NORTH DAKOTA LEGISLATIVE MANAGEMENT

Minutes of the

HEALTH SERVICES COMMITTEE

Tuesday, January 10, 2012
Roughrider Room, State Capitol
Bismarck, North Dakota

Senator Judy Lee, Chairman, called the meeting to order at 9:00 a.m.

Members present: Senators Judy Lee, Ralph L. Kilzer, Tim Mathern, Gerald Uglem, John Warner; Representatives Kathy Hogan, Karen Karls, Robert Kilichowski, Jon Nelson, Mark S. Owens, Vonnie Pietsch, Karen M. Rohr, Mark Sanford, Robin Weisz

Members absent: Senator Spencer D. Berry; Representative Stacey Dahl

Others present: See Appendix A

It was moved by Senator Mathern, seconded by Representative Weisz, and carried on a voice vote that the minutes of the October 26, 2011, meeting be approved as distributed.

REGIONAL PUBLIC HEALTH NETWORK PILOT PROJECT STUDY

Ms. Kelly Nagel, Public Health Liaison, State Department of Health, provided information (Appendix B) regarding the geographic coverage areas of health programs in the state, the effects of the pilot project on the wellness of the consumers in the pilot project area, the status of the development of any recommendations or legislation relating to the regionalization of public health services, and options for a regional network to become self-sustaining. She said there are 28 independent local public health units in the state--75 percent of which serve single county, city, or combined city/county jurisdictions, while the other 25 percent serve multicounty jurisdictions. She said local public health units are required to meet state standards and follow state laws and regulations, but have the authority to determine service area and jurisdiction. The most common services provided include immunizations (adult and child), tobacco prevention, blood pressure screening, injury prevention screening, blood lead screening, and the child health component of Medicaid.

Ms. Nagel said in 2002 when the emergency preparedness and response (EPR) program began, local public health unit administrators developed eight public health planning regions around the eight most populated cities in the state. She said the health unit whose jurisdiction covers the largest city in each region has been designated as the lead health unit for that region. She said public health emergency preparedness funding from the Centers for Disease Control and Prevention (CDC) provides for 2.5 employees in each lead local public health unit to assist with health and medical planning and preparedness activities with the stakeholders in the region.

Ms. Nagel said geographic boundaries do not exist for hospital preparedness planning regions which are based on referral patterns into the four largest cities with tertiary care centers. She said hospitals may choose their planning region.

Ms. Nagel said the CDC has regional arrangements with local public health units regarding infectious and communicable disease surveillance and investigations. She said in this arrangement, the state is divided into eight field epidemiology areas and each field epidemiologist has an office in the lead local public health unit in each region. She said although the lead local public health unit location corresponds to the EPR defined lead health units, the field epidemiologist coverage areas are not the same as the EPR regional geographic boundaries.

Ms. Nagel said local public health units and other partners across the state contract with the Community Health Section of the State Department of Health to provide services in cancer prevention and control, chronic disease, family health, injury prevention and control, and nutrition and physical activity. She said the department enters the contracts to allow for the best possible statewide coverage, but many of the contracts do not define geographical coverage between health units and other providers.

Ms. Nagel said the Department of Human Services provides direct care services through the State Hospital, Developmental Center at Westwood Park, eight regional human service centers, eight regional child support enforcement units, and county social service offices. Except for the southwest and southeast regions, she said, counties within the human services regions differ from the EPR regions.

Ms. Nagel said the health outcomes of the regional public health network pilot project are not yet known. She said the 12-month pilot project was not adequate to plan shared services and functions, implement activities, and evaluate long-term health outcomes. She said the network implemented an electronic billing system which generated revenue, but the effect on clients was not measured. She said impacts related to shared public health services also were not measured, but extending the family planning clinic hours has improved access to clients and establishing a local sexual assault response team may increase the availability of sexual assault resources and create

collaborations that improve access. She said the standardized screening and education protocols of a chronic disease management program also allowed for improved client identification of chronic disease and self-management. She said the pilot project demonstrated the need for improvement in measuring and monitoring program and service performance.

