fund must be deposited with and disbursed by the treasurer of the district board of health. Each county in a health district quarterly shall remit and make settlements with the treasurer. Any funds remaining in the fund at the end of any fiscal year may be carried over to the next fiscal year.

2. ~~The~~Except for a tribal health district, the district board of health, or the president and secretary of the board when authorized or delegated by the board, shall audit all claims against the health district fund. The treasurer shall pay all claims from the health district fund. The district board of health shall approve or ratify all claims at the board's quarterly meetings.

SECTION 7. AMENDMENT. Section 23-35-08 of the North Dakota Century Code is amended and reenacted as follows:

23-35-08. Boards of health - Powers and duties.

Except when in conflict with a local ordinance or a civil service rule within a board of health's jurisdiction, or a tribal code, ordinance, or policy, each board of health:

1. Shall keep records and make reports required by the department.
2. Shall prepare and submit a public health unit budget.
3. Shall audit, allow, and certify for payment expenses incurred by a board of health in carrying into effect this chapter.
4. May accept and receive any contribution offered to aid in the work of the board of health or public health unit.
5. May make rules regarding any nuisance, source of filth, and any cause of sickness which are necessary for public health and safety.
6. May establish by rule a schedule of reasonable fees that may be charged for services rendered. Services may not be withheld due to an inability to pay any fees established under this subsection. If a tribal board of health establishes fees for services rendered, the fees may not exceed the highest corresponding fee of any of the public health units that border the tribal public health unit.
7. May make rules in a health district or county public health department, as the case may be, and in the case of a city public health department may recommend to the city's governing body ordinances for the protection of public health and safety.
8. May adopt confinement, decontamination, and sanitary measures in compliance with chapter 23-07.6 which are necessary when an infectious or contagious disease exists.
9. May make and enforce an order in a local matter if an emergency exists.
10. May inquire into any nuisance, source of filth, or cause of sickness.
11. Except in the case of an emergency, may conduct a search or seize material located on private property to ascertain the condition of the property as the condition relates to public health and safety as authorized by an administrative search warrant issued under chapter 29-29.1.
12. May abate or remove any nuisance, source of filth, or cause of sickness when necessary to protect the public health and safety.
13. May supervise any matter relating to preservation of life and health of individuals, including the supervision of any water supply and sewage system.
14. May isolate, kill, or remove any animal affected with a contagious or infectious disease if the animal poses a material risk to human health and safety.
15. Shall appoint a local health officer.

16. May employ any person necessary to effectuate board rules and this chapter.

17. If a public health unit is served by a part-time local health officer, the board of health may appoint an executive director. An executive director is subject to removal for cause by the board of health. The board of health may assign to the executive director the duties of the local health officer, and the executive director shall perform these duties under the direction of the local health officer.

18. May contract with any person to provide the services necessary to carry out the purposes of the board of health.

19. Shall designate the location of a local health officer's office and shall furnish the office with necessary equipment.

20. May provide for personnel the board of health considers necessary.

21. Shall set the salary of the local health officer, the executive director, and any assistant local health officer and shall set the compensation of any other public health unit personnel.

22. Shall pay for necessary travel of the local health officer, the local health officer's assistants, and other personnel in the manner and to the extent determined by the board."

Page 4, remove lines 30 and 31

Page 5, replace lines 1 through 3 with:

"**SECTION 12. STATE DEPARTMENT OF HEALTH REPORTS TO THE LEGISLATIVE MANAGEMENT - TRIBAL PUBLIC HEALTH UNIT PILOT PROJECT.** During the 2013-14 interim, the state department of health shall report semiannually to the legislative management on the status of the tribal public health unit pilot project, including services provided, resources available, expenditures, and the future sustainability of the pilot project.

SECTION 13. APPROPRIATION. There is appropriated out of any moneys in the general fund in the state treasury, not otherwise appropriated, the sum of $700,000, or so much of the sum as may be necessary, to the state department of health for the purposes of planning or establishing, or both, a regional public health network, for the biennium beginning July 1, 2013, and ending June 30, 2015. The department may not spend more than $250,000 for each regional public health network."

Renumber accordingly

SB 2030 was placed on the Seventh order of business on the calendar.

2013 TESTIMONY

SB 2030

Attachment #1

Madame Chair, members of the committee:

For the record, my name is Sheila Sandness and I am a Senior Fiscal Analyst for the Legislative Council. I am here to present information on Senate Bill No. 2030 relating to regional public health networks. I appear neither for nor against the bill, but just to provide information and answer any questions you may have.

Last session the 2011-13 executive recommendation for the State Department of Health in House Bill No. 1004 included $275,000 of one-time funding from the general fund to establish joint powers agreements to form another regional public health unit during the 2011-13 biennium. In addition, the executive recommendation included $2.4 million from the general fund for grants to local public health units. The 2011 Legislative Assembly increased funding from the general fund for grants to local public health units by $600,000 to provide a total of $3 million from the general fund, removed the one-time funding included in the executive budget to establish another regional public health network, and provided for a study of the regional public health unit pilot program that was conducted during the 2009-11 biennium.

Section 8 of 2011 House Bill No. 1004 directed a study which was to include an assessment of the regional public health network pilot project, including services provided, effects of the project on participating local public health units, efficiencies achieved in providing services, cost-savings to state and local governments, and possible improvements to the program. This study was assigned to the interim Health Services Committee.

The interim Health Services Committee received information regarding the pilot project summary, the effect on participating public health units, an evaluation of the pilot project, and proposed changes to the regional public health unit program.

The interim Health Services Committee recommends Senate Bill No. 2030 which continues the regional public health program, but amends Chapter 23-35.1 relating to regional public health networks. The bill removes the requirement that

participating local public health units share administrative functions, provides that any joint powers agreement include core activities rather than specific types of services, and includes outcome measures for the regional public health network program. The bill appropriates $4 million from the general fund to the State Department of Health to establish, administer, and operate regional public health networks in the state.

The Health Services Committee's findings and recommendation regarding regional public health networks can be found in the "Report of the North Dakota Legislative Management".

The executive recommendation for the State Department of Health does not provide for regional public health networks.

That concludes my testimony and I would be happy to answer any questions you may have.

Attachment #2

Testimony
Senate Human Services Committee
Senate Bill 2030
Tuesday, January 22, 2013
North Dakota Department of Health

Good morning, Chairperson Lee 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 amendments in SB 2030 relating to Regional Public Health Networks.

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 (1.5 FTE being a nurse), and an average annual 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. 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.

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 preparedness and 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 receive $50,000 a biennium to provide environmental health services within their region. For most of the lead health units, this amount of funding has not been adequate to cover the actual cost of travel and delivery of services throughout the region. Most are supplementing the costs of services through fees for licensing and inspecting facilities, contributions charged to other health units in the region, local government revenue, and state aid payments.

SB 2030 Amendments 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 amendments 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:

- The 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 that 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.
  - Resource availability.

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 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.

Another recommendation is to remove the requirement for the network to correspond to one of the Emergency Preparedness and Response (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 local public health unit jurisdiction.

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.

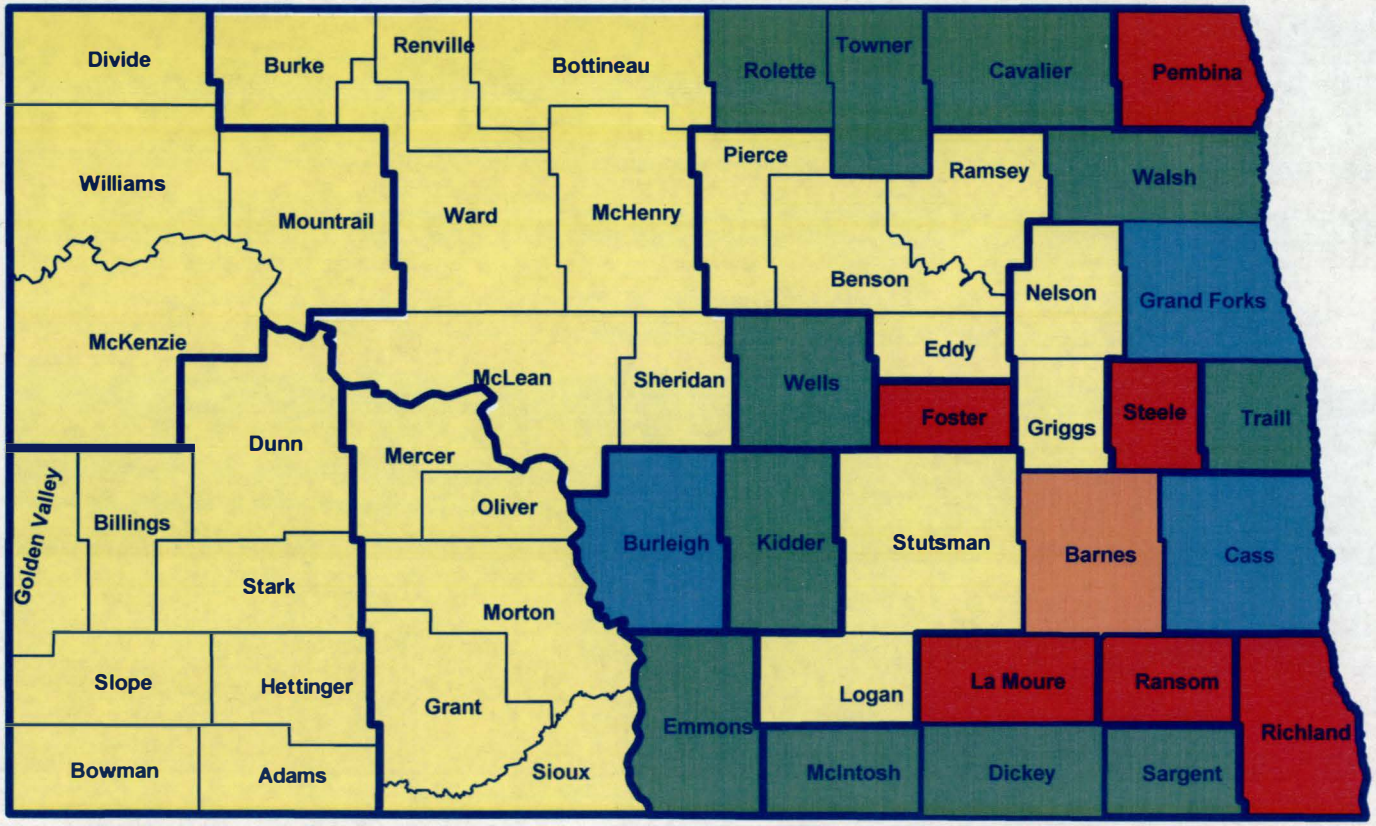
The Southeast collaborative project is specifically focused on improving capabilities and capacity to provide more consistent environmental health services throughout the region; effectively implementing and utilizing electronic health records for population-based services; and preparing for National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

Southeast collaborative 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 achieve. 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.

