NORTH DAKOTA LEGISLATIVE MANAGEMENT

Minutes of the

# HEALTH SERVICES COMMITTEE

Wednesday, October 26, 2011
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 Stacey Dahl, Karen Karls, Robert Kilichowski, Jon Nelson, Mark S. Owens, Vonnie Pietsch, Karen M. Rohr, Mark Sanford, Robin Weisz

**Members absent:** Senator Spencer D. Berry and Representative Kathy Hogan

**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 July 28, 2011, meeting be approved as distributed.**

## REGIONAL PUBLIC HEALTH NETWORK PILOT PROJECT STUDY

Ms. Robin Iszler, Administrator, Central Valley Health District, Jamestown, appeared on behalf of the Southeast Central Regional Public Health Network to provide information (Appendix B) regarding the 2009-11 biennium regional public health network pilot project, including services added and improved by the regional public health network pilot project and the locations benefiting from the service improvements, efficiencies achieved in providing services, effects of the project on participating local public health units, cost-savings to state and local governments, and possible improvements to the program. She said funding should not depend on directives or services but rather the broad goals of the regional public health network.

Ms. Iszler said more information is needed regarding the services public health should provide because not all local public health units provide the same services. She suggested:

- Modeling services based on a national standardization framework such as accreditation and the 10 essential public health services;
- Networking and relationship building; and
- Focusing on planning and community assessment as a guide to meet the needs of the community.

Ms. Iszler said research suggests local infrastructure and protection of the public's health is improved through regionalization, especially in regions with populations under 50,000. She said the total population of the counties participating in the regional public health network pilot project is 41,102. She said the regional public health network project improved services provided. She said the regional public health network pilot project has allowed Central Valley Health District to:

- Improve the environmental health program in the region;
- Improve collection processes;
- Compile a community assessment document for use in grant writing;
- Observe services provided by other local public health units; and
- Forge relationships with regional public health partners.

In response to a question from Senator Warner, Ms. Iszler said the community assessment document is data at the county level, including demographics and health risks for the population. She said information is from the State Department of Health, census data, national profiles, and the Centers for Disease Control and Prevention.

In response to a question from Senator Kilzer, Ms. Iszler said Central Valley Health District is part of a multicounty collaborative effort to reduce tobacco use. She said efforts have resulted in smoke-free communities. Senator Kilzer requested a copy of baseline smoking statistics and information regarding program results when available.

In response to a question from Senator Mathern, Ms. Iszler said foreign travel immunization is not a public health service. She said some of the vaccines required are not provided by the state and must be purchased, so Central Valley Health District does not provide foreign travel immunizations.

Senator Lee said the five-mill limitation on local public health funding makes it difficult to provide services in smaller local public health units. She said the intent of the regional public health network pilot project was to encourage collaboration among local public health units. She said the challenges of implementation resulting from the requirements of a joint powers agreement could be addressed if stakeholders agreed there is merit to having the opportunity and option for local public health units to collaborate in a regional public health network.

Ms. Iszler said the regional structure improved services and funding will encourage local public health unit partners to collaborate.

In response to a question from Senator Lee, Ms. Iszler said improved services and infrastructure changes included in the project were beneficial, and the project should continue. She suggested local public health units identify services that should be available at all local public health units. She said a survey of local public health units could identify which services are provided at each local public health unit and how local public health units could partner for services they do not provide.

Ms. Karen Volk, Nurse Administrator, Wells County District Health Unit, Fessenden, provided information (Appendix C) regarding the challenges and successes of the regional network pilot project. She said hardware, software, and training brought to the Wells County District Health Unit by being part of the project increased professionalism. She said efficiencies were gained by implementing an electronic billing system and web-based time management system and by replacing a dial-up system used for Medicaid, Medicare, and Blue Cross Blue Shield. She said adopting Central Valley Health District's online policies has improved the operating policies of the Wells County District Health Unit, and a contract for environmental health services with the Central Valley Health District has increased and improved environmental health services. She expressed support for regional public health network projects.

Mr. Tony Hanson, Administrator/CEO, LaMoure County Public Health Department, LaMoure, provided information (Appendix D) regarding the regional network pilot project. He said the regional public health network pilot project helped the LaMoure County Public Health Department realize efficiencies that have maximized the department's ability to provide efficient, quality public health services in LaMoure County. He said educational opportunities improved the quality of care. He said training and the implementation of the billing and time management systems resulted in $22,000 of additional revenue, and clients served increased from 300 to over 1,100. He said the collaboration resulted in improved documentation of clinical services, and policies developed provide a uniform quality of care. He said participating in the collaboration has enhanced positive community support of the department.

Ms. Theresa Will, Executive Director, City-County Health District, Valley City, provided information (Appendix E) regarding the effects of the regional network pilot project on the City-County Health District. She said prior to the pilot project, service records for individual visits were kept in a number of files based on type of service or screening event, and all billing was entered manually. She said the pilot project has allowed the district to implement a system where all client information is in one location, invoices and billing files are created electronically, and statistics are generated for program evaluation.

Ms. Mona Klose, Assistant Professor of Nursing, Jamestown College, Jamestown, provided information (Appendix F) regarding an evaluation of the regional public health network pilot project conducted during the 2009-11 biennium, and possible improvements to the regional public health network program. She said the baseline evaluation was completed in August 2010, and formative evaluation activities were performed in February 2011.

Ms. Klose provided a copy of the *Final Evaluation Report: Southeast Central Regional Public Health Network Pilot Project* (Appendix G), including information regarding efficiencies. She said the pilot project resulted in the following benefits:

- Business process improvement;
- Uniform client charting and documentation;
- Nursing policy and procedure framework website for sharing and support;
- Expense-monitoring improvements;
- Higher security for client information and improvements in Health Insurance Portability and Accountability Act compliance;
- Annual report efficiencies and data enhancements;
- Credible relationship building to aid in future collaborative projects;
- Improvements in standards of care--specifically chronic disease management;
- Professionalism of staff and process improvements;
- Availability of expertise and training;
- Level of trust between participating agencies; and
- Comprehensive health assessment and community health improvement planning.

Ms. Klose said challenges include continuing education to fully utilize the electronic billing system, time to manage and maintain the website, lack of adequate realized savings to increase and/or share services, consideration of regional accreditation for participating agencies, and the need for improvements to environmental health tracking. She said most participating agencies lack community assessment information for each community. She said it is imperative that the assessment be conducted in each area. She said emergency preparedness, human services, public health departments/districts, and others have each outlined different geographic boundaries for their purposes, making collaborative efforts more difficult.