Ms. Nagel said the North Dakota State Association of City and County Health Officials organized a task force to develop recommendations for amendments to the regional public health network legislation. She said the task force recommends more flexibility in establishing a regional public health network. She said the Legislative Assembly in 2011 allowed greater flexibility for change to the regional education associations (REAs) after which the regional public health network legislation was modeled. She said the task force suggests the Legislative Assembly:

- Allow more flexibility by removing the list of shared services, but requiring networks to create a work plan that includes activities based on the core public health activities.
- Remove the geographic region requirement to allow local public health units with existing working relationships to form a network.
- Provide that regional public health networks serve a minimum population of 15,000 or include at least three local public health units.
- Remove the requirement for the network to have a regional network health officer.

Ms. Nagel said expanding and sharing services at local public health units is not feasible without fiscal support. She said funding could be derived from cost-savings, increased revenue, state assistance, or funding contributions from participating local public health units.

In response to a question from Senator Mathern, Ms. Nagel said adding core services to statute would encourage standardization. She said the change would provide structure, but allow for flexibility in how the core services are provided.

In response to a question from Representative Rohr, Ms. Nagel said network participants select a governing body to provide oversight regarding the activities in the joint powers agreement. She said there has been confusion regarding the authority in the network of the local public health unit director and the regional network health officer.

In response to a question from Senator Lee, Ms. Nagel said local public health units in areas of the state impacted by oil activity are already multicounty health districts and collaborate as necessary. She said those local public health units could benefit from regional public health network funding to expand collaborations and services.

In response to a question from Representative Weisz, Ms. Nagel said fiscal support of the regional network is needed to reimburse the lead health unit for administrative costs relating to establishing the network and for ongoing coordination. She said ongoing support is needed to meet the regional public health network goal of expanding services in the smaller units and providing more equitable care statewide.

In response to a question from Senator Lee, Ms. Nagel said Steele County is a part-time local public health unit with one staff person providing nursing services, such as immunizations. She said in an emergency, Steele County would need the state or another county to provide assistance.

In response to a question from Senator Lee, Representative Sanford said REAs learned that administrative activities were easier to share than service activities. He said there were some successes in the collaboration of services, but it takes time to build relationships and participants must experience the value of the collaboration.

In response to a question from Representative Hogan, Representative Sanford said REAs receive a basic state grant for staff and per student state funding for providing services. He said local school districts are responsible for the cost of accessing the services. Initially, he said, REAs required certain administrative and program functions, but recent changes now identify core services to be offered.

In response to a question from Representative Sanford, Ms. Nagel said, depending on the type of local public health unit, funding may be derived from a combination of local mill levy tax revenue, city or county general fund sources, federal funds, state grants, third-party reimbursement, and fees.

Mr. Keith Johnson, Administrator, Custer Health Unit, Mandan, and representative of the North Dakota State Association of City and County Health Officials, provided information (Appendix C) regarding recommendations for regional public health network improvements. He said the regional public health network program will require funding separate from and in addition to state aid currently provided to local public health units. He said the decline in federal funds, the need for enhanced local response to disasters, and a demand for more social services have caused challenges for the public health units. He said some counties have had difficulty raising adequate funds from their five-mill property tax limit. He said the regional public health network program will improve the delivery of services and result in cost-savings but not in the first two years to three years. He said the association's recommendations will be finalized and approved by the association in March 2012.

In response to a question from Senator Lee, Mr. Johnson said health districts in the western part of the state are having difficulty attracting environmental health personnel, especially those with expertise in the oil industry. He said collaboration among these districts could make it possible to hire environmental health personnel to inspect man camps and reserve pits and to assist in planning and zoning issues.

In response to a question from Senator Lee, Mr. Johnson said the Custer Health Unit receives funding from local property taxes (19 percent), federal funding (52 percent), state funding (6 percent), and revenue from fees and contracts (23 percent).

In response to a question from Senator Mathern, Mr. Johnson said many health units need additional resources for environmental health services.

In response to a question from Representative Hogan, Mr. Johnson said state aid to public health units averages 7 percent of local public health unit budgets statewide but varies by health unit.

Representative Weisz suggested the committee receive information from the North Dakota State Association of City and County Health Officials regarding a proposed timeline and funding for the regional public health network project to continue.

