Testimony
Health Services Committee
Wednesday, October 26, 2011
North Dakota Department of Health

Good morning, Chairperson Lee and members of the Health Services Committee. My name is Kelly Nagel, and I am the public health liaison for the North Dakota Department of Health. I am here to provide background information on the local public health units' operations and service delivery and information on the Regional Public Health Network Pilot Project Study.

Background

Governance and organizational structure of state and local health departments vary greatly across the nation. 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. 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 42 percent of the total annual revenue sources for all North Dakota local public health units is from local government, 24 percent is federal pass through, 13 percent is state general fund, 7 percent is direct from Medicare and Medicaid and 13 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.

Collaborations and Environmental Health Services

A regional infrastructure has been developed to coordinate the resources necessary to meet public health challenges. A lead local public health unit has been identified to provide emergency preparedness and response services in each of the eight regions of the state. These 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. Lead health units that do not have all counties in their jurisdiction and that have financial contracts with outlying health units for a small contribution are Fargo Cass Public Health and Central Valley Health District. Fargo requests a contribution based on the level of services so the dollar amount ranges from $235 to $6,072 per year. Central Valley charges a fee based on 40 cents per person. Custer Health, Lake Region District Health and Grand Forks Public Health do not receive additional funding from the outlying counties.

The capacity to provide a standardized level of environmental health services to health units in each region varies. The service hours for outlying health units are unknown. There have been some reports of 40 to 50 hours a month spent in a region's outlying health units, while others report that they do not provide much service outside of their residing city or county. Central Valley has 1 FTE environmental health practitioner (EHP) on staff, Grand Forks has 5, Lake Region has 1.5, First District has 6, Custer has 3, Southwestern District has 3, Upper Missouri has 1.3, and Fargo has 7. The services the lead public health unit typically provides to its neighboring health unit jurisdictions are sewer system, swimming pool and facility inspections; indoor air quality or mold evaluations; and responses to nuisance and other environmental complaints.

In addition, the Women's Way, Family Planning and Women, Infant, and Children (WIC) Nutrition programs have established a regional infrastructure for program and service delivery. In these arrangements, there are no formal agreements between health units. Rather the contract is between the state health department and a health unit to expand services outside of their jurisdiction. For example, Custer Health provides WIC services to Burleigh and Kidder County in addition to the counties in their jurisdiction.

The Center for Tobacco Prevention and Control Policy provides individual local tobacco control policy grants to all local public health units. Local public health units have the option of submitting a cooperative grant with one or more other health units. If a cooperative grant is submitted, the cooperative or collaborative can apply for up to an additional $20,000. This helps offset the cost of any additional administration incurred by the lead health unit and can also provide an incentive to collaborate.

The Center for Tobacco Prevention and Control Policy has funded two cooperatives or collaboratives: Central Valley Health District (Stutsman and Logan

counties) is the lead agency on a cooperative grant with four other single county health units in Emmons, Kidder, McIntosh and LaMoure counties. Traill District Health Unit is the lead agency with Steele County Public Health Department on a cooperative grant. In Central Valley's collaborative, they have outreach coordinators in each health unit jurisdiction with Central Valley being the administrative health unit. In Traill and Steele's collaborative, there is one shared tobacco coordinator with Traill being the administrative health unit.

Regional Network Pilot Project Study

The establishment and requirements of the Regional Public Health Networks were modeled after the Regional Educational Associations (REAs). 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 laundry 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 which are related to professional development, technology support services, performance improvement, data collection, analysis and interpretation and expansion and enrichment of curricular offerings.

I have the following suggested possible regional network improvements:

1) Dedicate state aid to the establishment of regional networks. As noted in the pilot project evaluation report, expanding and sharing services is not feasible without fiscal support. In addition, there was a large amount of effort from Central Valley, the administrative health unit, invested in the regional network operations. It is unlikely that other health units would have the capacity to invest this much effort. The need for administrative capacity has also been demonstrated in the REAs and as a result state aid funding has been dedicated to hiring staff to coordinate planning and implementation of activities and to manage the association.
2) Require that networks include quality improvement methods in the delivery or activity plan. Quality improvement (QI) in public health refers to continuous and ongoing efforts to achieve measurable improvements in the efficiency, effectiveness, performance, accountability, outcomes and other indicators of quality in services or processes. QI methods allow activities in a process to be looked at continually in order to determine if changes need to be made throughout the entity to ensure effectiveness of services rather than waiting until the evaluation period. The request-for-reimbursement expense

reports received by the Department of Health indicated that the cumulative hours for Southeast Central's pilot project period was about 6,000 staff time hours. The majority of the hours were involved in the billing system. The total dollar amount reimbursed for staff time was $161,146, which was 76 percent of total funding expended. Since costs were not separately tracked, it is difficult to identify one-time costs versus ongoing costs and to determine whether some of the captured personnel hours were from planned network activities or existing activities. The implementation of quality improvement methods with determined measures and baseline data would provide more reliable data and measurements of outcomes in order to demonstrate actual effectiveness.

3) Allow for adequate planning time. Communities need to determine their local needs in order to determine the most appropriate and effective approach to sharing services and administrative functions. The pilot project timeline only allowed 1 year to plan and implement activities. Community health assessments are a useful tool for this planning and to engage key local partners.
4) Add a requirement for networks to submit an annual expense report to the state health officer. Currently, statute requires local health units to meet department maintenance of effort funding requirements so any funding allocated to the regional network cannot supplant existing funding or activities. Statute also requires the regional network to submit an annual plan regarding the provision of the required and optional services to the state health officer. If in the future state aid is appropriated, I would suggest requiring the networks to submit an annual report detailing all expenses incurred by the network, similar to what is required by the Regional Education Associations.

There are other local public health units that are interested in establishing a regional network. I recently initiated local health board orientations in which I provide information on the public health regional network statute and the pilot project results. Rolette and Dickey County have expressed interest. Both boards said there would need to be additional funding to participate in a regional network and both felt it would be a good approach to expanding expertise and possibly services to their communities. In addition to providing information to health board members, I have also been participating in discussions regarding another possible regional network pilot project in southeast North Dakota. Local public health units included in the southeast geographic area include: 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. All of these health units are interested in participating in the pilot project.

The proposed southeast North Dakota pilot project will examine the feasibility of creating a cross-jurisdictional quality improvement team coupled with training a cohort of public health professionals to form an effective regional network model for public health service delivery. Team members will work towards a Certificate in Performance Improvement; a 12 credit, graduate level, online course offered by the University of Minnesota School of Public Health. The program will provide public health professionals the skills and knowledge needed to lead quality improvement efforts in their communities, which will ultimately lead to healthier communities. Thus the project will provide the opportunity to determine whether or not we can 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 the southeast region of North Dakota.

The project has high potential to be funded by the Bush Foundation. The Bush Foundation expressed much enthusiasm over North Dakota's proposal. The Bush Foundation recognizes that quality population-based programs and services can improve the overall health of the nation, but at the same time public health needs to do better at defining, achieving and proving desired outcomes. The Bush Foundation is in the developmental stages of creating a program that focuses on a team approach in addressing common community issues and measuring community change. North Dakota's proposal aligned very well with this concept.

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