Local Public Health Units



April 2006

#2

Attachment #3

Human Services Committee
Senate Bill 2030
January 22, 2013
Ruth Bachmeier, Fargo Cass Public Health

Good Morning Chairperson Lee, and members of the committee. My name is Ruth Bachmeier, and I am the Director at Fargo Cass Public Health. I am here today to provide comment on the benefits of the regional public health network in the southeast corner of North Dakota. As Kelly mentioned, local public health units in the southeast area are involved in a 3 year grant funded by the Bush Foundation. This area includes the counties of Cass, Ransom, Richland, Sargent, Steel and Traill. We are all independent single county health units who have chosen to work together to address the public health needs of our communities.

I would like to share some highlights of the first year of our Collaborative and some lessons learned through this experience. First, we have chosen to formally call this group the Southeast North Dakota Public Health Collaborative. We intentionally did not use the word Regional or Regionalization in our new name as our individual health departments will remain independent entities in contrast to how public health is structured regionally in other parts of the state. As outlined in statute, we have developed a draft Joint Powers Agreement (JPA) that describes our collaborative and the work that is proposed. The current focus is on three areas; addressing environmental health capacity, transition to electronic health records, and preparation for National Public Health Accreditation.

I have learned many important lessons this past year through our work as a collaborative; the first is that collaboration at this level is hard work and time consuming. This is not to diminish what I truly believe will be great benefits for our collaborative in the long term, but rather to highlight the importance of funding for initiatives such as these. Our Collaborative has met every 2 weeks throughout the past year in order to keep in line with pre-established objectives.

Secondly, I have learned that local public health units are all different in their individual capabilities and yet we have common goals for our communities. By strategically planning for program development, capitalizing on available resources, and providing the evaluation and data to support our work, the entire collaborative, and most importantly the residents of our communities will benefit from improved core public health functions.

Lastly, I have learned that work of this nature does not happen quickly. We are fortunate to currently have the support of the Bush Foundation grant; however it is certainly my desire and the desire of the Southeast North Dakota Public Health Collaborative to continue our work to provide efficient and effective public health services to our communities well after the grant funding is exhausted. This important bill would provide financial resources to allow such work to continue.

This concludes my testimony. Thank you for your consideration of this important bill. I would be happy to answer any questions.

Attachment #4

Senate Bill 2030
Human Services Committee
January 22, 2013
Wanda Kratochvil, Walsh County Health District

Good morning, Senator Judy Lee and members of the Human Services Committee. I am Wanda Kratochvil, Administrator for Walsh County Health District in Grafton. I'm here today to support SB 2030 and to discuss the potential benefits of the regional public health network funding for Walsh County Health District. We are a small health unit, comprised of 4.5 FTE staff. (Our staff includes 2.5 RNs, 1 LPN, and 1 WIC Nutritionist). The population of Walsh County is just under 12,000, including 13 towns and 3 unincorporated communities.

As a small health unit, we recognize that we are not able to provide the same level of services that are available in the larger regional health units in our state; however there are core public health activities, such as environmental health services, that are essential to assure the safety and wellbeing of our county residents. With limited staffing we need to look at alternative ways to assure we have the capacity to serve our county residents. SB2030 provides a method for us to build infrastructure and develop that capacity without duplicating services and hiring positions that we cannot afford. Currently Walsh County Health District receives environmental health services as follows:

- State Health Department: Food, Lodging, Tanning beds, Tattoo Parlors
- Regional EHP Services from Grand Forks: Pool inspections, Nuisance, Mold, and Sanitation

The services from the regional EHP have been very helpful, but they have also identified a need for capacity building beyond what current funding is able to even consider. The regional public health network funding would assist us in at least meeting minimum environmental health services.

One other area that our health district struggles with is the need to put into place electronic health records (EHR). EHRs have the ability to streamline office procedures, assist with health data retrieval and transfer, and provide a system for more comprehensive services that can result in better client care. We would consider utilizing regional health networks to help us develop an EHR system for our agency. There is currently an informal network of public health agencies that exists for this very purpose. However, the health units are struggling with the enormity of putting such a system in place. Once we would have an EHR in place we could begin to address a comprehensive billing system and integration with other electronic medical systems within the state including NDIIS (the immunization registry).

Regional public health network funding is a good thing for small public health units. We could be more efficient, accomplish tasks beyond our current ability, and better serve our county residents. Thank you for hearing about potential uses for this funding.

Attachment #5

Testimony
To the
Senate Human Services Committee
On
SB 2030

Good morning Chairman Lee 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.

First District Health Unit has been challenged this past biennium with an unprecedented flood and population growth brought on by the oil development. Upper Missouri Health Unit and Southwest Health Unit are also addressing these challenges that First District Health Unit is faced with such as:

- public waste water and drinking water facilities nearing or exceeding capacity,
- increased number of private water inspections,
- rocketing demand for on-site septic systems,
- regulating the increased number of lodging and food facilities,
- recruiting and retaining a public health work force,
- substantial increase in sexually transmitted diseases.
- increased mental and emotional health issues

Senate Bill 2030 will provide the necessary resources to develop the expertise and capability needed to respond to our changing communities. Funds would be utilized to train sewer contractors, train and license the additional staff to address sewer applications, train developers on local codes and regulations, chaplaincy emotional health training, public education on sexually transmitted diseases, and a development of uniform regulation standards.

Thank you for your consideration of this important bill. I would be happy to answer any questions you may have.

Attachment #6

Regional Public Health Networks
Benefits to Local Health Departments
from ND Local Public Health Administrators
January 22, 2013

● *Brenda Stallman, Traill District Health Unit, Hillsboro*- To be fiscally responsible, a public health department cannot possibly provide every type of service as perceived as a need by each citizen. What a funded regional network could do is eliminate the silo effect of trying to address all requests for services by all citizens and allow us to work on bigger outcomes in population health that would provide a larger benefit for the investment. Every area of the state is short of environmental health workers. A regional approach would reduce administrative costs and allow for broader assessment and delivery of services. Training and response to environmental and other public health issues would be stream-lined. Assurance of service delivery does not always mean providing the service itself, but through a regional network, it may be easier and more cost effective to provide access through another department within a region.

● *Wanda Kratochvil, Walsh County Health District, Grafton* - Local public health units are very individualized in what types of services they are able to offer, many times focusing on areas of health care that are not provided by other health care agencies within their community. This makes each public health unit very unique in what they offer to the community. Regional networks for public health offer the ability to provide necessary services (environmental health, home visiting, etc.) in a coordinated manner thus saving money through the pooling of hard to recruit professionals. Networks have the potential of decreasing the duplication of efforts that may occur as we develop programs and set up policies and procedures.

- *Ruth Bachmeier, Fargo Cass Public Health, Fargo-* The desire of the Southeast North Dakota Public Health Collaborative is to provide efficient and effective public health services to our communities. SB 2030 is an important bill that would allow this type of collaborative work to continue.
- *Jeanne Chaput, Pembina County Public Health, Cavalier-* Regional health network services have proven to be beneficial to the state, the public health units and the people we serve. For the past seven years we have utilized a regional Environmental Health Inspector for nuisance/health hazard complaints, inspections, and general public safety consultations. These services have provided consistent enforcement of regulations for health standards and environmental concerns within the northeast region (Grand Forks, Walsh, Nelson, Griggs and Pembina counties). Regional Public Health Networks would make it possible to further strengthen this collaboration among neighboring counties.
- *Javayne Oyloe, Upper Missouri District Health Unit, Williston-* Regional Public Health Networks would provide an opportunity to strengthen capacity for public health accreditation, Environmental Health (including training, such as septic installer training by partnering with First District Health Unit) and public health nursing via shared nursing staff.
- *Karen Volk, Wells County District Health Unit, Harvey-* Having a lead agency to rely on has been very valuable when in need of expertise with building a new billing system, saving time and providing cleaner data. Karen recommends this to all single health departments as a way to upgrade computer systems & bring smaller agencies up to a more professional level.
- *Bev Voller, Emmons County Public Health, Linton-* In home nursing care is a very much needed nursing service in Emmons County due to the large amount of elderly living in their homes.

Frequently, we must travel to distant corners of the county for one in-home client consuming most of our time in travel. This client may be just a few miles from another public health dept., but not in their county. Through the regional network, an agreement to provide in-home nursing services to this client by another county public health dept. could be made, thus saving valuable time and mileage expenses.

● *Keith Johnson, Custer Health, Mandan*- Custer Health, a five county health unit based in Mandan, has several initiatives ready to go that would assist in meeting community needs when regional funding becomes available:

1. We supply EH services to rural Burleigh, Emmons and Kidder Counties. These programs are in their fundamental stages, stymied by limitations on time and funding. We need to get subdivision planning put in place around the lakes in Kidder, municipal nuisance ordinances in the small towns in every county, and regulations passed on sewage systems, swimming pools, and tattoo parlors in every jurisdiction.
2. School nursing is a service that we would market to the schools that want more nursing service. Immediate payback would be in the areas of decreased absenteeism, med administration for students, health curriculum development, and input on Individual Education Plans for students for whom health is a learning parameter.
3. Incorporation of our electronic records into the NDHIN system.

● *Robin Iszler, Central Valley Health District, Jamestown and Napoleon-* Central Valley and their partners accomplished many improvements to the local public health system in 2010 with funding from the previous regional network bill. During the pilot project many of the enhancements made to local health departments in the SE central region still remain in existence today proving that local agencies made good investments to improve PH servies. SB 2030 will allow CVHD and others to improve services and focus on community health needs that are specific to each individual area as our communities have identified health needs in our 2012 Community Health Assessment and Health Improvement Plans.

● *Barb Frydenlund, Rolette County Public Health District, Rolla-*

Each public health unit within ND delivers very unique services. The services delivered are often funding driven, meaning if funding is available for a specific program, then that program is implemented. The programs too often do not fully represent the needs of the community. This lack of programming is typically related to lack of available funding to local public health. The establishment of a Regional Network could allow for structured sharing of services/programming. Two examples of programming through a Regional Network that our residents could benefit from are environmental health services and family planning. Currently, we receive environmental health services from Lake Region Public Health through state aid funding allocated to Lake Region to provide environmental services to areas within the region not otherwise receiving environmental health services. This funding is limited to $25,000.00 per year. Rolette County could greatly benefit with increased environmental health services, so that we could enhance and have a proactive approach to environmental health issues. Currently due to very limited funding and staff time much of our environmental health

service is reactive. Family Planning services are a much needed and frequently requested by our county residents. To date we have been unable to acquire funding for family planning services and have been cited the reason as lack of funding and funding for family planning with in ND was allocated prior to the establishment of Rolette County Public Health in 2001. The concept of the Regional Network sharing could allow for Family Planning services to be provided in a high needs area. Each health district/unit is unique in the services provided and each county is unique in the area of health needs, services desired and in its culture. A regional health network for public health can provide services that can be shared thus increasing availability and decreasing fiscal overhead. Existing health districts/units must maintain autonomy, support/buy in from local residents, and the culture of the county must be preserved.