In response to a question from Representative Rohr, Ms. Klose said information regarding services available at the local public health units is provided through public service announcements and the school system. In addition, she said, all of the pilot project partners have websites.

In response to a question from Representative Weisz, Ms. Klose referred to a schedule (Appendix H) of cost-savings realized on the purchase, training, and implementation of the billing system software. She said the network arrangement saved $15,000 on the purchase of the billing system software, and savings on training provided by the Central Valley Health

District ranged from $4,147 to $11,429 depending on training arrangements.

Ms. Kelly Nagel, Public Health Liaison, State Department of Health, provided information (Appendix I) regarding collaborations by other public health units that are not part of the pilot project, the level to which smaller public health units participate in the cost of environmental health services provided by the lead public health unit, possible improvements to the regional public health network program, and local public health unit interest in establishing additional regional public health networks. She said there are 28 local public health units in the state--75 percent serve single county, city, or combined city/county jurisdictions and 25 percent serve multicounty jurisdictions. She said based on a national survey, 54 percent of the local public health units in North Dakota serve a population of less than 10,000, have an average budget of $115,000, and an average of 3.0 full-time equivalent (FTE) positions, including 1.5 FTE nurse positions. She said the survey also indicated that 42 percent of all local public health unit revenue in the state is from local government, 24 percent is from federal funds, 13 percent is from the state general fund, 7 percent is from Medicare and Medicaid, and 14 percent is from fees and other sources.

Ms. Nagel said 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. She said the lead public health units receive $50,000 each biennium to provide environmental health services in the region. She said for most of the lead health units, the funding has not been adequate to pay the actual cost of travel and delivery of services. She said lead health units that have financial contracts with outlying health units include Fargo Cass Public Health, which requests a contribution based on the level of services, and Central Valley Health District, which charges $.40 per person. She said Custer Health, Lake Region District Health, and Grand Forks Public Health do not receive additional funding from the outlying counties. She said the level of environmental health service provided to each region's outlying health units varies from minimal service to 50 hours per month. She said services typically provided by the lead public health unit include sewer system, swimming pool, and facility inspections; indoor air quality or mold evaluations; and responses to nuisance and other environmental complaints.

Ms. Nagel said Women's Way, family planning, and women, infants, and children (WIC) nutrition programs have established a regional structure for program and service delivery. She said these arrangements do not include a formal agreement between health units but rather a contract between the State Department of Health and a health unit to expand services outside of its jurisdiction. In addition, she said, the Center for Tobacco Prevention and Control Policy provides individual local tobacco control policy grants to all local public health units. She said local public health units have the option of submitting a cooperative grant with one or more other health units. She said if a cooperative grant is submitted, the collaboration is eligible for an additional $20,000, which can offset the cost of any additional administrative costs incurred by the lead health unit. She said the center has provided the additional funding for two collaborations.

Ms. Nagel provided the following suggestions for improving regional public health networks:

- Dedicate state aid to the establishment of regional networks.
- Require networks to include quality improvement methods in the delivery or activity plan.
- Allow for adequate planning time.
- Add a requirement for networks to submit an annual expense report to the State Health Officer.

Ms. Nagel said Rolette County and Dickey County boards have expressed interest in establishing a regional network and have said additional funding would be needed to participate. She said there is also interest in a regional public health network in the southeast, including Ransom, Richland, Sargent, and Steele Counties, and Traill District with Fargo Cass Public Health as the lead health unit. She said the proposed southeast regional public health network would examine the feasibility of creating a cross-jurisdictional quality improvement team with training of public health professionals to form an effective regional network model for public health service delivery. She said funding for the project may be available from the Bush Foundation.

In response to a question from Senator Mathern, Ms. Nagel said her suggestions are based on the State Department of Health administration of the pilot project program. She said the changes would require legislation.

Senator Lee suggested the State Department of Health facilitate a stakeholder meeting and bring recommendations to the committee. She said the recommendations should include whether the regionalization project should continue, and what, if any, legislation is necessary.

In response to a question from Representative Rohr, Ms. Nagel said quality improvement methods are becoming more important in public health. She said baseline data is gathered and then improvements are measured throughout the grant cycle instead of just at the end of the program. She said these methods make it possible to change the program to make it more effective.

Representative Weisz said the intent of the pilot project was to provide funding for the implementation of a regional network not the ongoing cost. He said the cost-savings of the regional network should allow the regional network to be self-sustaining. Senator Lee asked that information on how the regional

network may become self-sustaining be provided at a future meeting.

Ms. Lisa Clute, Executive Officer, First District Health Unit, Minot, suggested the committee receive information from the North Dakota State Association of City and County Health Officials. Senator Lee asked that recommendations for regional network improvements be received from the North Dakota State Association of City and County Health Officials at a future meeting.

Representative Rohr suggested the committee receive information on how the pilot project improved the wellness of the consumers in the regional health network. Senator Lee asked that the information be provided at a future meeting.

Senator Warner suggested the committee receive information regarding the geographic areas of various health programs, including a map of where services are provided. Senator Lee asked the State Department of Health to provide the information at a future meeting.

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

At the request of Chairman Lee, the Legislative Council staff presented a memorandum entitled *Tribal Gaming in North Dakota and Wisconsin*. The Legislative Council staff said in North Dakota five tribes have 10-year gaming compacts with the state which expire on various dates in 2012 and 2013. The compacts require the tribes to pay the actual cost of state regulation, and the 2011-13 biennium appropriation for the Attorney General includes $261,128 of revenue from the tribes to pay for these costs. North Dakota receives no other tribal gaming payments.

