TESTIMONY OF ARNE SORENSON BEFORE THE NORTH DAKOTA LEGISLATIVE MANAGEMENT HEALTH SERVICES COMMITTEE, REGARDING THE FEASIBILITY AND DESIRABILITY OF PLACING THE ENTIRE FORT BERTHOLD RESERVATION IN A SINGLE PUBLIC HEALTH UNIT – GOVERNANCE MODEL.

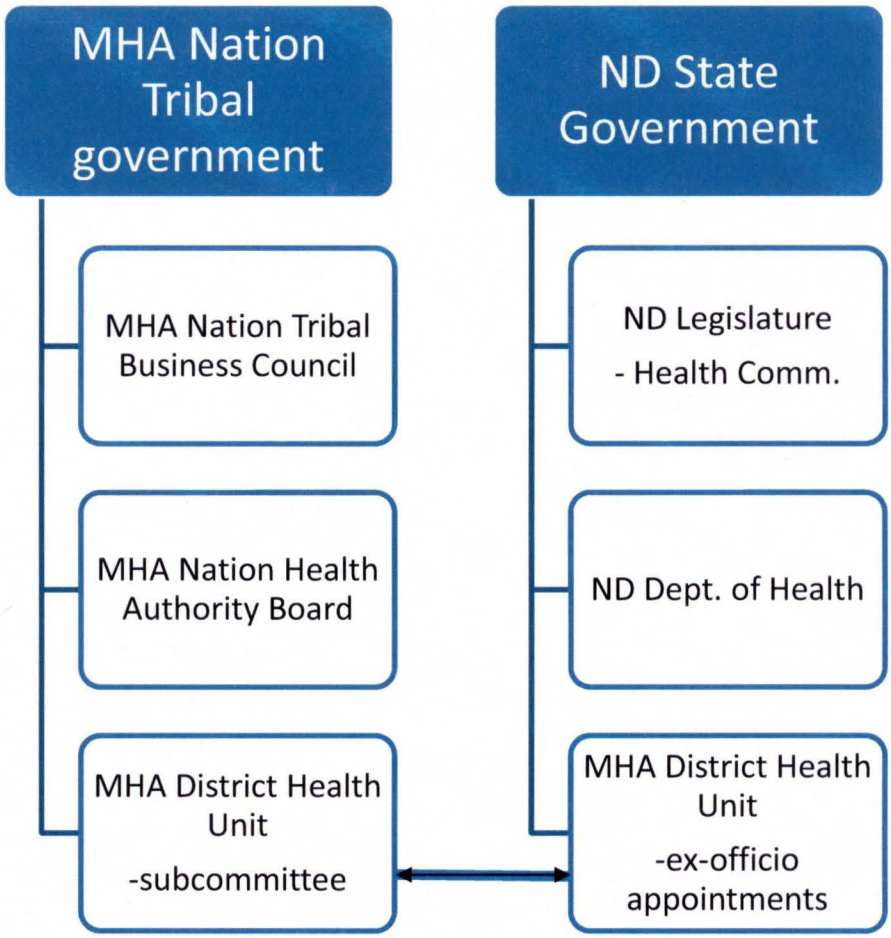
Thursday April 12, 2012, State Capital Building.

Good morning Chairman Lee and Members of the Committee, My name is Arne Sorenson. Thank you for inviting me back to present testimony on behalf of the MHA Nation. Our Chairman, Tex G. Hall, continues to support Concurrent Resolution 4012, because it called for a study to determine whether the health care needs of citizens who live and work on the Fort Berthold Reservation would be more efficiently served by designating the Reservation as a single Public Health Unit (PHU).