Testimony Senate Bill 2030

Thursday, January 31, 2013

Good Morning, Chairman Senator Ray Holmberg and members of the Senate Appropriations committee, my name is Robin Iszler, Administrator at Central Valley Health District. I am here today to tell you a little history and highlight the benefits of the SE Central Regional PH network pilot that was funded in 2009. At that time $275,000 was appropriated for a regional network pilot through SB 2333. On July 1, 2010, a contract was awarded from the State Health Department to Central Valley Health District and their partners: City County Health District– Valley City, Wells County District Health Unit– Fessenden and LaMoure County District Health Unit – LaMoure.

Some of the work that was completed as a group during the one year network include: Computer based time recording system (TIMS) for standardized employee time reporting, Computerized billing system (Ahlers) which allowed for scheduling, billing and data collection of services provided at the local public health offices, standardized policies and sharing of policies among the health departments, community health assessment which helped identify local needs, training to nurses on a chronic disease management, expanded family planning services to the smaller communities, and increasing environmental health services to the counties.

As a lead agency Central Valley Health District learned that we have an obligation to make sure that members of a smaller health department continue to have a voice in the decision-making process when entering a regional network. Some ways we shared authority was through clear communication like having an organizational chart and job description to clarify roles. For example – if you hire someone to work for a regional network – who do they report to, who can fire them or if a nurse from one agency is doing work in another

agency who does that nurse report to? In addition to the benefit of strengthened relationships among the health departments in the southeast central network pilot there were financial benefits (or "bang for the buck") as well. Specifically, our network pilot purchased an electronic billing system for the three health departments and added a clearinghouse feature that reduced clerical staff time by over 90%. The total cost to our network pilot for these components was $5,533, which is $147 less than what one neighboring health department paid in 2012 for the same system with comparable functionality.

The work that was completed by our network, has been shared with members of the Health Service Committee (chaired by Judy Lee) and detailed in a report by an external evaluator (copy of the final report is attached). The North Dakota Association of City and County Health Officials (SACCHO) (local public health administrators) selected a group of representative members to serve on a task force, as recommended by the interim committee, to develop recommendations for amendments to CC 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. These amendments are based on feedback from our regional network pilot, the interim committee and comments from the task force members.

SB 2030 includes an appropriation of 4 million dollars to assure that all of the population of North Dakota will be covered by regional networks. Additionally, it will allow for continued improvements to the local public health departments here in North Dakota by encouraging regional capacity building, increased efficiency and shared services (much like the educational REA's).

The previous regional network did provide improvements for Central Valley Health District and their partners. We operating today with many of the improvements realized through the regional network pilot. We are excited about new opportunities that may result from SB 2030. I hope you will support SB 2030. I would be happy to try to answer any questions you may have. Thank you.

Testimony – ND Senate Appropriations Committee
1/31/13
Theresa Will, RN, Director
City-County Health District-Valley City

Good morning, Chairman Holmberg and members of the Senate Appropriations Committee. My name is Theresa Will and I am the Director at City-County Health District (CCHD) in Valley City. Our agency provides public health services for the citizens of Barnes County. In 2009, we were fortunate to be a participant in the Southeast Central Regional Public Health Network Pilot and look forward to the prospect of continuing such work in the future.

The regional network pilot enabled us to make major progress in improving our billing practices and making in-office processes more efficient. By implementing a computerized system, we are able to bill for services electronically as well as generate service utilization statistics quickly and accurately, no longer using paper logs and paper receipts to gain this information. As a result, billing has become increasingly faster and more accurate. After the network project was completed we estimated that our billing efficiency savings alone, for the project period was over $6,000.

Throughout our network pilot project we shared policies, worked on various grant applications jointly and also gathered and compiled health-related data for our region (one of the first steps to prepare for public health accreditation). Recently, Barnes County partners gathered and completed our Community Health Assessment which was initiated by this pilot. Our focus areas for needed improvement (Community Health Improvement Plan) are:

1. Prevention of Chronic Disease
2. Violence Prevention which includes suicide prevention, neglect, abuse, etc.
3. Improving access for mental health services and substance abuse prevention

These are all HUGE issues that **have** and **will** require a great deal of on-going public health effort, working on policy and systems changes on the local level as well as at the state level. They are all issues that cannot be tackled alone; we will need to work with our surrounding public health partners if we hope to effect any change in these areas which our community has identified for improvement. All of these focus areas tie back to Key Public Health Activities that are supported by this bill: "Prevent injuries," "Promote and encourage healthy behaviors," and "Assure the quality and accessibility of health services."

Like any business in today's world, we need to "work smarter" as we provide services and be more efficient with the staff that we employ. By working more closely with our peers (via regional networks), we can continue to improve efficiencies at the local public health level. Overall, our regional network pilot provided an opportunity for our health departments to improve the way we serve our communities, achieve some standardization in services where possible and assist in preparation for public health accreditation.

As a small local public health unit, I realize that there are many efficiencies that can be gained by working collaboratively with other health units and I appreciate the opportunity that this legislation allows. I hope you will support SB 2030 because it will help public health gain a better capacity to improve health in our communities. Thank you for the opportunity to visit with you today. I would be happy to answer any questions you may have.

Final Evaluation Report: Southeast Central Regional Public Health Network Pilot Project

June 30, 2011

Mona P. Klose, MS, RN, CPHQ

Introduction

The Southeast Central Regional Network Pilot (SECRN) project was a collaborative between Central Valley Health District (CVHD)—the grant administrator, City-County Health District, LaMoure County Public Health Department and Wells County District Health Unit. A collaboration describes efforts of people or organizations working together to achieve a common goal that could not be done with individual efforts. (Strieter & Blalick, 2006) The collaborative formed to increase capabilities, create consistency and realize efficiencies with respect to administrative (capacity building) functions - billing, standard policies, community health assessment and public health accreditation; public health services - family planning, chronic disease management (CDM), sexual assault response team (SART) and immunizations. The functions selected for the project were chosen because participants determined they were capacity-building activities; services selected for the project were identified according to county health profile information in addition to being existing services that had potential to be expanded within the pilot area. For the purposes of this report, efficiencies are defined as steps or practices that generated new revenue and those which demonstrated time/cost savings (interchangeable) realized by identification of avoidable costs. The final evaluation report includes findings from all pilot agencies gathered utilizing personal interviews and online survey monkey which will be presented in general discussion, administrative function efficiencies, public health services, fiscal revenues, benefits and challenges, succession planning and implications for future regionalization of public health services.

General Discussion:

Funds for the regionalization project were received in July 2010, one year later than expected, with a completion date for the project of June 30, 2011. This 'fast track' time period of less than 2 years as planned for organization, relationship building, as well as implementation and training must be considered. Staff at the grant holding agency should be commended for their efforts to provide service to the 3 affiliating collaborative agencies over and above already existing duties. The affiliating agencies should also be commended for the addition to regular provision of services to implement this system. Evaluation data presented includes primarily qualitative data, as the short time period makes it extremely difficult to produce reliable quantitative data. The data presented in this report identify the following: where efficiencies were gained (+), where efficiencies were not gained (-) and where efficiencies may be gained by a change in approach (*) – please see categorization in the table on page 2, where N/A denotes not applicable.

Efficiency Type:	Function or Service:	Efficiency Gained (+)	Efficiency Not Gained (-)	Change in Approach Necessary (*)
Capacity Building	Time Information Management System (TIMS)	+ Time Savings	N/A	* Env Health IMS
Capacity Building	Single Client Chart	+ Time Savings	N/A	N/A
Capacity Building	Billing System (Ahlers)	+ Cost Savings	N/A	N/A
Capacity Building	Standardized Policies	+ Time Savings	N/A	N/A
Capacity Building	Community Health Assessment (CHA)	+ Cost Savings	N/A	N/A
Service Sharing	Family Planning	+ Cost Savings	-	* Gas Cards
Service Sharing	Chronic Disease Management	+ Time Savings	N/A	* Billable Service
Service Sharing	Sexual Assault Response Team (SART)	N/A	-	N/A
Service Sharing	Immunizations	N/A	-	N/A

Capacity (Administrative) Functions – Efficiency Detail:

- **Time Information Management System (TIMS)**: TIMS is a web-based time recording system that offers report functionality. It is particularly useful for payroll and fiscal purposes in that manual tabulation is minimized and hours by cost center (program) can be tracked in summary or detail formats. TIMS also useful for completing request for reimbursement reports where personnel and fringe costs are listed. Additionally, TIMS is used to track statistics such as number served when providing immunizations, number of participants receiving health education and county served for regional programs. As a web-based system, TIMS is accessible anywhere there is internet connectivity and requires virtually no annual maintenance. By utilizing TIMS as a time recording tool, end users involved in payroll and fiscal-related activities reduce time spent by about half compared to manual processes.

When TIMS is used for statistical purposes, such as for state aid reports identifying skilled nursing services, results are instantaneous. Although tracking time by county is possible with TIMS, more detail is needed with respect to the provision of Environmental Health Services so that counties readily know the status of work in their particular area. Central Valley Health District staff implemented an Excel-based tracking method previously used by Fargo-Cass public health to record such work, however an information management system with inspection documentation capability is needed to fully maximize provision of regional environmental health services.

The online survey of administrative support personnel (N=3) provided the following data:

- **Client Charts**: Client charts were condensed into one chart with uniform forms and tabs. 100% reported utilizing 1 chart per client for services and inactive charts are separated from active charts. Utilization of one client chart resulted in minimizing time spent (at least 1 minute per client = $3,218.00) checking several different places to obtain the desired client information and expedited the process of checking in for client visits/appointments. By utilizing the Ahlers system, clients are identified by a chart number, which also enhances confidentiality and HIPAA compliance.

- **Ahlers Billing System**:
  - 100% reported NOT utilizing the appointment scheduler.
    ** One respondent reported inadequate time to learn and use the system, no comments from the others.

  - 66.6% reported 100% of client demographic and insurance information is entered into the system, 33.3% reported 50% of their client demographics and 25% of their client insurance information is entered into the system.
    **Respondents reported this information is entered at the time of the encounter. Note one health department reported the volume of 3300 charts to update.

  - 33.3% reported services are entered into Ahlers at the time of the client encounter, 66.6% reported entering at a different time.