The Legislative Council staff said in Wisconsin, Indian gaming compacts require the tribes to submit annual independent financial audits of casino operations to the Department of Administration and to the Legislative Audit Bureau. The audits are confidential, and the revenue data for individual tribal operations may not be publicly disclosed. The first state-tribal gaming compacts, signed in 1991 and 1992, required tribes to jointly provide $350,000 annually to the state as reimbursement for its costs of regulation of Class III gaming under the compacts. Each tribe's share of this amount is calculated annually, based on its relative share of the total amount wagered on tribal gaming statewide during the previous fiscal year. These state payments are still in effect. Each tribe must also directly reimburse the Department of Administration and the Department of Justice for their actual and necessary costs of providing requested services and assistance. Subsequent amendments to the compacts increased payments and were agreed to by the tribes in recognition of an exclusive right to operate Class III gaming without additional competition from other parties in the state. The intended use of the additional state revenue under the amendments was specified, with some variations, in most of the amended compact agreements. Most of the memorandums of understanding list economic development initiatives to benefit the tribes, economic development initiatives in regions around casinos, promotion of tourism within the state, and support of programs and services of the county in which the tribe is located as intended uses of the additional payments. A dispute with the Ho-Chunk Nation resulted in litigation and additional compact amendments in 2008, which included a provision authorizing the tribe to offset a portion of the payments to the state in several ways, including:

- Payments to the counties of $1,000 per acre of land owned by the United States government in trust for the tribe located within each county's jurisdiction in July 2003;
- Amounts paid by the tribe for public works projects that benefit both the tribe and the state; and
- Any additional amounts paid by the tribe for projects that the state and the tribe agree provide a substantial public benefit in the areas of economic development; infrastructure improvement; or public health, welfare, or safety.

The Legislative Council staff said Wisconsin statutes provide that Indian gaming receipts are appropriated to the Department of Justice for gaming law enforcement and to the Department of Administration for general program operations relating to Indian gaming regulation under the compacts and for transfers to other state programs. Indian gaming receipts remaining after these allocations are deposited in the state's general fund. An analysis of the 2011-13 biennial budget of the Department of Administration, Division of Gaming, by the Wisconsin Legislative Fiscal Bureau estimates tribal payments will total approximately $108.4 million during the 2011-13 biennium. After reducing the tribal payments for statutory distributions totaling approximately $27 million each year, including funding for health services, and other adjustments, the Fiscal Bureau estimates Indian gaming receipts deposited in the state's general fund will total $52.6 million during the 2011-13 biennium.

At the request of Chairman Lee, the Legislative Council staff presented a memorandum entitled *Revenues Distributed to the Three Affiliated Tribes*. The Legislative Council staff said revenue from oil and gas gross production tax, oil extraction tax, and tribal highway tax collected by the State Treasurer and distributed to the Three Affiliated Tribes of the Fort Berthold Reservation during fiscal year 2011 totaled $28.6 million, an increase of $26 million from fiscal year 2009 revenue of $2.6 million. Revenue for the first three months of fiscal year 2012 totaled $13.7 million.

At the request of Chairman Lee, the Legislative Council staff presented a memorandum entitled *Property Tax Mills Assessed for Health Districts in 2010*. The Legislative Council staff said property tax mills assessed for health districts in 2010 ranged from 2.01 mills in Cavalier County to the maximum of 5.00 mills in Barnes, Foster, Kidder, Logan, McIntosh, and Stutsman Counties, and revenue ranged from $11,228 in Sioux County to $518,530 in Grand Forks County. In certain city/county and single county health departments, including Burleigh, Cass, LaMoure, Pembina, Ransom, Richland, and Steele Counties, funding for local public health is provided from the county general fund. The Fort Berthold Reservation is served by the following four multicounty health districts:

- First District Health (Minot) - Burke, Bottineau, McHenry, McLean, Renville, Sheridan, and Ward Counties with 2010 health district assessments totaling $875,414.
- Upper Missouri District Health (Williston) - Divide, McKenzie, Mountrail, and Williams Counties with 2010 health district assessments totaling $361,517.
- Custer Health (Mandan) - Grant, Mercer, Morton, Oliver, and Sioux Counties with 2010 health district assessments totaling $545,642.
- Southwestern District Health (Dickinson) - Adams, Billings, Bowman, Dunn, Golden Valley, Hettinger, Slope, and Stark Counties with 2010 health district assessments totaling $493,470.

At the request of Chairman Lee, the Legislative Council staff presented a memorandum entitled *Tribal Liaisons in Arizona and Maine*. The Legislative Council staff said in Arizona, county health departments provide public health services, and the Division of Public Health Services operates within the Arizona Department of Health Services to protect and improve public health through prevention and control of disease and disability. In 2006 the Governor of Arizona issued an executive order that required all executive branch agencies:

- Develop and implement tribal consultation policies to guide their work and interaction with federally recognized tribes in Arizona;
- Designate a staff member to assume responsibility for the agency's implementation of the tribal consultation policy and to act as the principal point of contact for tribal issues; and
- Review tribal consultation policies each year and submit an electronic report to the Governor and the legislature to describe activities resulting from implementation of these policies.

The Legislative Council staff said as a result, tribal liaisons exist in key state agencies, including the Arizona Department of Health Services. A local health liaison strengthens coordination and collaboration between the Department of Health Services and local health departments through communication, advocacy, and consultation.

The Legislative Council staff said Maine has four federally recognized tribes consisting of five tribal communities, and although most of the Native American population of Maine belong to one of these four tribes and reside on tribal lands, many live in towns and cities across the state. The Maine Department of Health and Human Services adopted, for the purpose of coordinating services, eight public health districts in the state. The boundaries are based on population, geographic spread, hospital service areas, and county borders. The Office of Local Public Health was created in 2008 in order to strengthen and improve public health services and infrastructure at the local and district levels and is located within the Maine Center for Disease Control and Prevention, which is an office of the Maine Department of Health and Human Services. The Office of Local Public Health staff collaborate and partner with other Maine Center for Disease Control and Prevention and Department of Health and Human Services programs and divisions, local service providers, municipal governments, and community partners to coordinate and integrate local and districtwide public health activities. The Office of Local Public Health employs a number of district public health liaisons placed throughout the state at district Department of Health and Human Services offices. Liaisons provide public health leadership at the district level and work in close collaboration with other Maine Center for Disease Control and Prevention field staff, including district field epidemiologists, public health nurses, and health inspectors.

The Legislative Council staff said in June 2011 the Maine Legislature approved legislation establishing a ninth district--a tribal district composed of any lands belonging to the Indian tribes in the state and including any member of a tribe living outside of tribal lands. The tribal district is defined as an administrative district established in a memorandum of understanding or legal contract among all Indian tribes in the state. The tribal district's jurisdiction includes tribal lands, tribal health departments or health clinics, and members of the tribes anywhere in the state. The mission of the Tribal Public Health District Unit is to collaborate and provide public health infrastructure by:

- Ensuring the effective delivery of the 10 essential public health services through respect of the people and culture.
- Focusing on health issues by providing health promotion and prevention.
- Collaborating, creating, and sustaining partnerships with federal, state, and local entities.
- Promoting tribalwide collaboration in public health assessment, planning, implementation, and evaluations.