In response to a question from Representative Nelson, Ms. Lisa Clute, Executive Officer, First District Health Unit, Minot, said First District Health Unit has not received any oil impact funding. She said First District Health Unit is not only dealing with the impact of the oil industry on environmental services, but is also addressing the environmental effects of summer flooding.

In response to a question from Senator Warner, Ms. Clute suggested funding for property-related public health services not be separated from funding for people-related public health services.

It was moved by Senator Mathern, seconded by Representative Hogan, and carried on a roll call vote that the Legislative Council prepare a bill draft to amend North Dakota Century Code Chapter 23-35.1 relating to regional public health networks to provide that any agreement include core activities rather than specific types of services and to include funding and outcome measures for the regional public health network program. Senators Lee, Kilzer, Mathern, Uglem, and Warner and Representatives Hogan, Karls, Kilichowski, Nelson, Owens, Pietsch, Rohr, Sanford, and Weisz voted "aye." No negative votes were cast.

Ms. Jeanne Prom, Executive Director, Center for Tobacco Prevention and Control Policy, provided information regarding baseline smoking statistics prior to awarding tobacco prevention and control grant funds and information regarding the results of programs that were awarded grant funds (Appendix D). She said the state, through the State Department of Health and the center, has supported a comprehensive program based on the *Best Practices for Comprehensive Tobacco Control Programs*, published by the CDC in 2007. She said the five best practice components include community interventions, cessation, health communications, surveillance/evaluation, and management.

Ms. Prom said the CDC-recommended funding level for tobacco control in North Dakota is $9.3 million per year. She said tobacco control funding has increased from $4.9 million per year prior to July 2009 to $9.5 million for fiscal year 2012. She said funding to local public health units for tobacco control has increased from $2.4 million per year to $3.8 million per year during the same period.

Ms. Prom said since July 2009, 42 school districts/private schools and five college campuses have adopted tobacco-free campus policies, five communities have passed comprehensive smoke-free city ordinances, and all 28 local public health units have received funding to adopt an ask, advise, and refer policy for clients who use tobacco. She said North Dakota allows for the exemption of certain workplaces and public places from the state's smoke-free law adopted in 2005. She said currently 25 states have enacted laws to prohibit smoking in all workplaces, including restaurants and bars.

Ms. Prom said the adult smoking rate in North Dakota has decreased from 18.1 percent in 2008 to 17.4 percent in 2010 and the youth smoking rate has decreased from 21.1 percent in 2007 to 19.4 percent in 2011. She said per capita cigarette pack sales have decreased from 30.36 packs per year in fiscal year 2008 to 27.98 packs per year in fiscal year 2011.

In response to a question from Senator Warner, Ms. Prom said the cigarette tax is $1.586 per pack in Minnesota, $1.53 per pack in South Dakota, $1.70 per pack in Montana, and $.44 per pack in North Dakota.

In response to a question from Representative Rohr, Ms. Prom said information regarding trends in adult smoking rates is available on their website. She said youth survey data is collected every other year and is available on the Department of Public Instruction website. She said smoking rates are trending downward.

In response to a question from Senator Lee regarding the increase in cigarette tax revenue reported by the Office of Management and Budget, Ms. Prom said the increase could be related to an increase in population. She said the residency of the buyer is not available.

In response to a question from Senator Lee, Ms. Prom said the behavioral risk factor surveillance survey system includes the Indian reservations. She said smoking rates are higher on the reservation. She said the center provides funding for the local public health units, and they are required to work with all of the communities in their area, including the reservations.

Senator Lee suggested the center consider using trust fund reserves to supplement the State Department of Health's outreach on the reservations and that the center focus its efforts on reducing the smoking rates of college students.

Senator Lee suggested the committee receive information regarding the demographics of individuals in the state who smoke, including age, gender, and ethnicity.

Representative Nelson suggested the committee receive information regarding the state's smoking rates compared to other states, including information on spending levels in other states.

Senator Lee suggested the committee receive a copy of a *Survey of Agency Alcohol, Drug, Tobacco, and Risk-Associated Behavior Prevention Programs* prepared by the Legislative Council in January 2011. She said the survey indicated there is substantial spending by state agencies in alcohol, drug addiction,

tobacco, and other risk associated behaviors. A copy of the report was provided to the committee.