  - 100% reported nurses are NOT filling out the billing/charge sheet at the time of the client encounter

  - 33.3% reported front desk and billing staff enter the billing/charge sheet information completed by the nurse at the time of the client encounter, 66.6% reported no.
    Respondents reported nurses have difficulty remembering to fill out forms or are not filling them out timely, charge/billing slips are not being used at all, and slips are fill out when nurse returns from the field. **These findings indicate process issues among staff at the health departments which need to be corrected in order for full efficiency potential to be met.

- 66.6% reported entering client payments at the time of receipt and printing receipt for client from Ahlers, 33.3% do not.
  **Respondent reported entered at the time billing sheet is entered, and hand written receipts continue to be used. One respondent would like itemized receipts for their clients, however this is not possible with the Ahlers system.

- 100% reported utilizing Zirmed (claims clearinghouse) to process insurance claims – cost savings identified by using Ahlers and converting to Zirmed is approximately $12,208.00 (time spent reduced from 98.5 minutes to 6 minutes, or 16 times less).

- 66.6% are entering insurance payments into Ahlers at the time they are received, running monthly reconciliation reports for clients and insurance and using worksheets from CVHD for monthly reconciliation, 33.3% are not
  **one agency has not fully implemented---just beginning lack of time to commit and learning curve identified as problematic

- 33.3% reported using the procedure code report to identify service statistics, 66.6% are not.
- 33.3% reported using Ahlers reports to complete AAR chart audits, 66.6% are not
  ** The respondent utilizing Ahlers noted time savings from approximately 60 minutes to 5-10 minutes in the process, and hoping to also use it for program evaluations and to figure actual cost of services. Respondents not using the system to the fullest note lack of knowledge.

- 100% reported no longer using manual processes for statistical purposes; however they are not using Ahlers for mailings.
- 66.6% reported implementing the sliding fee scale and providing education to clients regarding it, 33.3% have not.

This data collected indicates a positive response for implementation of the Ahlers system with efficiencies gained. Additional time to fully learn and utilize the potential of the system is needed. Processes within agencies need to continue to be modified and reinforced to assist in the full use of the system. Overall, the implementation of the Ahlers billing system has reduced staff time resulting in cost savings. Additionally, the Ahlers system has provided a mechanism for participating health departments to track outstanding balances, payments, generate service-related statistics, and more accurately identify revenue.

Cost Savings, Revenue and Return on Investment:

The SECRN was successful in cost savings and efficiencies in several areas. The largest cost savings (70 %) was on the implementation of the Ahlers system as a network for the collaborative agencies. Proceeding in this manner saved roughly $15,000 in software costs versus implementing each agency as its own entity.

	Cost Per User	# of users	Reg cost	Rate per addl user	Network cost	Total savings
City-County	2400	3	**7200**	733.33	**2,200**	**5,000**
Wells	2400	2	**4800**	733.33	**1,467**	**3,333**
LaMoure	2400	2	**4800**	733.33	**1,467**	**3,333**
CVHD	2400	2	**4800**	733.33	**1,466**	**3,334**
			$21,600		**$6,600**	**$15,000**

Implementing the Ahlers billing system has made to it possible for these sites to function more like a business and in one particular case resulted in establishing a revenue stream of at least $10,000 per year. The billing system also provides the means to convey the value of public health services to clients. The pilot group partners are currently working on calculating an estimated Return on Investment (ROI) with respect to implementation of the Ahlers billing system.

- **Standardized Policies**: Over the twelve-month period policies and procedures utilized by all agencies were evaluated in an effort to develop a standard set that could be agreed upon and posted on Central Valley Health District's website. After careful evaluation, it was determined that because each health department had subtle variations due to medical director and services that standard policies and procedures would not be possible (except for environmental health where standardization was accomplished). Central Valley Health District staff posted the agency's policies and procedures on www.centralvalleyhealth.org (facilitating current and future updates). As a result, LaMoure County Public Health Department was able to become up-to-date on policies and procedures, which saved staff time and personnel expense. Individual websites were also created by Central Valley Health District staff for each health department where agency-specific policies are accessible. Staff at each health department was trained to facilitate in-house website updating, which saves consultant costs for web updates.

- **Community Health Assessment**: Community Health Assessment is the process of formally assessing and documenting the health status of a community. Community Health Assessments provide the ability to leverage community resources so they can do the most for you. A community health assessment document was completed for the SECRN and data was delineated by health department (county-level data distributed in summary form). Key data sources included the Behavioral Risk Factor Surveillance System (BRFSS) and the Youth Risk Behavior Survey (YRBS). The document was formatted in a way that will facilitate statistical updating in subsequent years when the CHA needs to be completed. From here, health departments can convene community partners to review the data, identify priorities and work toward creating a community health improvement plan (CHIP). Completion of a CHA is now a requirement of not-for-profit hospitals and for half of the health departments having a CHA document has strengthened the relationship between the health department and local hospital. CHA's and CHIP's are key aspects of sustainability due to the comprehensive (non-programmatic silo) approaches required for each component.

- **Public Health Accreditation:** Strong administrative policies and a Community Health Assessment are two key components in preparing for public health accreditation. SECRN health departments have engaged in both activities and Central Valley Health District staff has shared recommendations from the beta test site process completed in 2010.

Public Health Services – Efficiency Detail:

The members of the collaborative project all provide services to their constituents as identified by needs and federal programs in their jurisdiction. The four main services targeted for this project included chronic disease management, immunizations, family planning and sexual assault response team (SART).

Due to the fact that no formal comprehensive assessment of the regional communities were conducted prior to the establishment of the pilot group through the Joint Powers Agreement the services area was not able to meet full potential. The following depicts the progress:

- **Chronic Disease Management (CDM)**: City-County Health District and Central Valley Health District are completing the third year of a Health Resources and Services Administration (HRSA) – funded chronic disease management program (Tri-County Chronic Disease Management Program). This program is the only public health CDM program in North Dakota and CDM is an Evidence-Based Practice. Copies of all CDM program materials including protocols, educational materials (such as My Personal Health Journal) were shared. Training in the form of videos and concepts were provided. SECRN staff indicated the CDM training was beneficial and would like to expand the CDM program to each respective area. Currently, the HRSA funding cannot support additional counties. SECRN collaborative agencies are exploring partnering for the next application cycle of the HRSA grant as well as pursuing discussions to facilitate billing for CDM services.

- **SART**: Much information was gained with this collaboration. Services for SART are available in other regions for 2 of the 3 participating health units. Lamoure County has a resource in the Kedish house in Ellendale (neighboring Dickey County), and Wells County has services out of Devils Lake. Even with these other existing services, there are gaps that must be addressed. One agency is interested in services from Central Valley Health District and details are being investigated.

- **Family Planning**: The need has been assessed and is present, however SECRN participants determined it would not be cost effective for Central Valley Family Planning staff to travel and provide services in the outlying areas (substantiated by a survey to gage interest in outlying communities if services were offered onsite). Hours for CVHD Family Planning have been modified to include evening hours, which has proven to be successful. Five evening clinics were scheduled over a six-month time period and clients from the SECRN areas received services during two of the five evening clinics. Providing transportation assistance (gas cards) may be a way to increase provision of services to clients in outlying areas.

- **Immunizations:** No new activities have transpired in this area due to the collaborative project. All involved agencies had worked together in the past with sharing of vaccines if needed and assisted in clinics as needed. A comparison of vaccine serum was completed by Central Valley Health District staff and it was determined that there is consistency in vaccine serum costs among the SECRN health departments, so group purchasing is not warranted.

- **Environmental Health:** This area has expanded services in a wider area than the SECRN collaborative agencies (Wells, Foster, Barnes, Dickey, LaMoure, Logan, McIntosh, Stutsman). It is also self sustaining as each health department contributes a portion of funds to augment state aid dollars from the general fund allocation.

Expanding or sharing services is not feasible without further fiscal support. Efficiencies realized are not enough to sustain any increases. Current funds minimally cover cost of living and maintaining existing services where they are currently provided. The collaborative agencies continue to plan 'cooperative' events such as immunization clinics to share staff and assist. Discussions on 'sharing' an FTE for a designated service, such as school nursing, chronic disease management nurse etc., is occurring, however is not recommended as fragmentation could occur---problems arise on non scheduled days for the FTE in that area. Also, it is known that communities respond more positively with local personal providing services. Nutrition services may be an option for sharing an FTE due to the nature of the type of service provided.

Benefits/Challenges:

The participants in the SECRN grant project reported many benefits as well as challenges. General consensus overwhelmingly emphasizes the benefits gained.

- **Benefits:**

    - SECRN enabled agencies to improve business processes—billing and Ahlers Protocols
    - Uniform client charting and documentation
    - Nursing policy and procedure framework
    - Website for sharing and support
    - Improved tracking of expenses
    - Higher security for client information improving HIPAA compliance
    - Decrease time and increase efficiency for annual reports with more accurate data
    - Credible relationship building to aid in future collaborative projects
    - Improved standards of care—specifically Chronic Disease Management
    - Increased the professional level of staff as well as processes utilized
    - Availability of expertise and training
    - Trust between and among participating agencies
    - Established roadmap for the future (CHA/CHIP) to enhance sustainability

- **Challenges:**

    - Continue to learn and fully utilize Ahlers to the fullest potential
    - Time to manage and maintain website
    - Lack of adequate realized savings to move forward in increasing and/or sharing services
    - Consideration of "Regional Accreditation" for participating agencies
    - More specific tracking for Environmental Health needed over and above what TIMS offers

Succession Planning:

It is clear that although initial thoughts of hesitation existed with some employees, throughout the entire evaluation process participants fully supported the activities of the grant and worked hard to accomplish goals within the short one year time period. 100% of participants possess a desire to continue to work cooperatively and look into opportunities to do so as evidenced by the following statements reported in the survey:

- Be creative and continue to work with agencies who desire to partner or develop new areas if more conducive
- Partnering is the only way to ensure needed services at lower costs
- Build on established relationships where common trust of members is present
- Possibly utilize geographic regions or Emergency Preparedness regions as a model
- Reported areas of interest for future expansion of sharing services: Chronic Disease Management, Family Planning, Immunizations, and possibly tobacco. (note: due to short implementation time period, these areas were not able to be fully developed by the SECRN)
- Exploration of a 'shared' nutritionist for the region is necessary. Population need due to increasing obesity is the key driver. Potential funding may also be available to assist in supporting this FTE through various grant opportunities
- Funding needs to be considered in all cooperative activities, fiscal support is an incentive, details are needed to evaluate options that will benefit all. Any opportunity to save healthcare dollars and administrative costs is a way to provide improved and expanded services to the public.