The Legislative Council staff said the legislation requires the tribal district to deliver components of

essential public health services through the tribal district's public health liaisons. Tribal public health liaisons:

- Serve as liaison between the tribal, district, and state public health entities--Tribal Health Directors, Office of Public Health, and as tribal representation for certain district coordinating councils and a public health district.
- Assist with coordinating public health functions at the tribal level and for coordinating districts.
- Produce the quarterly *Maine Intertribal Health Newsletter*.
- Provide educational opportunities to tribal communities in a variety of settings, including groups, and at tribal health fairs on the prevention and management of cardiovascular health and heart health events, blood pressure and cholesterol screenings, and tobacco abuse.
- Participate as members of the Maine Public Health Association.

The Legislative Council staff said the tribal public health district is funded by a combination of tobacco settlement proceeds and state grants. The tribal district is eligible for the same funding opportunities offered to any other district, and the district or a tribe is eligible to partner with any coalition in the Healthy Maine Partnerships for collaborative funding opportunities that are approved by the tribal district coordinating council or a tribal health director.

Representative Weisz suggested the committee receive information regarding how services provided to tribal members not living on the reservations in Maine are paid, and whether the costs are reimbursed or otherwise offset by the tribal public health district.

Ms. Marcy Dickerson, State Supervisor of Assessments, and Director, Property Tax Division, Tax Department, provided information (Appendix J) regarding property tax revenues generated for local public health by nontrust land on the reservations and estimated property tax revenues that would be generated for local public health if all reservation trust lands were taxed. She said parts of six counties--Dunn, McKenzie, McLean, Mercer, Mountrail, and Ward--lay within the boundaries of the Fort Berthold Reservation. She said while trust lands are exempted from ad valorem taxation, some properties on the reservation are subject to property taxation by the counties. She said in 2010 the six counties within the boundaries of the Fort Berthold Reservation collected health district revenue totaling $907,406, of which an estimated $36,436 was collected on taxable property on the reservation. She said to determine the amount of property tax revenue that could be raised by ad valorem taxation of trust lands, it would be necessary to value the trust lands in each county. She said only Dunn County and Mercer County were able to provide an estimate of the taxable value of trust lands located within their counties. She said based on these estimated taxable values and 2010 mill levy rates, health district tax revenues, if levied on trust land, would total an estimated $4,280 in Dunn County and $1,331 in Mercer County.

In response to a question from Representative Weisz, Ms. Dickerson said current mapping technology should make it possible to determine the number of acres of trust land within each county. However, she said, assessment officials are not required to value trust lands. She said one county estimated the value of trust land by applying the average value per acre for noncropland to the number of acres held in trust.

In response to a question from Senator Warner, Ms. Dickerson said the Tax Department does not have information on the value of homes on trust lands. She said their value was not included in the estimates.

Dr. John Baird, Special Populations Section Chief, State Department of Health, provided information (Appendix K) regarding reservations in other states that have been placed in a single public health unit and the challenges and benefits of the change, the delivery of public health services on the other reservations in the state, methods of funding emergency medical services operations on the reservations in the state, and the availability of federal Bureau of Indian Affairs (BIA) funding for placing the Fort Berthold Reservation in a single public health unit. He said there is little information available regarding local public health units on reservations in the United States. He said a 2006 survey by the Centers for Disease Control and Prevention identified 70 tribal codes in 25 states. He said some tribal codes contained no relevant public health provisions, while a limited number contained laws specifically addressing disease control and surveillance authorities. He said three codes provided for the establishment of tribal health boards but did not clearly articulate board authority, while 19 tribal government websites showed evidence of a health department or public health program for which no statutory basis was evident in their respective codes.

Dr. Baird said, unlike the other three reservations in North Dakota which are each contained in a single local public health unit, Fort Berthold is in four local public health units. He said local public health units containing reservations include Custer Health Unit--Standing Rock Reservation, Lake Region District Health Unit--Spirit Lake Reservation, and Rolette County Public Health District--Turtle Mountain Reservation. He said the proximity of Fort Totten to Devils Lake makes it easier for the Lake Region District Health Unit to provide a variety of services. He said Rolette County has a significant Native American population which is represented on the board of health and the county commission.

Dr. Baird said the Fort Berthold Reservation is served by seven nonnative, private/local ambulance services--Watford City, Beulah, Halliday, Killdeer, New Town, Garrison, and Parshall. However, he said, a majority of the calls are responded to by Parshall, Watford City, and New Town. He said increased oil activity in the area has doubled the demand for

ambulance services since 2007. He said funding for ambulance services provided to Native Americans on the reservations are generally paid for by the tribes with Indian Health Service (IHS) funds provided through 638 contracts. He said the ambulance service on the Turtle Mountain Reservation is owned by IHS, while ambulance services on the Spirit Lake Reservation and the Standing Rock Reservation are tribal services funded by 638 contracts.

Dr. Baird said he has been unable to find information regarding the availability of federal BIA funding for a public health unit on the Fort Berthold Reservation but will continue to submit inquiries and notify the committee if he becomes aware of any funding opportunities.

Dr. Baird said a local public health unit on the Fort Berthold Reservation could contract, as needed, for services regionally or from the state and develop partnerships with other reservations.

In response to a question from Senator Warner, Dr. Baird said IHS is required to provide certain services to Native Americans. He said 638 contracts allow the tribes to contract with IHS to provide the services and receive payment from IHS.

In response to a question from Senator Lee, Senator Uglem said work done to date on the state plan for integrated emergency medical services by the Emergency Medical Services Advisory Council does not specifically address emergency medical services on reservations, but the reservations are part of designated service areas.

In response to a question from Senator Lee, Mr. Tom Nehring, Director, Division of Emergency Medical Services and Trauma, State Department of Health, said the primary focus of the Emergency Medical Services Advisory Council has been to establish funding districts throughout the state. He said funding districts will include the reservations.