I am here today to further discuss a governance model that will allow this project to succeed in improving the public health status of all citizens of our Reservation. As you may recall, I previously discussed several organizational models for tribal public health delivery that were suggested by Allison, M. in the Journal of Public Health article entitled Future public health delivery models for Native American tribes[1]. The MHA Nation continues in its progress towards the suggested small tribe model discussed in this article primarily through the process of self determination in our PL 638 contracting process with the Indian Health Service. The MHA Nation Health Authority Board was created to address the governing body requirements for our health care systems. The board includes

[1] Allison M. et al. Future public health delivery models for Native American tribes. Public Health (2007), doi:10.1016/j.puhc.2006.11.005

representation from across healthcare disciplines. This board serves as the primary accounting and finance, auditing, legal, and personnel management authority for the present primary and public health care system for the MHA Nation. This board reports directly to the MHA Nation Tribal Business Council. The addition of public health unit functions and required reporting would be well served by a subcommittee of this board with the addition of ex-officio appointments from the ND Department of Health (see chart below).



As outlined in the North Dakota Department of Health executive summary, potential services provided by the present Public Health Units are as follows:

1. Environmental health program
2. Maternal and Child Health program
3. **Health Promotion**
4. **Communicable Diseases**
5. **School Health**
6. Occupational Health Nurse activities
7. Mental Health
8. **Skilled Nursing Activities**
9. MCH Initiative Grants

Health Promotion (screenings for BP, Scoliosis, and Vision), Communicable Diseases (Immunizations for all ages), School Health (screenings), and non certified Nursing Home visits comprise the majority of services as outlined in this summary.

MHA Nation health care services are arranged to provide these services such that formation of a single Public Health Unit would augment the delivery and continuity of care for all residents of our reservation.

We have again attached a copy of the 2010 Census to this testimony. The Census puts the population of the Fort Berthold Reservation at 6,341, a figure that I believe to be much higher because of the ongoing oil boom which has engulfed our Reservation. Of this number, the Census lists 4,556 residents as Native American and 1,511 as White. With the continued exponential growth of the oil exploration and production, all infrastructures for public health care are taxed

making the need for cooperation and collaboration even greater than the last time we discussed this issue.

The Institute of Medicine of the National Academies (IOM) recently published a consensus report entitled Primary Care and Public Health: Exploring Integration to Improve Population Health (see attached Report Brief). This report describes the principles of success for integration of primary care and public health activities. The core principles include a common goal of improving population health, as well as involving the community in defining and addressing its needs. Strong leadership that works to bridge disciplines, programs, and jurisdictions; sustainability; and the collaborative use of data and analysis are the other principles.

The MHA Nation is prepared to enter into collaboration with the State of ND that allows for this continued integration of primary and public health care based on the core principles listed above. Perhaps a contract with annual review could be arranged that would allow for improved public health care for all people on our reservation. Shared costs based on population would be one way of approaching the financial model for this agreement.

The IOM report stresses that integration can start with any of these principles and that beginning is more important the waiting until all requisite components are in place. We would agree that this is the time for moving into a relationship that will benefit all people on our reservation.

Chairman Lee and committee members, we stand on the edge of a prime opportunity to set a new paradigm for state and tribal collaboration. On behalf of the MHA Nation, thank you again for the opportunity to appear and offer this testimony. I am happy to answer any questions.

U.S. Census Bureau

GCT-PL1. Race and Hispanic or Latino: 2010

American Indian Area/Alaska Native Area/Hawaiian Home Land within North Dakota

Note: For information on data collection, confidentiality protection, nonsampling error, and definitions, see http://www.census.gov/prod/cen2010/pl94-171.pdf

		Race								
		One race								
Geographic Area	Total population	Total	White	Black or African American	American Indian and Alaska Native	Asian	Native Hawaiian and Other Pacific Islander	Some Other Race	Two or More Races	Hispanic or Latino (of any race)
Fort Berthold Reservation	6,341	6,127	1,511	13	4,556	4	1	42	214	272
Lake Traverse Reservation and Off-Reservation Trust Land (part)	169	167	159	0	8	0	0	0	2	8
Spirit Lake Reservation	4,238	4,181	580	0	3,587	0	1	13	57	48
Standing Rock Reservation (part)	4,153	4,034	525	7	3,492	4	2	4	119	82
Turtle Mountain Reservation and Off-Reservation Trust Land (part)	8,656	8,564	223	10	8,320	3	1	7	92	69