Current cooperative endeavors being overseen by Central Valley Health District include:

- $2500 grant promoting of school based immunization: Barnes, LaMoure, Logan, Stutsman
- Applied for CDC study school flu clinics: Barnes, LaMoure, Logan Stutsman
- Plans to work together to apply for the HRSA Chronic Disease

Implications for future regionalization of public health services

The 'greatest good for the greatest number' is a well known phrase in the community and public health arena. This overarching concept must be kept in mind at all times when planning for the future of services. Core functions of public health services include assessment, policy development and assurance.

The Minnesota Department of Health http://www.health.state.mn.us/divs/cfh/ela/index.html has provided a well documented model to follow. The areas of essential public health responsibility identified include:

1. Assure an adequate local public health infrastructure.
2. Promote healthy communities and healthy behavior.
3. Prevent the spread of infectious disease.
4. Protect against environmental health hazards.
5. Prepare for and respond to disasters and assist communities in recovery.
6. Assure the quality and accessibility of health services.

Keeping these important areas of responsibility in mind, it is also imperative that planning must be done in a methodological fair manner. The Quality Improvement Department of Public Health in the county of Los Angles http://publichealth.lacounty.gov/qi/index.htm has documented useful method for priority-setting. The priority setting provides accountability at three levels:

- Focus resources on health issues that are of greatest importance to the community
- Must apply those resources to support interventions and strategies effective and acceptable to the community
- Must dedicate resources to evaluate work performed in order to demonstrate performance done well or improve if needed.

Conclusion

SECRN accomplished a huge task in a short one year time period and has demonstrated the ability to effectively share what works in public health. The short time-frame also inhibited participants in experiencing the full potential particularly with respect to the provision of services. Participants were engaged and worked together in a positive manner and desire to continue with this model. Continued fiscal support from local, state and federal entities with a focus on community health assessment and community health improvement planning is essential to most effectively and efficiently conduct public health programs and provide public health services.

Respectfully Submitted,

Mona P. Klose, RN, MS, CPHQ

Lisa Clute
SB 2030 #1
2-4-13

SB 2030 – REGIONAL PUBLIC HEALTH NETWORKS

- The $4 million request was originally based on $6.00 per capita (Investing in America's Health National Report)
- Funding is for formation of regional public health networks
  - bill defines a regional network as two LPHU's serving a population of 15,000 or 3 LPHU's
  - Networks are approved by State Health Officer
  - Intent of the bill is for linking core activities to community needs Community needs may include: environmental health, prevention (diabetes, obesity, mental health, suicide, cancer, chronic disease management, colorectal, breast cancer). Several LPHU's have completed community health assessments improvement plans and are working toward public health accreditation and this type of funding is pertinent.
  - Accountability is the workplan -- suggested committee to review workplans (3 State reps + 4 LPH reps determined by ND SACCHO by geography, size and diversity)
- Modeled after REA's, which are established networks

Sample allocation spreadsheet:

- Two components to funding (one is admin, one is services); REA model is structured according to administrative costs and services based on 15,000 population

ND Department of Health
Local Public Health ****SAMPLE****
(2010 Census)

		2010 Census	Base Allotment	Per Capita Amount	Total State Aid
NW	Divide	2,071			
	McKenzie	6,360			
	Mountrail	7,673			
	Williams	22,398			
SW	Adams	2,343			
	Billings	783			
	Bowman	3,151			
	Dunn	3,536			
	Golden Valley	1,680			
	Hettinger	2,477			
	Slope	727			
	Stark	24,199			
NW Central	Bottineau	6,429			
	Burke	1,968			
	McHenry	5,395			
	McLean	8,962			
	Renville	2,470			
	Sheridan	1,321			
	Ward	61,675			
	Total	165,618	$ 50,000	$ 911,084	$ 961,084
SE Central	Logan	1,990			
	Dickey	5,289			
	McIntosh	2,809			
	LaMoure	4,139			
	Barnes(City County)	11,066			
	Foster	3,343			
	Wells	4,207			
	Stutsman	21,100			
	Total	53,943	$ 50,000	$ 296,747	$ 346,747
SW Central	Grant	2,394			
	Mercer	8,424			
	Burleigh	81,308			
	Emmons	3,550			
	Kidder	2,435			
	Morton	27,471			
	Oliver	1,846			
	Sioux	4,153			
	Total	131,581	$ 50,000	$ 723,842	$ 773,842
NE Central	Benson	6,660			
	Eddy	2,385			
	Cavalier	3,993			
	Towner	2,246			
	Rolette	13,937			
	Pierce	4,357			
	Ramsey	11,451			
	Total	45,029	$ 50,000	$ 247,710	$ 297,710
NE	Nelson	3,126			
	Walsh	11,119			
	Grand Forks	66,861			
	Pembina	7,413			
	Griggs	2,420			
	Total	90,939	$ 50,000	$ 500,266	$ 550,266
SE	Fargo/Cass	149,778			
	Ransom	5,457			
	Richland	16,321			
	Sargent	3,829			
	Steele	1,975			
	Traill	8,121			
	Total	185,481	$ 50,000	$ 1,020,352	$ 1,070,352
Regional Health		**672,591**	**$ 300,000**	**$ 3,700,000**	**$ 4,000,000**

KEY Amounts	
Base Allotment	$50,000
Ttl Amt Distributed	$4,000,000

Total Available	$	4,000,000
Less Admin Portion	$	(300,000)
Balance to allocate per capita	$	3,700,000
Per capita amount	$	5.50

Keith Johnson
SB 2030
2-12-13
#1

Recommended Amendments to SB 2030 Regional Public Health Networks

- Remove strike, line 14-15, to include "verified as meeting the requirements of this chapter and chapter 54-40.3."
- Page 2, line 11, c. strike "comply with requirements adopted by the health council by rule.
- Page 2., #2, b. change "needs of the region" to needs of the Regional public health network".
- Add, line 16, 4., The joint powers agreement must
  a. Establish the number of members of the governing board
  b. Establish the manner in which members of the governing board are determined
  c. Require that each member of the governing board be an individual currently serving on the board of a participating public health unit or the designee of a participating public health unit's board
- Page 4, line 20, remove "Annual" from the title and line 21, remove "annual" to read, "prepare a plan regarding the provision..."
- **Add 23-35.1-06 Funding Distribution**

Funding appropriated for implementation of this chapter shall be distributed to the approved regional public health networks based on an approved work plan and budget. A base allotment for administration of each approved network may be provided. If the approved work plans and budgets exceed the amount available, a distribution formula may be used.

Add, Section 5 Appropriation, line 3, The State Health Department will distribute appropriated funds with input from a committee of 3 local public health representatives appointed by the North Dakota State Association of City and County Health Officials and 3 members appointed by the State Health Officer.

13.0034.03001
Title.

Prepared by the Legislative Council staff for
Senator Mathern
February 13, 2013

#1

PROPOSED AMENDMENTS TO SENATE BILL NO. 2030

Page 1, line 1, after "to" insert "create and enact section 23-35.1-06 of the North Dakota Century Code, relating to the distribution of funding to regional public health networks; to"

Page 1, line 14, remove the overstrike over "~~verified as meeting the requirements of this chapter~~"

Page 1, line 15, remove the overstrike over "~~and chapter 54-40.3~~"

Page 2, line 10, replace "region" with "regional public health network"

Page 2, line 11, remove "c."

Page 2, line 11, overstrike "Comply with requirements"

Page 2, line 11, remove "adopted by"

Page 2, line 11, overstrike "the health council"

Page 2, line 11, remove "adopts"

Page 2, line 11, overstrike "by rule;"

Page 2, line 12, remove the overstrike over "~~c.~~"

Page 2, line 12, remove "d."

Page 2, line 15, replace "e." with "d."

Page 4, line 17, after the period insert: "The joint powers agreement must:

a. Establish the number of members of the governing board;

b. Establish the manner in which members of the governing board are approved; and

c. Require that each member of the governing board be an individual currently serving on the board of a participating public health unit or the designee of a participating public health unit's board."

Page 4, line 20, overstrike "**Annual plan**" and insert immediately thereafter "**Plan**"

Page 4, line 21, overstrike "an annual" and insert immediately thereafter "a"

Page 4, after line 29, insert:

"**SECTION 5.** Section 23-35.1-06 of the North Dakota Century Code is created and enacted as follows:

23-35.1-06. Distribution of funding to regional public health networks.

For the purposes of this section, the state health officer shall seek input regarding the distribution of funding to approved regional public health networks from a committee made up of three local public health representatives appointed by the North

Dakota state association of city and county health officials and three representatives of the state department of health appointed by the state health officer. Funding appropriated for the implementation of this chapter must be distributed to an approved local public health network based on an approved work plan and budget. Base funding for administration of each approved network may be provided. If the total of approved regional public health network workplans and budgets exceed funding available, the committee may develop a distribution formula for allocating the funds available."

Renumber accordingly

STATEMENT OF PURPOSE OF AMENDMENT:

This amendment:

- Removes the requirement that local public health networks comply with requirements adopted by the Health Council;
- Identifies the requirements of the joint powers agreement relating to the structure of the governing body of a regional public health network; and
- Provides for the distribution of funding to regional public health networks.

#1

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 area) 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.