Ms. Sherry Adams, Executive Officer, Southwestern District Health Unit, Dickinson, provided information (Appendix L) regarding the benefits and challenges of placing the entire Fort Berthold Reservation in a single public health unit. She said the Southwestern District Health Unit serves eight counties in southwestern North Dakota, including Stark, Dunn, Golden Valley, Billings, Bowman, Slope, Adams, and Hettinger. She said the Southwestern District Health Unit serves a portion of the Fort Berthold Reservation in Dunn County, which includes the city of Twin Buttes. She said services provided at Twin Buttes include nursing, environmental health, emergency preparedness, the Pathways to Healthy Lives program (cancer screenings), and Women's Way. She said the challenges of placing the entire Fort Berthold Reservation in a single existing local public health unit include:

- Long travel times - The reservation is divided by a river, and road damage has caused detours resulting in long travel times to reach portions of the reservation.
- Increased oil activity - The local public health units in the western part of the state already face challenges, such as increased workload and difficulty recruiting staff.

Ms. Adams said if the reservation were placed in a single existing public unit, the unit could contract with other area public health units to provide services in the distant areas of the reservation. She said if the entire reservation were designated a separate health unit, the tribal health unit could likewise contract for services it was unable to provide from any of the surrounding public health units.

Ms. Adams provided testimony (Appendix M) for Ms. Javayne Oyloe, Interim Executive Officer, Upper Missouri District Health Unit, Williston, regarding the benefits and challenges of placing the entire Fort Berthold Reservation in a single public health unit. Ms. Adams said the Upper Missouri District Health Unit is a four-county health unit serving Williams County, Divide County, and the reservation counties of Mountrail and McKenzie. She said reservation cities include New Town, Parshall, and Mandaree. She said services the Upper Missouri District Health Unit provides in the Fort Berthold area include health promotion, emergency preparedness, and environmental health collaboration as requested. She said nursing services include family planning; maternal and child health; WIC services; school health services; communicable disease management; tuberculosis testing and medication; immunizations; and adult health, such as Women's Way and senior services. She said the need to work with tribal health services, federal health services, and local health care providers creates a challenging situation for public health decisionmaking. She suggested the Upper Missouri District Health Unit assemble a team of local health care providers to create a plan to improve the chronic and developing health concerns for individuals living in the Fort Berthold area. She said funding would be necessary to develop public health infrastructure and training.

In response to a question from Senator Lee, Ms. Adams said the Southwestern District Health Unit communicates regularly with IHS and provides services not provided by IHS.

In response to a question from Senator Lee, Ms. Adams said the Upper Missouri District Health Unit contains the largest Native American population of the four local public health units serving the reservation, but it would be a challenge for any one of the four local public health units to begin to serve the entire reservation.

Representative Nelson suggested the committee receive information on whether tribal members serve on local public health unit boards. Senator Lee suggested the information be provided to the Legislative Council staff.

Representative Rohr suggested the committee receive information regarding the collaboration of the Upper Missouri District Health Unit with IHS to avoid the duplication of services. Senator Lee suggested

the information be provided to the Legislative Council staff.

In response to a question from Senator Lee, Ms. Adams said collaboration is currently informal, but if the reservation is put into one local public health unit, the collaboration would need to be more formal.

Senator Lee said regional cooperation among the four local public health units may enhance the services provided to the reservation.

Commander Arne Sorenson, United States Public Health Service, Director, Diabetes Prevention Program, Mandan, Hidatsa, and Arikara (MHA) Nation, provided information (Appendix N) regarding the status of a proposed governance model for a local public health unit that includes the entire reservation. He said the Fort Berthold Reservation is part of the Aberdeen area of IHS. He said the MHA Nation Health Authority was created to address governing body requirements of the health care systems on the reservation. He said the authority includes representation from various health care disciplines and could serve as the primary accounting and finance, audit, legal, and personnel management authority for a proposed public health unit. He said the authority would report directly to the MHA Nation Tribal Business Council.

Commander Sorenson said given recent oil activity, the 2010 census population of the Fort Berthold Reservation of 6,341 is likely lower than the actual population. He said the census indicates 4,556 Native American residents. He said "man camps" have substantially increased the number of nonnative residents on the reservation, and the increased oil activity has increased the need for injury prevention and emergency response services. He said reaching tribal members within the boundaries of the reservation would be less of an obstacle if the Fort Berthold Reservation were designated a single public health unit. He said improved communication between state and tribal governments would result in better disease monitoring and immunization rates. He said currently data is fragmented, making it difficult to eradicate disease and illness.

Commander Sorenson said while a governance structure exists to support a public health unit, challenges include geography, energy-impacted roads, jurisdiction, increased staffing, and funding.

In response to a question from Senator Lee, Commander Sorenson said the infrastructure exists in the MHA Nation Health Authority to operate a tribal public health unit, but adequate funding will be a major obstacle. He said the tribe will continue to discuss possible funding sources.

In response to a question from Senator Mathern, Commander Sorenson said IHS has proposed a chronic care model for the provision of care which includes a public health component.

Senator Lee suggested the committee receive information from a representative of the Wilson Health Planning Cooperative regarding a report on the disparities between Native American and nonnative health care.

Senator Mathern suggested the University of North Dakota (UND) School of Medicine and Health Sciences provide information at a future meeting regarding services or education resources it has available that may benefit Fort Berthold Reservation and the local public health units in that region.

In response to a question from Representative Weisz, Senator Lee said options for addressing public health services on the Fort Berthold Reservation include:

- Setting up a separate public health unit to include only the reservation;
- Assigning the entire reservation to an existing public health unit; and
- Setting up a task force to develop a memorandum of understanding between the public health units that currently serve parts of the reservation to provide services.

Senator Lee said even if the entire reservation were set up as a separate health unit, the challenges of geography and oil-impacted roads will still exist.

Senator Kilzer suggested the committee receive information regarding the history of public health unit boundaries.

Representative Nelson said the regional public health network concept might be useful in this area and provide efficiencies where four public health units are serving the reservation. However, he said, the tribe needs to be represented to ensure their needs are met.