STUDY OF THE FEASIBILITY OF PLACING THE FORT BERTHOLD RESERVATION IN A SINGLE PUBLIC HEALTH UNIT

Mr. Fred Larson, President, Wilson Health Planning Cooperative, provided information (Appendix E) regarding a report on the disparities between Native American and non-Native American health care. He said the Wilson Health Planning Cooperative was formed to study and design a new health care system in an 11-county area that includes the Fort Berthold Reservation to eliminate health care disparities. He provided copies of *The Wilson Report* (on file in the Legislative Council office).

Mr. Larson said the cooperative gathered research, visited health care facilities in the region, held public meetings, hosted seminars, and toured facilities in Idaho and Washington--considered leaders in health care. He said the Three Affiliated Tribes has received an $80,000 community health center planning grant to demonstrate the need for health services in the community and to plan for the development of a comprehensive community health center under Section 330 of the Public Health Service Act. He said the purpose of the health center program is to extend comprehensive primary and preventative health services, including mental health, substance abuse, and oral health services, to populations currently without access and to improve the health status of local residents. He said the planning grant funds will be used to conduct a comprehensive needs assessment, design an appropriate health care service delivery model, increase community involvement in the health center, and develop partnerships with other providers in the community.

Mr. Larson said barriers to health care on the Fort Berthold Reservation include travel distance to emergency and hospital care and inability to hire and keep health care providers in the area. He said placing the Fort Berthold Reservation in a single public health unit will aid in the integration of the delivery of health care service and will contribute to a reduction of health disparities.

In response to a question from Senator Warner, Mr. Larson said Indian Health Service (IHS) is no longer considered a health insurance program by the Department of Commerce. He said claims are often denied because IHS does not have adequate funding.

Senator Lee suggested information regarding the number of cancer deaths and suicides among Native Americans presented to the committee based on each 100,000 population be converted to actual numbers and provided to the Legislative Council.

In response to a question from Senator Lee, Mr. Larson said the IHS policy that excludes nonnative individuals from receiving services at an IHS facility is a barrier to the integration of services. He said the Coeur d'Alene, Idaho, facility serves native and nonnative individuals because the facility is designated a community health center.

In response to a question from Representative Hogan, Mr. Larson said the planning grant for a community health center must be completed by September 2012.

In response to a question from Representative Hogan, Mr. Larson said the cooperative did not analyze local public health services because it was not part of the grant requirement.

Senator Lee recognized Dr. Herbert Wilson and thanked him for his many years of service to the citizens of North Dakota.

Dr. John Baird, Special Populations Section Chief, State Department of Health, provided information (Appendix F) regarding the history of the determination of public health unit boundaries. He said the organization of public health in North Dakota has always emphasized local control, and in the early years of the state's history, emphasis was placed on nursing services, immunizations, and childhood examinations. He said several of the larger cities and a few counties formed local health departments, and legislation in 1943 allowed the formation of health districts, the pooling of resources, and the ability to levy a tax for public health services. He said First District Health Unit formed when Ward County commissioners passed a resolution to establish a health district which would include adjacent and nearby counties. By 1956 Southwestern District, Upper Missouri District, Custer District, and Lake Region District had formed. He said district formations ended in the mid-1950s when federal and state budgets were reduced and incentive money for district formation was withdrawn. He said Chapter 23-35 allows for public health departments or districts. He said the boundaries of the public health units were described as single county, multicounty, or city-county. He said expansion, merger, or dissolution of health units is allowed by county areas, but there is no provision for subcounty areas to be included or excluded from districts. He said the current study of a single public health unit for the Fort Berthold Reservation provides an opportunity to reexamine the definitions of public health unit boundaries.

In response to a question from Representative Nelson, Dr. Baird said currently each county has a representative on the district health unit board, but there could be a designation to include a tribal government representative. He said placing the Fort Berthold Reservation in a single public health unit would allow the public health unit to focus on the unique needs of the reservation.

Ms. Phyllis Howard, member, Three Affiliated Tribes, and Director, Office for Elimination of Health Disparities, State Department of Health, said Commander Arne Sorenson, United States Public Health Service, Director, Diabetes Prevention Program, Mandan, Hidatsa, and Arikara Nation, was unable to attend the meeting. She said Commander Sorenson

plans to submit information to the Legislative Council for distribution to the committee.