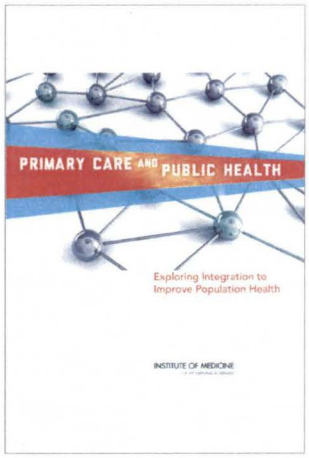
Source: U.S. Census Bureau, 2010 Census Redistricting Data (Public Law 94-171) Summary File
Tables P1 and P2

INSTITUTE OF MEDICINE
OF THE NATIONAL ACADEMIES
Advising the nation • Improving health

For more information visit www.iom.edu/primarycarepublichealth

Primary Care and Public Health

Exploring Integration to Improve Population Health



Although primary care and public health share a goal of promoting the health and well-being of all people, these two disciplines historically have operated independently of one another. Problems that stem from this separation have long been recognized, but new opportunities are emerging for bringing the sectors together in ways that will yield substantial and lasting improvements in the health of individuals, communities, and populations.

In recognition of this potential, the Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA), both agencies of the Department of Health and Human Services (HHS), asked the Institute of Medicine (IOM) to convene a committee of experts to examine the integration of primary care and public health. The United Health Foundation also provided support for the study.

The IOM committee presents its findings and recommendations in *Primary Care and Public Health: Exploring Integration to Improve Population Health.*

Although primary care and public health share a goal of promoting the health and well-being of all people, these two disciplines historically have operated independently of one another.

Principles of Success

As part of its study, the IOM committee identified and analyzed past and current efforts to integrate primary care and public health. Put simply, primary care focuses on providing medical services to individual patients with immediate health needs. Public health focuses on offering a broader array of services across communities and populations that collectively will help people to be healthy. The committee finds that the types of interactions between the two sectors are so varied and dependent on local circumstances, such as the avail-

ability of resources and differences in health challenges, that it is not possible to prescribe a specific model or template for how integration should look. Instead, it identifies a set of core principles derived from successful integration efforts.

The core principles include a common goal of improving population health, as well as involving the community in defining and addressing its needs. Strong leadership that works to bridge disciplines, programs, and jurisdictions; sustainability; and the collaborative use of data and analysis are the other principles.

While the committee regards all of these principles as ultimately necessary for successful integration of primary care and public health, it concludes that integration can start with any of the principles. Beginning is more important than waiting until all of the requisite components are in place.

Moreover, the committee notes that the time is right for action. There is a growing recognition that the current model of investment in the nation's health system is unacceptable, and the dramatic rise in health care costs has led many stakeholders to explore innovative ways of reducing costs and improving health. Research findings also continue to clarify the importance of social and environmental determinants of health and the effect of primary prevention. An unprecedented wealth of health data is providing new means to understand and address community-level health concerns. In addition, passage of the Patient Protection and Affordable Care Act (ACA) provides new opportunities to encourage integration to occur, changing the way the nation improves health.

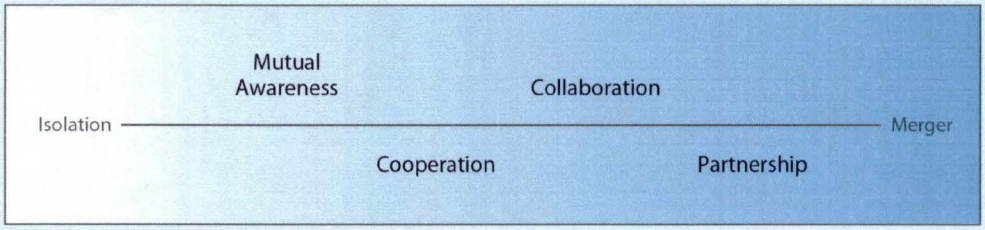
Scope of Integration

The committee acknowledges that integration of primary care and public health can occur on a continuum (see Figure). While it stresses the need to move away from isolation, where the sectors work in separate silos, the committee does not advocate for complete merger. Rather, it identifies degrees of integration that can be used to achieve better health results: mutual awareness, cooperation, collaboration, and partnership.