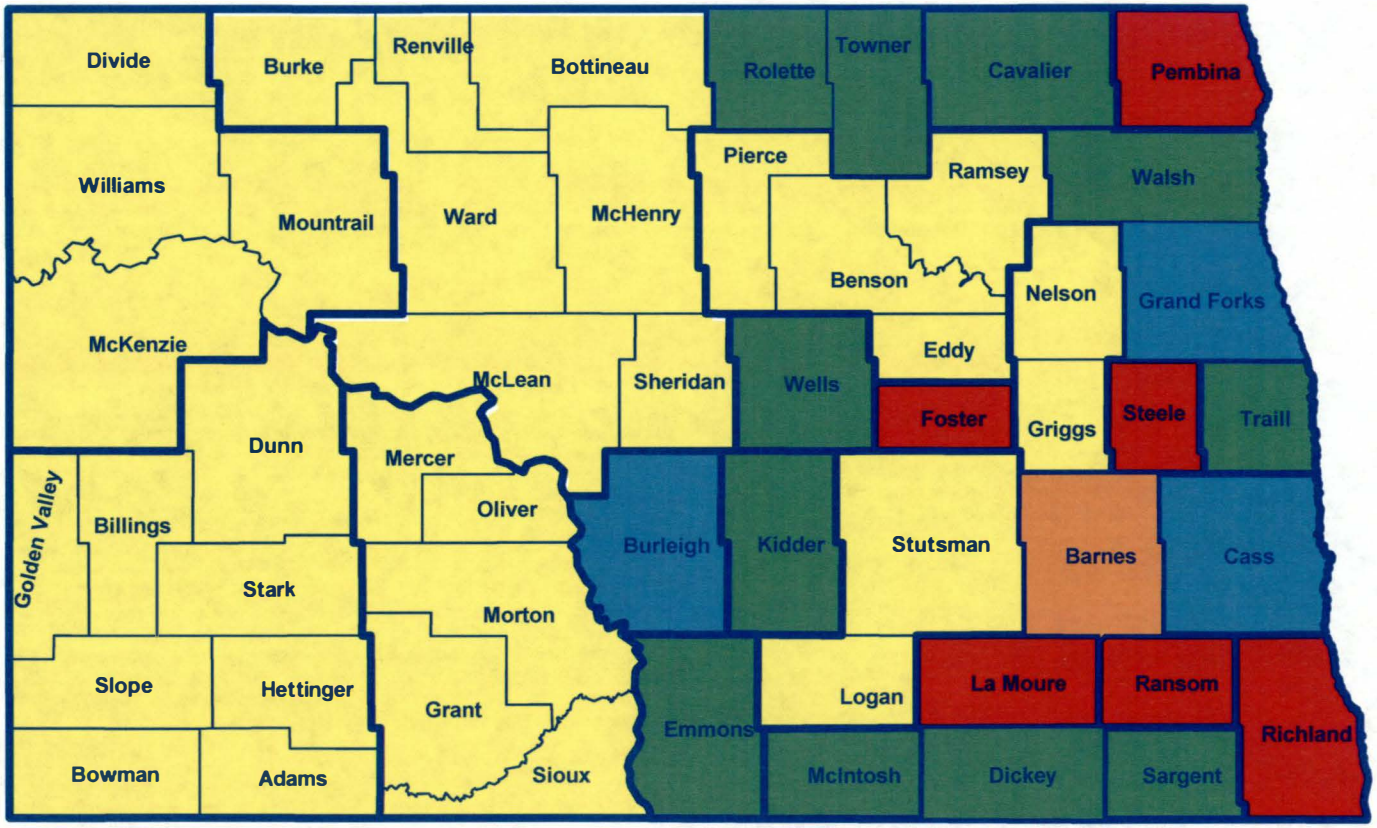
Southeast local public health region partners believe that shared capacity in environmental health will be sustained by the adoption of ordinances throughout the region which will result in a requirement for additional inspections and fee collections. Accreditation can be achieved and sustained by sharing 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.

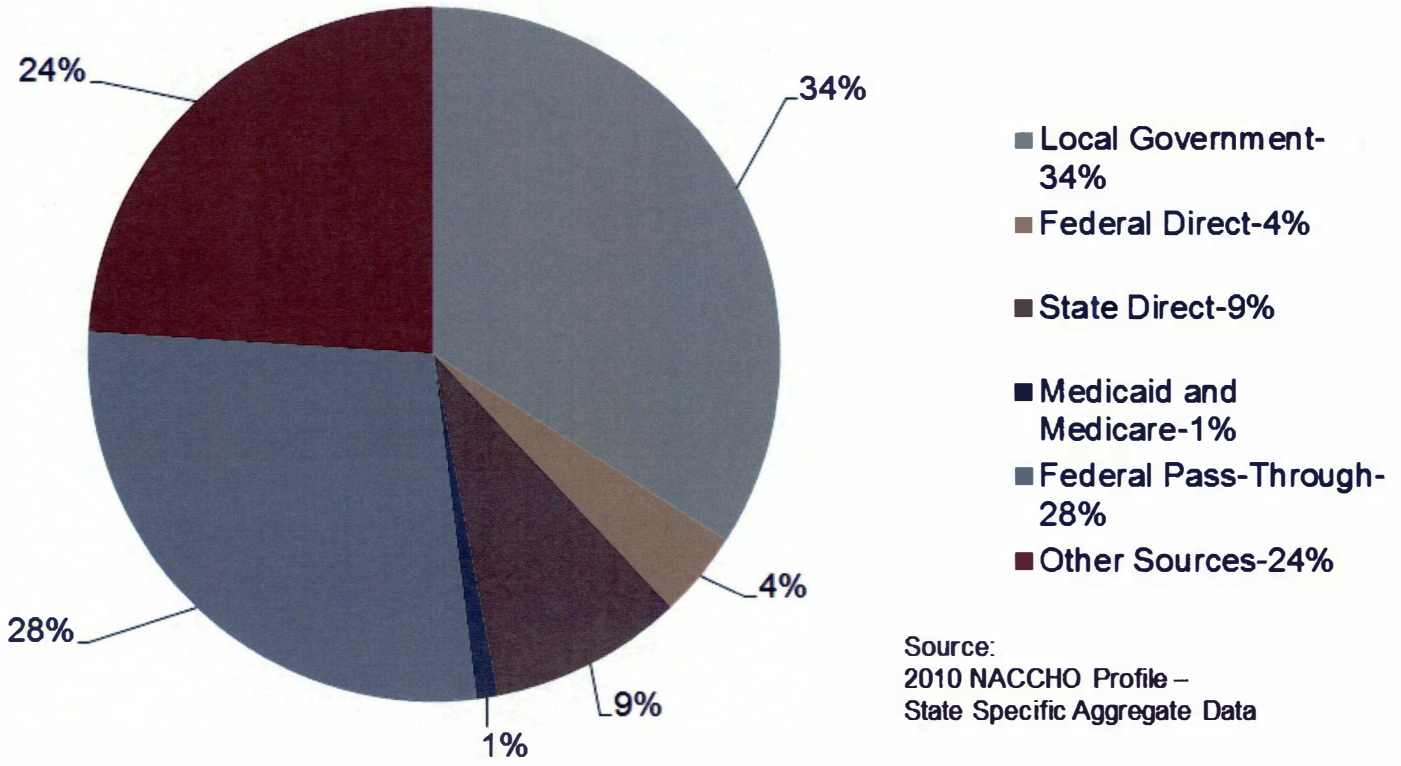
This concludes my testimony. I am happy to answer any questions you may have.

Local Public Health Units



April 2006

Percentage of Total Local Public Health Revenues from various sources



Source:
2010 NACCHO Profile –
State Specific Aggregate Data

#2

House Human Services Committee
Senate Bill 2030
March 18, 2013
Ruth Bachmeier, Fargo Cass Public Health

Good Morning Chairman Weisz, and members of the committee. My name is Ruth Bachmeier, and I am the Director at Fargo Cass Public Health. I am here today to provide comment on the benefits of the regional public health network in the southeast corner of North Dakota. As Kelly mentioned, local public health units in the southeast area are involved in a 3 year grant funded by the Bush Foundation. This area includes the counties of Cass, Ransom, Richland, Sargent, Steel and Traill. We are all independent single county health units who have chosen to work together to address the public health needs of our communities.

I would like to share some highlights of the first year of our Collaborative and some lessons learned through this experience. First, we have chosen to formally call this group the Southeast North Dakota Public Health Collaborative. We intentionally did not use the word Regional or Regionalization in our new name as our individual health departments will remain independent entities in contrast to how public health is structured regionally in other parts of the state. As outlined in statute, we have developed a draft Joint Powers Agreement (JPA) that describes our collaborative and the work that is proposed. The current focus is on three areas; addressing environmental health capacity, transition to electronic health records, and preparation for National Public Health Accreditation.

I have learned many important lessons this past year through our work as a collaborative; the first is that collaboration at this level is hard work and time consuming. This is not to diminish what I truly believe will be great benefits for our collaborative in the long term, but rather to highlight the importance of funding for initiatives such as these. Our Collaborative has met every 2 weeks throughout the past year in order to keep in line with pre-established objectives.

Secondly, I have learned that local public health units are all different in their individual capabilities and yet we have common goals for our communities. By strategically planning for program development, capitalizing on available resources, and providing the evaluation and data to support our work, the entire collaborative, and most importantly the residents of our communities will benefit from improved core public health functions.

Lastly, I have learned that work of this nature does not happen quickly. We are fortunate to currently have the support of the Bush Foundation grant; however it is certainly my desire and the desire of the Southeast North Dakota Public Health Collaborative to continue our work to provide efficient and effective public health services to our communities well after the grant funding is exhausted. This important bill would provide financial resources to allow such work to continue.

This concludes my testimony. Thank you for your consideration of this important bill. I would be happy to answer any questions.

#3

Public Health Networks Testimony

Senate Bill 2030

March 18, 2013

Good Morning, Chairman Weisz and members of the House Human Services Committee, my name is Robin Iszler, Administrator at Central Valley Health District. I am here today to tell you a little history and highlight accomplishments of the SE Central Regional PH network pilot project that was funded in 2009. At that time $275,000 was appropriated for a regional pilot project through SB 2333. On July 1, 2010, a contract was awarded from the State Health Department to Central Valley Health District and their partners: City County Health – Valley City, Wells County District Health – Fessenden and LaMoure County District Health Unit – LaMoure. The work that was completed by our Southeast Central pilot project was shared with members of the Health Service Committee (as detailed in an external evaluator report).

As you may know, some of the work that was completed as a group during our <u>one</u> year pilot project includes: Computer based time recording system (TIMS) for standardized employee time reporting, Computerized billing system (Ahlers) which allowed for scheduling, billing and data collection of services provided at the local public health offices, standardized policies and sharing of policies among the health departments, community health assessment which helped identify local needs, training to nurses on a

chronic disease management, expanded family planning services to the smaller communities, and increasing environmental health services to the counties.

During the pilot project, many of the improvements made to local health departments changed the way we do business and were sustained as they remain in place today. By working collaboratively as a network, in addition to strengthening our relationships as agencies, we saved $15,000 on the purchase of the billing system. As a result, three local public health units have the system for about the same money as it would cost one local public health unit to purchase it independently. These examples illustrate how the pilot enabled our local agencies to make good investments to improve the provision of public health services.

A report released by Trust for America's Health in July 2008 found that a small strategic investment in disease prevention could result in significant savings in health care costs. This report concluded that an investment of $10 per person per year in proven community based programs could save the country billions of dollars annually within five years. LPHUs in ND appreciate that you as legislators have devoted some funding to local public health state aid. As Kelly mentioned, the current local public health general state aid funding is $3,000,000 (biennial investment) calculates to about $4.4 per capita. The additional $4,000,000 in SB 2030 for regional public health networks would invest another $5.8 per capita. Together the state aid and regional public health network funding would provide the recommended $10 per person investment for public health programs and services. The proposed regional public health network funding amount of $4 million could potentially provide an opportunity to meet the minimum, finally achieve

consistency in public health services and most importantly put EHPs to work in communities that are not able to meet the community needs. As you are aware, these are exciting and challenging times in our state, with public health implications. Local public health units appreciate that legislators are receptive to this type of opportunity (modeled after the Regional Education Associations – REAs) as the timing is right for regional public health networks.