Senator Lee suggested the committee consider incremental changes that could improve public health services on the Fort Berthold Reservation, including collaborations with the community health center, representation of the tribe on the health boards, regionalization of services, and tribal financial support.

STUDY OF THE FUTURE OF HEALTH CARE DELIVERY IN THE STATE AND THE ABILITY OF THE UNIVERSITY OF NORTH DAKOTA SCHOOL OF MEDICINE AND HEALTH SCIENCES TO MEET THE HEALTH CARE NEEDS OF THE STATE

Mr. Alex Schweitzer, Cabinet Lead for Institutions and Regional Human Service Centers, Department of Human Services, provided information (Appendix G) regarding the telepsychiatry program. He said regional human service centers and the State Hospital currently provide rural outreach services through telepsychiatry in Williston, Minot, Grafton, Valley City, Jamestown, and Dickinson. He said telepsychiatry services are anticipated to be expanded to New Rockford and Lakota. He said telepsychiatry services planned by the State Hospital and Mercy Medical Center in Williston will allow the medical center to reopen a five-bed to six-bed inpatient psychiatric unit. He said the State Hospital will soon by piloting telepharmacy services at the South Central Human Service Center and will eventually provide the services at all of the regional human service centers.

In response to a question from Senator Warner, Mr. Schweitzer said a case manager, psychiatric nurse, or other provider remains with the patient during the video appointment. He said tests are done in advance, depending on the needs of the patient. He said Health Insurance Portability and Accountability Act (HIPPA) rules are followed, and patients are aware the session is recorded.

In response to a question from Senator Mathern, Mr. Schweitzer said a telepsychiatry visit is charged and reimbursed the same as an onsite psychiatry visit.

In response to a question from Representative Rohr, Mr. Schweitzer said there have been no liability issues related to telepsychiatry.

Mr. Sheldon Wolf, Director, Health Information Technology, Information Technology Department, provided information (Appendix H) regarding the role of health information technology and other technological innovations in providing health care services in the state, including telemedicine. He said currently the Health Information Technology Advisory Committee is involved in projects to assist providers implement and use electronic health records, including low-interest revolving loans, regional extension center program match, and seminars and presentations to providers and associations. As of January 2012, he said, 36 eligible professionals, six critical access hospitals, five large urban hospitals, and two IHS hospitals have indicated they meet requirements to obtain an incentive payment though Medicaid.

Mr. Wolf said the health information exchange is the electronic movement of health-related information among organizations according to nationally recognized standards. He said the simplified exchange known as DIRECT is a simple secure method to send information from one provider to another through a secure electronic system. He said "push/pull" technology not only includes the ability to send information between providers, but also includes the ability to find information on a patient needed to provide quality care in an emergency. He said the implementation of electronic health records and a health information exchange will make medical information available in a format that is accessible quickly, easily, and securely, helping providers make quality health care available anywhere, anytime.

In response to a question from Representative Rohr, Mr. Wolf said HIPPA rules and guidelines address how information may be shared, so exchanges will not become registries nor the information sold.

Ms. JoAnne Hoesel, Director, Division of Mental Health and Substance Abuse Services, Department of Human Services, provided information (Appendix I) regarding the department's statewide behavioral health plan. She said the statewide behavioral health plan reflects a broad view of the entire public behavioral health system. She said the plan includes a description of the current system of care, a needs assessment, a description of activities, changes in technology, and advances in research and knowledge. She said the plan is comprehensive and reflects access to physical medical services, dental services, employment supports, indigent defense service, collaboration with military support organizations, guardianship services, and workforce demands. She said the public, state agency partners, and stakeholders are involved and provide input in development of the plan. She said the plan identifies strengths, needs, and service gaps. She said the department uses this plan to develop its budget priorities and program focus.

In response to a question from Senator Lee, Ms. Hoesel said law enforcement representatives are not currently involved in plan development but should be in the future.

In response to a question from Representative Hogan, Ms. Hoesel said the plan is distributed through a press release and is available on the department's website. Senator Lee suggested a link to the plan be sent to committee members.