When there is mutual awareness, primary care and public health are informed about each other and each other's activities. Cooperation denotes some sharing of resources, such as space, data, or personnel. Collaboration is more intense and involves joint planning and execution, with both sectors working together at multiple points to carry out a combined effort. Partnership implies integration on a programmatic level, with the two sectors working so closely together that, from the individual's perspective, there is no separation.

In practice, every community will be different, and not all will be able to achieve true partnership. In some communities, achieving mutual awareness will mark a significant step forward. However, it will be useful to strive for greater integration when possible.

FIGURE: Degrees of Primary Care and Public Health Integration



There is a growing recognition that the current model of investment in the nation's health system is unacceptable, and the dramatic rise in health care costs has led many stakeholders to explore innovative ways of reducing costs and improving health.

Framework for Action

With these principles as a framework for action, the committee proposes an array of recommendations whose implementation would assist the CDC, HRSA, and HHS in creating an environment that would foster broader integration of primary care and public health.

At the agency level, the CDC and HRSA should take steps to connect staff, funding, and data at the regional, state, and local levels. The agencies should create opportunities for staff to build relationships with each other and local stakeholders by taking advantage of opportunities to work through the 10 regional HHS offices, state primary care offices and association organizations, state and local health departments, and other mechanisms. In addition, the committee recommends that the agencies inventory health and health care databases in order to create a consolidated platform for sharing and displaying local population health data that could be used by communities.

The CDC and HRSA also should work together to create research and learning networks that disseminate best practices in order to foster and support the integration of primary care and public health to improve population health at the state and local levels. The agencies should support the evaluation of existing local and regional models of primary care and public health integration, and they should support the development of new models of integration. Such efforts should include working with the Agency for Healthcare and Research Quality's Action Networks to educate others about best practices related to the integration of primary care and public health, and convening stakeholders at the national and regional levels to share best practices for integration.

The CDC and HRSA should join forces to develop the workforce needed to support the integration of primary care and public health. Among needed actions, the CDC and HRSA should work with the Centers for Medicare and Medicaid Services (CMS) to identify regulatory options for graduate medical education funding that give priority to provider training in primary care and public health settings and specifically support programs that integrate primary care practice with public health. They also should develop training grants and teaching tools that can prepare the next generation of health professionals for more integrated clinical and public health functions.

HHS should focus on improving the integration of primary care and public health through its existing programs as well as new initiatives being developed as a result of the ACA. For example, the CMS Innovation Center can use its focus on improving community health to support pilot projects that better integrate primary care and public health. Some health data that doctors collect from patients already are used to help improve public health. To bolster that effort, the Office of the National Coordinator for Health Information Technology should consider developing population measures that support the integration of community-level clinical and public health data.

At a broader level, HHS should work with its agencies to develop a national strategy and invest-

ment plan for creating a primary care and public health infrastructure robust enough and appropriately integrated to enable the agencies to play their appropriate roles in furthering the nation's population health goals.

Conclusion

The challenges in integrating primary care and public health are great—but so are the opportunities and rewards. The IOM report offers the most detailed portrait yet of the current landscape for integrating, along with principles that can serve as a roadmap to move the nation toward a more efficient health system. The status quo of siloed enterprises is not good enough. Moving along a path of integration will promote better health and well-being for all Americans.

INSTITUTE OF MEDICINE
OF THE NATIONAL ACADEMIES

Advising the nation • Improving health

500 Fifth Street, NW
Washington, DC 20001
TEL 202.334.2352
FAX 202.334.1412

www.iom.edu

The Institute of Medicine serves as adviser to the nation to improve health. Established in 1970 under the charter of the National Academy of Sciences, the Institute of Medicine provides independent, objective, evidence-based advice to policy makers, health professionals, the private sector, and the public.