SB 2030 will allow for improvements to the local public health departments here in North Dakota by encouraging regional shared services. We are excited about new opportunities that will result from this bill. I hope you will support SB 2030 and I'm happy to try to answer any questions you may have. Thank you.

#4

Testimony – ND House Human Services Committee
3/18/13
Theresa Will, RN, Director
City-County Health District-Valley City

Good Morning, Chairman Weisz and members of the House Human Services Committee. My name is Theresa Will and I am the Director at City-County Health District (CCHD) in Valley City. Our agency provides public health services for the citizens of Barnes County. In 2009, we were fortunate to be a participant in the Southeast Central Regional Public Health Network Pilot and look forward to the prospect of continuing such work in the future.

The regional network pilot enabled us to make major progress in improving our billing practices and making in-office processes more efficient, in many ways changing the way we do business. By implementing a computerized system, we are able to bill for services electronically as well as generate service utilization statistics quickly and accurately, no longer using paper logs and paper receipts to gain this information. As a result, billing has become increasingly faster and more accurate. After the network project was completed we estimated that our billing efficiency savings alone, for the project period was over $6,000.

Throughout our network pilot project we shared policies, worked on various grant applications jointly and also gathered and compiled health-related data for our region (one of the first steps to prepare for public health accreditation). Recently, Barnes County partners gathered and completed our Community Health Assessment which was initiated by this pilot. Our focus areas for needed improvement (Community Health Improvement Plan) are:

1. Prevention of Chronic Disease
2. Violence Prevention which includes suicide prevention, neglect, abuse, etc.
3. Improving access for mental health services and substance abuse prevention

These are all HUGE issues that **have** and **will** require a great deal of on-going public health effort, working on policy and systems changes on the local level as well as at the state level. They are all issues that cannot be tackled alone; we will need to work with our surrounding public health partners if we hope to effect any change in these areas which our community has identified for improvement. All of these focus areas tie back to Key Public Health Activities that are supported by this bill: "Prevent injuries," "Promote and encourage healthy behaviors," and "Assure the quality and accessibility of health services."

Like any business in today's world, we need to "work smarter" as we provide services and be more efficient with the staff that we employ. By working more closely with our peers (via regional networks), we can continue to improve efficiencies at the local public health level. Overall, our regional network pilot provided an opportunity for our health units to improve the way we serve our communities, achieve some standardization in services where possible and assist in preparation for public health accreditation.

As a small local public health unit, I realize that there are many efficiencies that can be gained by working collaboratively with other health units and I appreciate the opportunity that this legislation allows. I hope you will support SB 2030 because it will help local public health of all types/sizes gain a better capacity to improve health in our communities. Thank you for the opportunity to visit with you today. I would be happy to answer any questions you may have.

Attached #5

Regional Public Health Networks
Benefits to Local Health Departments
from ND Local Public Health Administrators

● *Brenda Stallman, Traill District Health Unit, Hillsboro-* To be fiscally responsible, a public health department cannot possibly provide every type of service as perceived as a need by each citizen. What a funded regional network could do is eliminate the silo effect of trying to address all requests for services by all citizens and allow us to work on bigger outcomes in population health that would provide a larger benefit for the investment. Every area of the state is short of environmental health workers. A regional approach would reduce administrative costs and allow for broader assessment and delivery of services. Training and response to environmental and other public health issues would be stream-lined. Assurance of service delivery does not always mean providing the service itself, but through a regional network, it may be easier and more cost effective to provide access through another department within a region.

● *Wanda Kratochvil, Walsh County Health District, Grafton* - Local public health units are very individualized in what types of services they are able to offer, many times focusing on areas of health care that are not provided by other health care agencies within their community. This makes each public health unit very unique in what they offer to the community. Regional networks for public health offer the ability to provide necessary services (environmental health, home visiting, etc.) in a coordinated manner thus saving money through the pooling of hard to recruit professionals. Networks have the potential of decreasing the duplication of efforts that may occur as we develop programs and set up policies and procedures.

- *Ruth Bachmeier, Fargo Cass Public Health, Fargo*- The desire of the Southeast North Dakota Public Health Collaborative is to provide efficient and effective public health services to our communities. SB 2030 is an important bill that would allow this type of collaborative work to continue.
- *Jeanne Chaput, Pembina County Public Health, Cavalier*- Regional health network services have proven to be beneficial to the state, the public health units and the people we serve. For the past seven years we have utilized a regional Environmental Health Inspector for nuisance/health hazard complaints, inspections, and general public safety consultations. These services have provided consistent enforcement of regulations for health standards and environmental concerns within the northeast region (Grand Forks, Walsh, Nelson, Griggs and Pembina counties). Regional Public Health Networks would make it possible to further strengthen this collaboration among neighboring counties.
- *Javayne Oyloe, Upper Missouri District Health Unit, Williston*- Regional Public Health Networks would provide an opportunity to strengthen capacity for public health accreditation, Environmental Health (including training, such as septic installer training by partnering with First District Health Unit) and public health nursing via shared nursing staff.
- *Karen Volk, Wells County District Health Unit, Harvey*- Having a lead agency to rely on has been very valuable when in need of expertise with building a new billing system, saving time and providing cleaner data. Karen recommends this to all single health departments as a way to upgrade computer systems & bring smaller agencies up to a more professional level.
- *Bev Voller, Emmons County Public Health, Linton*- In home nursing care is a very much needed nursing service in Emmons County due to the large amount of elderly living in their homes.

Frequently, we must travel to distant corners of the county for one in-home client consuming most of our time in travel. This client may be just a few miles from another public health dept., but not in their county. Through the regional network, an agreement to provide in-home nursing services to this client by another county public health dept. could be made, thus saving valuable time and mileage expenses.

● *Keith Johnson, Custer Health, Mandan-* Custer Health, a five county health unit based in Mandan, has several initiatives ready to go that would assist in meeting community needs when regional funding becomes available:

1. We supply EH services to rural Burleigh, Emmons and Kidder Counties. These programs are in their fundamental stages, stymied by limitations on time and funding. We need to get subdivision planning put in place around the lakes in Kidder, municipal nuisance ordinances in the small towns in every county, and regulations passed on sewage systems, swimming pools, and tattoo parlors in every jurisdiction.
2. School nursing is a service that we would market to the schools that want more nursing service. Immediate payback would be in the areas of decreased absenteeism, med administration for students, health curriculum development, and input on Individual Education Plans for students for whom health is a learning parameter.
3. Incorporation of our electronic records into the NDHIN system.

● *Robin Iszler, Central Valley Health District, Jamestown and Napoleon-* Central Valley and their partners accomplished many improvements to the local public health system in 2010 with funding from the previous regional network bill. During the pilot project many of the enhancements made to local health departments in the SE central region still remain in existence today proving that local agencies made good investments to improve PH servies. SB 2030 will allow CVHD and others to improve services and focus on community health needs that are specific to each individual area as our communities have identified health needs in our 2012 Community Health Assessment and Health Improvement Plans.

● *Barb Frydenlund, Rolette County Public Health District, Rolla-*

Each public health unit within ND delivers very unique services. The services delivered are often funding driven, meaning if funding is available for a specific program, then that program is implemented. The programs too often do not fully represent the needs of the community. This lack of programming is typically related to lack of available funding to local public health. The establishment of a Regional Network could allow for structured sharing of services/programming. Two examples of programming through a Regional Network that our residents could benefit from are environmental health services and family planning. Currently, we receive environmental health services from Lake Region Public Health through state aid funding allocated to Lake Region to provide environmental services to areas within the region not otherwise receiving environmental health services. This funding is limited to $25,000.00 per year. Rolette County could greatly benefit with increased environmental health services, so that we could enhance and have a proactive approach to environmental health issues. Currently due to very limited funding and staff time much of our environmental health

service is reactive. Family Planning services are a much needed and frequently requested by our county residents. To date we have been unable to acquire funding for family planning services and have been cited the reason as lack of funding and funding for family planning with in ND was allocated prior to the establishment of Rolette County Public Health in 2001. The concept of the Regional Network sharing could allow for Family Planning services to be provided in a high needs area. Each health district/unit is unique in the services provided and each county is unique in the area of health needs, services desired and in its culture. A regional health network for public health can provide services that can be shared thus increasing availability and decreasing fiscal overhead. Existing health districts/units must maintain autonomy, support/buy in from local residents, and the culture of the county must be preserved.

2050 - (4)

Southeast ND Public Health Collaborative

I am Brenda Stallman, Director at Traill District Health Unit. I would like draw your attention to some progress gained through the collaborative effort of six independent single county health departments in the southeast corner of North Dakota. Public health departments from the counties of Cass, Ransom, Richland, Sargent, Steele and Traill have partnered together along with funding from a Bush Foundation grant to address the public health needs of our communities.

Our collaborative chose to address projects that would increase our efficiency and capacity as health departments. More specifically, we are working together on broadening environmental health capacity, preparing for accreditation, and implementing electronic health records. We are approaching the midpoint of a 3 year grant cycle.

We have learned some valuable lessons at this point. The first is that collaboration at this level is hard work and time consuming. This is not to diminish what will be significant benefits for our collaborative in the long term, but rather to highlight the importance of funding for initiatives such as these. Our collaborative has met every 2 weeks throughout the past year in order to keep in line with pre-established objectives.

Secondly, we have learned that local public health units are all different in their individual capabilities and yet we have common goals for our communities. By strategically planning for program development, capitalizing on available resources, and providing the evaluation and data to support our work, the entire collaborative, and most importantly the residents of our communities will benefit from improved core public health functions.

Lastly, we have learned that work of this nature does not happen quickly. We are fortunate to currently have the support of the Bush Foundation grant; however it is certainly the commitment of the Southeast North Dakota Public Health Collaborative to continue our work to provide efficient and effective public health services to our communities well after the grant funding is exhausted. This important bill would provide financial resources to allow such work to continue.

Activities accomplished thus far include securing a consultant to assist in gathering required documentation while formulating a time line to achieve accreditation. Through this process we are pleased to find that we can apply as a collaborative for accreditation; however each health department must still complete the preparation work individually. Secondly, we have devised a plan to implement the same electronic health record program simultaneously while achieving technical support that is impractical to garnish on an individual basis. We are currently in the process of building our environmental health capacity by identifying key ordinances in anticipation of working with our local jurisdictions for approval.

Again this work would not be possible without the accompanying money from the Bush Foundation. Our budget for year one was $80,740 that included purchase of necessary hardware, staff and travel time for Collaborative meetings, and Quality Improvement training.

For year 2, we have budgeted $130,000 for technical support for electronic health records and environmental health support; while maintaining our collaborative through meetings and education.