## STUDY OF THE FUTURE OF HEALTH CARE DELIVERY IN THE STATE AND THE ABILITY OF THE SCHOOL OF MEDICINE TO MEET THE HEALTH CARE NEEDS OF THE STATE

Mr. Jerry Jurena, President, North Dakota Hospital Association, provided information (Appendix O) regarding health care needs, options to address the health care needs, the future of the delivery of health care services--especially in rural areas, the role of technological innovations and telemedicine in providing health care services, and the effects of the level of Medicaid reimbursement on the recruitment and retention of physicians in the state. He said areas of concern include reimbursement, professional staffing, and regulations that add to the cost of health care. He said there is a shortage of family practice, internal medicine, and mental health physicians in the state that continues to affect access to health care. He said the most pressing need is to increase residencies in these professions and create incentives to keep physicians in the state after completing their residencies. He said the influx of people in the western part of the state has compounded the need for primary care physicians and mental health specialists. He said increasing federal and state regulations have increased the need for staff that is

not providing patient care. Regarding the future of the delivery of health care services in the state, he suggested creating opportunities or options for critical access hospitals to use mid-level practitioners to provide primary care in rural areas and providing incentives for tertiary hospitals to expand the use of telemedicine. He said the level of Medicare, Medicaid, and commercial insurance reimbursement is critical. He said hospitals contract with physicians based on level of services, volume, and past reimbursements. If reimbursements are reduced, he said, the hospital is at risk because it is unable to cover costs and attract physicians.

Senator Lee said under Medicaid nurse practitioners may be designated as primary care providers.

Senator Lee said currently there are approximately 63,000 individuals eligible for Medicaid in the state, and the number is expected to increase by an estimated 33,000 in 2014, when eligibility guidelines are changed to increase the poverty level and include childless adults, bringing the total number of individuals eligible for Medicaid to an estimated 96,000.

Ms. Courtney Koebele, Executive Director, North Dakota Medical Association, provided information (Appendix P) regarding health care needs, options to address the health care needs, the future of the delivery of health care services--especially in rural areas, the role of technological innovations and telemedicine in providing health care services, and the effects of the level of Medicaid reimbursement on the recruitment and retention of physicians in the state. She said the need for physicians in North Dakota is affected by the state's geographic location and lack of adequate resources. She said other significant influences include demographics, physician practice arrangements, an aging patient population, decreasing payment for services, and increasing practice costs. She said there are 1,537 regular active physicians in the state, not including retired physicians, residents, and medical students. She said this number represents an 18 percent increase since 2005. She said 84 percent of all physicians in the state, or 1,291 physicians, practice in the four urban areas and 16 percent, or 246 physicians, practice in rural areas. She said of the 1,099 physicians affiliated or employed by the six major health systems, 91 percent practice in urban locations and 9 percent practice in rural locations. She said 36 percent of the physicians in the state, or 557 physicians, are primary care physicians, including family practice, general medicine, internal medicine, and pediatrics. She said nationally, as of December 2009, 15 percent of all physicians were in family practice, 28 percent were in internal medicine, and 13 percent were in pediatrics for a total of 56 percent of all physicians providing primary care services. She said statewide, 69 percent of primary care physicians practice in urban areas, and 31 percent practice in rural areas. She said nationally, 37 percent of all physicians are younger than the age of 45, and in North Dakota 54 percent of primary care physicians are age 50 or younger. In addition, she provided information regarding the number of physicians in the state by city and county.

Ms. Koebele said since its inception, telepharmacy has made it possible for 40,000 rural citizens to have their pharmacy services restored, retained, or established. She said audio and video computer links allow pharmacists to communicate face-to-face in real time with registered pharmacy technicians at remote sites.

Ms. Koebele said to prepare for future health care workforce needs, the state must increase the retention of the School of Medicine graduates; increase the class sizes of medical students, health science students, and residents; and continue to maintain a practice environment that facilitates recruitment and encourages physicians to stay in the state. She said the North Dakota Medical Association recommends:

- Enhancing physician recruitment and retention by addressing insufficient state investment in health care infrastructure and resources.
- Improving funding mechanisms and incentives to create more residency opportunities in state, increasing financial support of the physician loan repayment program, and exploring other options for physician recruitment and retention.
- Improving quality of care, including appropriate insurance benefits, patient health care education, technology, and care coordination.
- Maintaining payment levels for physicians and hospitals.
- Medical education and training, including the expansion of allied health, medical and residency programs, and policies that support the acceptance of highly qualified residents into medical school.

In response to a question from Senator Lee, Ms. Koebele said physicians graduating from international medical schools generally do not have student loans, so the loan repayment program is not an incentive for them. She said the state needs to explore other incentives, such as bonus payments in lieu of the loan payments.

In response to a question from Representative Nelson, Dr. Joshua Wynne, Dean, University of North Dakota School of Medicine and Health Sciences, Grand Forks, said the current medical school loan program is underutilized. He said the School of Medicine RuralMed program is modeled after the Indians into Medicine (INMED) program and provides the full cost of medical school if the student agrees to practice in family medicine in rural North Dakota. Initially, he said, the offer was made to first-year students, but most students are not ready to make the commitment in the first year of medical school. He said the program was modified to make the program available to students in subsequent years. He said the commitment is to serve in a rural setting for five years, and currently the medical school has filled seven of the nine contracts available. He said

residency training in the state is critical, because physicians are likely to settle in the area in which they complete their residency. He said expanding the number of residencies in the state is essential to increase the number of graduates that remain in the state.

In response to a question from Senator Uglem, Dr. Wynne said North Dakota students are given first priority when admitting students into the medical school. He said over time, the average medical school class consists of 80 percent North Dakota students, 10 percent Minnesota students, and 10 percent Western Interstate Commission for Higher Education (WICHE) students. He said these averages do not include the INMED students who are federally funded.

In response to a question from Senator Lee, Dr. Wynne said recruiting professionals to the state will require partnerships, because communities are recruiting physicians and their families.

Ms. Janis Cheney, State Director, AARP in North Dakota, provided information (Appendix Q) regarding health care needs, options to address the health care needs, the future of the delivery of health care services--especially in rural areas, and the role of technological innovations and telemedicine in providing health care services in the state. She said 34 percent of North Dakota's population is over the age of 50, and 15 percent is age 65 and older. She said North Dakota had 94,704 Medicare enrollees in 2009 who spent an average of $4,900 or 23.7 percent of their income on out-of-pocket health care costs. She said health care costs can be reduced if individuals are able to stay safely in their homes as they age. She said affordability and access can be improved by balancing resources available for nursing home care and home and community-based services. She said a federal grant is available to assist states in moving toward serving more individuals through home and community-based services. She said establishing a consumer-driven health insurance exchange will improve access to health care. She said the Aging and Disability Resource-LINK is a model for educating consumers and assisting them in making the best decisions regarding long-term care.