Mr. Mike Reitan, Assistant Chief, West Fargo Police Department, expressed concern regarding the lack of mental health and chemical dependency treatment services and its effect on law enforcement and communities (Appendix J). He said the lack of available mental health professionals and facilities across the state makes it difficult for individuals to access essential services. As a result, he said, law enforcement may become involved. He said increased efficiencies can be achieved when area stakeholders,

including law enforcement, health care providers, emergency responders, advocates, social service providers, and members of the criminal justice system collaborate to discuss trends, identify barriers to effective service, and develop strategies related to mental health and chemical dependency. He provided information regarding a mobile mental health crisis response program operating in two Minnesota counties. He said the program coordinator reported 56 fewer hospitalizations in 2011 as a result of the program.

In response to a question from Senator Lee, Mr. Reitan said during weekdays, clinical evaluations are generally available for individuals with a mental health or chemical dependency issue; however, after business hours or on weekends because evaluation services are not available, individuals are usually admitted to a hospital emergency room for evaluation.

In response to a question from Representative Rohr, Mr. Reitan said both adults and juveniles are in need of additional services.

Dr. Eric Swensen, Chairman, Adult Psychiatry Department, Sanford Health, Fargo, provided information regarding gaps and barriers to providing mental health services to individuals receiving care from the regional human service centers, including providing examples of inappropriate placements that result in the inefficient use of hospital and mental health resources.

Senator Lee said challenges exist for both private and public providers. She said private providers are often not reimbursed for costs incurred, and lack of adequate resources results in waiting lists for public providers. She suggested private providers participate in the Department of Human Service's development of the statewide behavioral health plan.

Senator Warner suggested the committee receive information regarding the funding sources for mental health services, including information regarding mental health parity and services for adults and children. Senator Lee asked the Department of Human Services to provide this information at the next meeting.

Ms. Carol K. Olson, Executive Director, Department of Human Services, provided information regarding mental health treatment and access to care. She said the department addressed payment structure for mental health services last interim. She said a meeting is tentatively set with law enforcement in late January to address mental health service issues.

Representative Rohr suggested the committee receive information regarding laws that prevent health information technology from being used as a registry where information can be sold. Senator Lee suggested the Health Information Technology Office provide this information to the committee at a future meeting.

Mr. Tom Nehring, Director, Division of Emergency Medical Services and Trauma, State Department of Health, provided information (Appendix K) regarding an Emergency Medical Services (EMS) Advisory Council report on the status of emergency medical services in the state. He said the Legislative Assembly in 2009 provided $500,000 to study the EMS system in the state. He provided a copy (Appendix L) of the SafeTech Solutions, LLP, report dated June 2011 on an assessment of challenges facing EMS in rural North Dakota. He said the report expresses concern regarding the lack of adequate rural, out-of-hospital EMS in North Dakota. He said in rural areas, where volumes of medical transports are low, EMS relies on donations, local tax revenues, and volunteer labor. He said challenges vary across the state. He said in western North Dakota increasing demand for services is a concern, including a need for specific training and environmental challenges to overcome. In other parts of the state, he said, an aging population is an issue. He said the Legislative Assembly in 2011 provided $940,000 for training grants for the 2011-13 biennium. He said during the first year of the 2011-13 biennium, $1.25 million was provided for staffing grants, and during the second year, $3 million is available for ambulance operations. He said the staffing grants will be combined with the ambulance operation funding to provide base funding of $4.25 million for the 2013-15 biennium. He said 86 percent of the ambulance services in the state rely primarily on volunteers whose labor cost would exceed an estimated $31 million per year. He said aging volunteers and the decline in volunteerism has resulted in a shortage of EMS workers. He said characteristics of successful rural services include engaged, trained, dedicated, and rested leaders; professional standards; recruitment and retention plans; organization; adequate funding; and well-maintained facilities and equipment. He said the EMS Advisory Council was directed by the Legislative Assembly in 2011 to make recommendations to the State Department of Health regarding the establishment of funding areas and criteria to determine funding levels for each area. He said funding areas have been determined, but the council continues to work on criteria for the allocation of funds to each area.

In response to a question from Senator Lee, Mr. Nehring said service districts may not be the same as funding districts, and collaboration is needed among ambulance services. He said districts are encouraged to review funding available, needs, and collaborations available to help meet identified needs.