Our final year of this project will consist of ordinance work throughout our regions, summarization of our objectives and accomplishments, and identification of future goals. The total grant amount for our six counties in this 3 year collaborative project is $225,740.

I hope this is helpful to you for understanding the value of networking through a collaborative such as ours and realizing the critical nature of funding to make these projects successful.

2

13.0034.03004
Title.

Prepared by the Legislative Council staff for
Representative Weisz
April 12, 2013

PROPOSED AMENDMENTS TO SENATE BILL NO. 2030

That the House recede from its amendments as printed on page 939 of the Senate Journal and page 1086 of the House Journal and that Senate Bill No. 2030 be amended as follows:

Page 1, line 1, after "Act" insert "to create and enact a new section to chapter 23-35 of the North Dakota Century Code, relating to tribal health districts;"

Page 1, line 1, after "reenact" insert "section 23-35-01, subsection 2 of section 23-35-03, subsection 1 of section 23-35-04,"

Page 1, line 1, after "sections" insert "23-35-06, 23-35-07, 23-35-08,"

Page 1, line 2, after "to" insert "health districts,"

Page 1, line 4, replace "an appropriation" with "a report to the legislative management"

Page 1, after line 5, insert:

"**SECTION 1. AMENDMENT.** Section 23-35-01 of the North Dakota Century Code is amended and reenacted as follows:

23-35-01. Definitions.

As used in this chapter, unless the context otherwise requires:

1. "Board of health" means a district, county, ~~or~~ city, or tribal board of health.
2. "Department" means the state department of health.
3. "Governing body" means, as applicable, a city commission, city council, board of county commissioners, ~~or~~ joint board of county commissioners, or tribal council.
4. "Health district" means an entity formed under section 23-35-04 or 23-35-05.
5. "Joint board of county commissioners" means the boards of county commissioners of two or more counties acting together in joint session.
6. "Local health officer" means the health officer of a public health unit.
7. "Public health department" means a city ~~or~~ county, or tribal health department formed under this chapter.
8. "Public health unit" means the local organization formed under this chapter to provide public health services in a city, county, or designated multicounty or city-county area, or Indian reservation. The term includes a city public health department, county public health department, tribal health department, and a health district.

SECTION 2. A new section to chapter 23-35 of the North Dakota Century Code is created and enacted as follows:

Tribal health units.

An Indian nation that occupies a reservation the external boundaries of which border more than four counties may form a health district or public health department as provided in this chapter. A tribal public health unit and boarding public health units shall collaborate regarding the provision of public health services. If an individual who is not an enrolled member of an Indian tribe of the Indian reservation that forms a tribal public health unit is a party to a civil action in which the tribal public health unit is also a party, that individual my bring the action in or move the action to tribal court or district court.

SECTION 3. AMENDMENT. Subsection 2 of section 23-35-03 of the North Dakota Century Code is amended and reenacted as follows:

2. A city's ~~or~~, county's, or tribe's governing body may establish a public health unit by creating and appointing a board of health, which in the case of a city, may be composed of the city's governing body, or in the case of a tribe, may be composed of the tribal council or governing body. A board of health must have at least five members.

   a. In the case of a board of health created by a joint board of county commissioners, each county in the health district must have at least one representative on the board; each county of over fifteen thousand population must have an additional representative for each fifteen thousand population or major fraction of that number; and in a health district of fewer than five counties, each county must have at least one representative on the district board of health, and the additional representatives selected to constitute the minimum five-member board must be equitably apportioned among the counties on a population basis.

   b. In the case of a joint city-county health district composed of only one county and having at least one city over fifteen thousand population, each city having a population over fifteen thousand must have a representative on the district board of health for each fifteen thousand population or major fraction of that number, and the remaining population of the county, exclusive of the populations of cities with more than fifteen thousand each, must have a representative on the district board of health for each fifteen thousand population or major fraction of that number, or at least one member if the remaining population is less than fifteen thousand.

SECTION 4. AMENDMENT. Subsection 1 of section 23-35-04 of the North Dakota Century Code is amended and reenacted as follows:

1. Upon the adoption of a resolution, the governing body may form a single county, multicounty, ~~or a~~ city-county, or tribal health district.

SECTION 5. AMENDMENT. Section 23-35-06 of the North Dakota Century Code is amended and reenacted as follows:

23-35-06. Health districts - Dissolution - Withdrawal.

1. ~~If~~Except for a tribal health district, if a health district has been in operation for two years, the district may be dissolved as provided for under this

section. If a petition is filed with the county auditor of each county of a health district which is signed by qualified electors of that county equal to ten percent or more of the votes cast in that county at the last general election, an election on the question of dissolution must be presented to the qualified electors in each county in the district at the next election held in each county in the district. If a majority of the votes cast on the question in a majority of the counties favor dissolution, the health district is dissolved on the second January first following the election. If a majority of the votes cast on the question in a majority of the counties are against dissolution, no other election on this issue may be held for two years.

2. If a health district has been in operation for two years, any county may withdraw from the district as provided under this section. If a petition is filed with the withdrawing county's auditor which is signed by qualified electors of the county equal to ten percent or more of the votes cast in that county at the last general election, an election on the question of withdrawal must be presented to the qualified electors in the county at the next election in the county. If a majority of the votes cast on the question favor withdrawing from the district, the county is withdrawn from the district on the second January first following the election. If a majority of the votes cast on the question are against withdrawal, no other election on this issue may be held for two years.

3. A tribal health district may be dissolved by the tribal council or governing body at any time.

SECTION 6. AMENDMENT. Section 23-35-07 of the North Dakota Century Code is amended and reenacted as follows:

23-35-07. Health district funds.

1. ~~A~~Except for a tribal health district, a district board of health shall prepare a budget for the next fiscal year at the time at which and in the manner in which a county budget is adopted and shall submit this budget to the joint board of county commissioners for approval. The amount budgeted and approved must be prorated in health districts composed of more than one county among the various counties in the health district according to the taxable valuation of the respective counties in the health district. For the purpose of this section, "prorated" means that each member county's contribution must be based on an equalized mill levy throughout the district, except as otherwise permitted under subsection 3 of section 23-35-05. Within ten days after approval by the joint board of county commissioners, the district board of health shall certify the budget to the respective county auditors and the budget must be included in the levies of the counties. The budget may not exceed the amount that can be raised by a levy of five mills on the taxable valuation, subject to public hearing in each county in the health district at least fifteen days before an action taken by the joint board of county commissioners. Action taken by the joint board of county commissioners must be based on the record, including comments received at the public hearing. A levy under this section is not subject to the limitation on the county tax levy for general and special county purposes. The amount derived by a levy under this section must be placed in the health district fund. The health district fund must be deposited with and disbursed by the treasurer of the district board of health. Each

county in a health district quarterly shall remit and make settlements with the treasurer. Any funds remaining in the fund at the end of any fiscal year may be carried over to the next fiscal year.

2. ~~The~~Except for a tribal health district, the district board of health, or the president and secretary of the board when authorized or delegated by the board, shall audit all claims against the health district fund. The treasurer shall pay all claims from the health district fund. The district board of health shall approve or ratify all claims at the board's quarterly meetings.

SECTION 7. AMENDMENT. Section 23-35-08 of the North Dakota Century Code is amended and reenacted as follows:

23-35-08. Boards of health - Powers and duties.

Except when in conflict with a local ordinance or a civil service rule within a board of health's jurisdiction, or a tribal code, ordinance, or policy, each board of health:

1. Shall keep records and make reports required by the department.

2. Shall prepare and submit a public health unit budget.

3. Shall audit, allow, and certify for payment expenses incurred by a board of health in carrying into effect this chapter.

4. May accept and receive any contribution offered to aid in the work of the board of health or public health unit.

5. May make rules regarding any nuisance, source of filth, and any cause of sickness which are necessary for public health and safety.

6. May establish by rule a schedule of reasonable fees that may be charged for services rendered. Services may not be withheld due to an inability to pay any fees established under this subsection. If a tribal board of health establishes fees for services rendered, the fees may not exceed the highest corresponding fee of any of the public health units that border the tribal public health unit.

7. May make rules in a health district or county public health department, as the case may be, and in the case of a city public health department may recommend to the city's governing body ordinances for the protection of public health and safety.

8. May adopt confinement, decontamination, and sanitary measures in compliance with chapter 23-07.6 which are necessary when an infectious or contagious disease exists.

9. May make and enforce an order in a local matter if an emergency exists.

10. May inquire into any nuisance, source of filth, or cause of sickness.

11. Except in the case of an emergency, may conduct a search or seize material located on private property to ascertain the condition of the

property as the condition relates to public health and safety as authorized by an administrative search warrant issued under chapter 29-29.1.

12. May abate or remove any nuisance, source of filth, or cause of sickness when necessary to protect the public health and safety.

13. May supervise any matter relating to preservation of life and health of individuals, including the supervision of any water supply and sewage system.

14. May isolate, kill, or remove any animal affected with a contagious or infectious disease if the animal poses a material risk to human health and safety.

15. Shall appoint a local health officer.

16. May employ any person necessary to effectuate board rules and this chapter.

17. If a public health unit is served by a part-time local health officer, the board of health may appoint an executive director. An executive director is subject to removal for cause by the board of health. The board of health may assign to the executive director the duties of the local health officer, and the executive director shall perform these duties under the direction of the local health officer.

18. May contract with any person to provide the services necessary to carry out the purposes of the board of health.

19. Shall designate the location of a local health officer's office and shall furnish the office with necessary equipment.

20. May provide for personnel the board of health considers necessary.

21. Shall set the salary of the local health officer, the executive director, and any assistant local health officer and shall set the compensation of any other public health unit personnel.

22. Shall pay for necessary travel of the local health officer, the local health officer's assistants, and other personnel in the manner and to the extent determined by the board."

Page 4, remove lines 30 and 31

Page 5, replace lines 1 through 3 with:

"**SECTION 12. STATE DEPARTMENT OF HEALTH REPORTS TO LEGISLATIVE MANAGEMENT - TRIBAL PUBLIC HEALTH UNIT PILOT PROJECT.** During the 2013-14 interim, the state department of health shall report semiannually to the legislative management on the status of the tribal public health unit pilot project, including services provided, resources available, expenditures, and the future sustainability of the pilot project."

Renumber accordingly

Prepared by the Legislative Council staff for
Representative Porter
April 19, 2013

PROPOSED AMENDMENTS TO SENATE BILL NO. 2030

That the House recede from its amendments as printed on page 939 of the Senate Journal and page 1086 of the House Journal and that Senate Bill No. 2030 be amended as follows:

Page 4, line 31, replace "$4,000,000" with "$700,000"

Page 5, line 3, after the period insert "The department may not spend more than $250,000 for each regional public health unit."

Renumber accordingly