Dr. Gary Hart, Director, Center for Rural Health, University of North Dakota School of Medicine and Health Sciences, Grand Forks, provided information (Appendix R) regarding health care needs, options to address the health care needs, the future of the delivery of health care services--especially in rural areas, and the role of technological innovations and telemedicine in providing health care services in the state. He said the United Health Foundation 2010 national health ranking for North Dakota is No. 16, a decrease from No. 2 in 1990. He said the national ranking for geographic disparity in North Dakota is 46 out of 50 states, indicating there is great disparity regarding health measures within the state. He provided information regarding the number of various selected health care providers in the state. He said although the information indicates a certain number of health care providers, nurse practitioners, physician assistants, and physicians, some do not work full time, and so the actual number of FTE positions is less. He said in 2009 the 213 active patient care physicians for every 100,000 people in North Dakota was close to the national state median of 214 per 100,000; however, the physicians in North Dakota must serve larger geographic areas and a population that is much older than the national average. In addition, he said, physicians in the state are not evenly dispersed. He said three things affect where physicians practice--where they grew up, where they attended medical school, and where they completed their residency. He said while North Dakota has a high number of medical students for every 100,000 people (38.8) relative to the national state median (24.6), the number of residents for every 100,000 people (18.1) is less than the national state median (26.8). He said in North Dakota the percentage of students that practice in the state after attending the School of Medicine and completing their residency in the state is 62.9 percent and compares to the national state median of 66.5 percent.

Dr. Hart said North Dakota is also experiencing shortages in specialized care physicians, including pediatricians and obstetricians and gynecologists. He said given the small statewide population, providing residencies in these areas to increase the likelihood of filling these positions is not possible. He said a large population is necessary to provide the cases and clinician educators necessary to train a resident. Of the direct patient care physicians in the state in 2011, he said, 18 percent attended only medical school in the state, 8 percent completed only a residency in the state, and 13 percent attended medical school and completed a residency in the state. He said 61 percent neither attended medical school nor completed a residency in the state. He said 31 percent of the physicians in North Dakota attended medical school in the state, while 24 percent attended medical school in the central states, and 23 percent graduated from an international medical school program. He said India produces more physicians practicing in North Dakota (7 percent) than any other state or country. He said policies that discourage physicians from other countries could compound the shortage of providers. He said 32 percent of the School of Medicine graduates stay in North Dakota, while 21 percent move to Minnesota, and the remaining 47 percent go to various other states. He said states that import more physicians from North Dakota than export physicians to North Dakota include Minnesota, Wisconsin, South Dakota, Michigan, Arizona, Washington, Colorado, Oregon, Florida, Ohio, Oklahoma, and California. He said physicians in certain specialties are more likely to leave the state. He said the state's most favorable retention rate is primary care physicians. He said 61 percent of the School of Medicine graduates in primary care stay in North Dakota. He said

41 percent of the School of Medicine graduates are in primary care, and that is among the highest percentages in the nation.

Dr. Hart said options to address the health care needs in the state include:

- Increase the number of physician residencies in the state, especially primary care, and extend the residencies across the state.
- Increase the number of all health professionals trained in the state and hold programs accountable by requiring them to report results.
- Continue and expand programs to encourage North Dakota students to pursue careers in health care.
- Provide a curriculum that best serves the state's population, including geriatric training for the state's aging population.
- Assure medical care is of the highest quality and access is adequate.
- Perform quality health workforce analyses upon which to base public policy.

Senator Lee suggested the committee receive information regarding the criteria responsible for the decrease in the United Health Foundation ranking for the state of North Dakota between 1990 and 2010.

In response to a question from Senator Lee, Dr. Wynne said the School of Medicine issued a request for proposal for the nine residency slots approved by the Legislative Assembly in 2011. He said the medical school received six responses, including an obstetrics and gynecology residency proposal. He said the state currently does not have an obstetrics and gynecology residency.

Ms. Maggie Anderson, Director, Medical Services Division, Department of Human Services, provided information (Appendix S) regarding the ability of the program of all-inclusive care for the elderly (PACE) to provide care for the elderly in rural communities. She said PACE is a capitated benefit program that provides a comprehensive services delivery system. She said the delivery system includes all needed preventative, primary, acute, and long-term care services so that individuals can continue to live at home. She said PACE services include all Medicaid and Medicare services. She said a team of professionals assess the participant's needs, develop a care plan, and deliver all of the services in either the home, adult day care, or inpatient setting. She said while PACE would be allowed to operate in any location, the ability to offer the comprehensive service delivery system may be challenging from both a service availability and cost perspective. She said PACE is required to provide all services offered through both Medicare and Medicaid, including transportation, and is also required to have a congregate type of gathering location. These requirements make it necessary to have enough participants to make the program financially viable. She said a model prepared for a rural area could work with a partnership of providers. She said the model may need a waiver from the Centers for Medicare and Medicaid Services of some services and would likely use telemedicine to provide other services.

In response to a question from Senator Warner, Ms. Anderson said PACE would have to provide hospice if it was needed. She said the PACE care plan is updated occasionally to include the needs of the participant as they arise.

In response to a question from Senator Kilzer, Ms. Anderson said the service payments for elderly and disabled (SPED) program is funded by the state (95 percent) and the county (5 percent), but it is not as comprehensive as PACE. She said functional and financial eligibility is more restrictive for PACE than it is for the SPED program.

In response to a question from Senator Kilzer, Ms. Anderson said since its inception, PACE has served 97 participants and is currently serving 62 participants. She later provided information to the committee indicating the number of SPED clients for September 2011 totaled 1,230, and the number of expanded SPED clients for September 2011 totaled 134.

Mr. Duane Houdek, Executive Secretary, State Board of Medical Examiners, provided information (Appendix T) regarding licensure issues related to innovative health care delivery methods, including telemedicine. He said the board has licensed approximately 3,400 professionals in the state, of which 1,800 professionals live outside of the state. He said each year the board issues between 300 and 350 new licenses, of which 150 to 175 licenses are to physicians that will reside out of state but will practice in North Dakota. He said to date in 2011 the board has issued 60 out-of-state licenses for the express purpose of telemedicine, compared to 30 licenses in 2010 and 44 licenses in 2009. He said the list of telemedicine services for which out-of-state licenses have been issued continues to expand and includes radiology, pathology, pediatrics, neurology, otolaryngology, psychiatry, emergency medicine, critical care medicine, internal medicine, pulmonary medicine, and cardiology. He said rules are modified as technology advances. He said nonresident physicians practicing telemedicine in the state should receive no less scrutiny and supervision than resident physicians. He said while the board believes a strenuous licensing process helps protect the public from poor medical practice, it does not unduly burden or prevent any qualified physician to practice telemedicine in the state.