In response to a question from Senator Lee, Mr. Nehring said the Energy Infrastructure and Impact Office is making $2 million of funding from the oil and gas impact grant fund available for EMS. He said an additional $30 million contingent appropriation from the oil and gas impact grant fund was provided for oil and gas impact grants related to emergency services during the November 2011 special session.

Senator Mathern suggested the committee receive information from the School of Medicine regarding programs to expand the number of psychiatric service providers in the state.

Senator Kilzer suggested the committee receive information regarding reasons psychiatrists choose not to practice in the state.

OTHER COMMITTEE RESPONSIBILITIES

Ms. Kim Mertz, Director, Division of Family Health, State Department of Health, provided a report (Appendix M) regarding the department's inventory of material relating to abortions and outlining the department's practice of gathering the inventory items pursuant to Section 15 of 2011 House Bill No. 1297. She said there has been no change in the inventory since the department's presentation to the committee in October 2011. She said the booklet related to the characteristics of the unborn child, the support obligations of the father, and the various methods of abortion and the publication related to the various public and private agencies available to assist during pregnancy are both in second draft form and will be distributed together. She said regarding the abortion compliance report and the abortion data report, the Red River Women's Clinic in Fargo continues to submit reports but does not complete the information that is the subject of a lawsuit filed by the clinic.

In response to a question from Senator Lee, Ms. Mertz said the publications will be available in booklet form and electronically. She said the publications will be distributed statewide to regional human service centers and local public health units. She said the publications are also required to be distributed at the Red River Women's Clinic in Fargo.

In response to a question from Senator Lee, Ms. Mertz said the publications do not include information related to family planning. She said family planning information is available from providers who are identified in the department's directory on public and private service providers.

Representative Karls suggested the committee receive information regarding the report questions not completed by the Red River Women's Clinic in Fargo.

Senator Mathern distributed information regarding the need to decrease the incidence of childhood abuse and sexual assault. He provided copies of a publication of North Dakota childhood abuse and sexual assault survivors distributed by Prevent Child Abuse North Dakota--*Authentic Voices*. A copy of the publication is on file in the Legislative Council office. He said it is important to not only provide services that prevent abortions but also to provide services that prevent situations where an abortion may be perceived as the solution.

Mr. Raymond Lambert, State Fire Marshal, provided information (Appendix N) regarding a report on the findings and recommendations for legislation to improve the effectiveness of the law on reduced ignition propensity standards for cigarettes. He said Section 18-13-02(6) requires the State Fire Marshal to review the effectiveness of the section related to reduced ignition propensity standards for cigarettes and report findings and recommendations for legislation to improve the effectiveness of the chapter. He said the law became effective August 1, 2010. He said the State Fire Marshal has received and certified 928 brand-style cigarettes from 22 manufacturers using 11 testing labs for certification testing. He said to date the State Fire Marshal has collected $232,000 to certify cigarettes sold in the state. He said the guidelines for testing cigarettes in Section 18-13-02 are the standards used nationwide, and they appear to be effective. He said there have been no fines or penalties for noncompliance, and the fire prevention and public safety fund under Section 18-13-08 has not received any funding. He said there are no recommended changes to Chapter 18-13.

Ms. Marlene Kouba, Chair, State Health Council, provided information (Appendix O) regarding the status of potential legislative changes related to the Health Care Data Committee. She said the Health Care Data Committee of the State Health Council is working with the State Department of Health to determine the most effective way to provide information. She said the Health Care Data Committee plans to change its reporting from providing comparisons of charges and costs for various health care services to providing information that will help individuals make better decisions regarding health care planning. She said information comparing the cost of various health care services will continue to be available through the Centers for Medicare and Medicaid Services. She said the Health Care Data Committee anticipates presenting recommendations for legislation to the committee by the summer of 2012.

COMMITTEE DISCUSSION AND STAFF DIRECTIVES

Chairman Lee asked committee members to consider dates in early April for the next committee meeting and to inform the Legislative Council of any conflicts.

No further business appearing, Chairman Lee adjourned the meeting at 3:02 p.m.

_____

Sheila M. Sandness
Senior Fiscal Analyst

_____

Allen H. Knudson
Legislative Budget Analyst and Auditor

ATTACH:15