In response to a question from Senator Mathern, Mr. Houdek said there is not a separate certificate for practicing telemedicine.

Ms. June Herman, Regional Vice President of Advocacy, American Heart Association, provided information (Appendix U) regarding cardiovascular disease, stroke, obesity, and smoking. She said many of these health-related risks can be addressed through chronic disease management programs existing in the state. She said there are 35 cardiologists in the state and one-third are over the

age of 60. She provided information (Appendix V) related to a report on an assessment of challenges facing emergency medical services in rural North Dakota. She said the value of volunteer services in rural emergency medical services totals an estimated $31 million per year in North Dakota, but the number of volunteers is declining. She said increasingly, rural ambulance services must provide incentives to recruit and retain volunteers.

Senator Lee suggested the committee receive a report from the Emergency Medical Services Advisory Council regarding its work on emergency medical services in the state.

Ms. Cyndy Skorick, Vice President for Clinic Operations, Sanford Health, Fargo, testified in support of health care delivery models that are integrated for physical health and behavioral health needs, including mental illness and substance abuse (Appendix W). She said ideal delivery models include a patient-centered medical home with integrated behavioral health specialists for consultation, assessment, and intervention. She said medical home models improve health outcomes for chronic disease, reduce readmissions to hospitals, and assist consumers to navigate the health care delivery system. She said pilot projects that support innovation and seamless health care improve access to care.

Dr. L. Read Sulik, Child and Adolescent Psychiatrist, Senior Vice President of Behavioral Health Services, Sanford Health, Fargo, provided information regarding the integration of mental illness and substance abuse treatment into the care provided by primary care physicians. He said a 2008 study indicated 80 percent of psychotropic medications in North Dakota are prescribed by nonpsychiatrists. He said while many primary care physicians are prescribing mental health medication, they may seek support from psychiatrists and psychologists. He said a shortage of psychiatrists and psychologists makes this difficult. He said the high rate at which children, especially children on Medicaid, are prescribed mental health medications is a concern. He said in Minnesota primary care physicians have access to expert consultations prior to prescribing mental health medications to children on Medicaid.

Mr. Tom Regan, member, Board of Directors, Mental Health America of North Dakota, expressed concern regarding the lack of a formal comprehensive plan to address the behavioral health needs of individuals in the state (Appendix X). He said a comprehensive plan that includes the expansion of public and private relationships and solutions, such as increasing the use of telemedicine, integrating primary and behavioral health care, and increasing attention to behavioral health in the curriculum of the School of Medicine, should be developed.

Senator Mathern suggested the committee receive a report from the Department of Human Services regarding its statewide behavioral health plan.

## OTHER COMMITTEE RESPONSIBILITIES

Ms. Kim Mertz, Director, Family Health Division, State Department of Health, provided a report (Appendix Y) 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 North Dakota Century Code Section 14-02.1-02.1 requires the State Department of Health to develop printed information as follows:

- Geographically indexed materials designed to inform women of public and private agencies and services available to assist them through pregnancy, upon childbirth, and while the child is dependent, including adoption agencies;
- Materials, published in booklet format, designed to inform the woman of the probable anatomical and physiological characteristics of the unborn child at certain stages of pregnancy;
- Materials that include information on the support obligations of the father; and
- Materials that contain objective information describing the various surgical and drug-induced methods of abortion, including the immediate and long-term medical risks.

Ms. Mertz said the department has previously produced and distributed the information related to public and private services available and the characteristics of the unborn child. She said the department has determined it would be more efficient to combine the materials related to the characteristics of the unborn child, the support obligations of the father, and the various methods of abortion and their effects into one publication. She said due to the volume of information related to available public and private services, this information will be produced in a separate document and referenced in the combined publication. She said all printed material is currently in draft form, and the department anticipates distribution in January 2012. She provided an inventory (Appendix Z) of materials as required in Section 15 of House Bill No. 1297.

Ms. Mertz said pursuant to Section 14-02.1-02.2, an abortion compliance report and an abortion data report (Appendix AA) must be filed for each abortion that takes place in the state. She said the existing data report was redesigned to include adverse event data collection (question No. 18 on the form), and the compliance report is a new report. She said the department began using both forms on August 1, 2011; however, a lawsuit has been filed objecting to the adverse event data collection and to several questions on the compliance report. She said the plaintiff in the lawsuit has continued to submit the reports but has not provided the information that is subject to the lawsuit. She said the Division of Vital Records is required to produce an annual report on abortions, and the report is on the State Department of Health website.

Mr. Howard Anderson, Chairman, Health Care Data Committee, State Health Council, provided information (Appendix BB) regarding the restructuring of health-related data. He said the Health Care Data Committee legislation was originally approved in 1987. He said the purpose of the legislation was to make public the information necessary for health care provider price comparisons. He provided copies (Appendix CC) of prior reports issued by the Health Care Data Committee. He said since the legislation was passed, Medicare began charging for data, and there has been a reduction in the information available. He said costs associated with the compilation and transmission of the data to the committee and concerns regarding the comparability of the health care service make gathering the data unpopular with health care providers. However, he said, other health care data currently available at the State Department of Health could be used for medical research in the new Masters of Public Health program at the state's two universities. He said the Health Care Data Committee should either work to increase the data provided under the existing law or consider legislation to change the data collected and distributed by the committee.

In response to a question from Senator Warner, Mr. Anderson said federal grants require certain data collection and reporting. He said technology has made it possible to collect more data. He said individuals are assigned an identifier, and all data is collected under that identity. He said information collected from birth to death provides valuable insight into what affects the health of an individual.

In response to a question from Representative Rohr, Mr. Anderson said when the Legislative Assembly identified the mission of the Health Care Data Committee in 1987, more individuals were personally responsible for the cost of health care. He said the ability of an individual to compare fees for various services was more beneficial. He said currently more health care costs are paid by third-party payers that already have access to provider rates.

Senator Lee suggested the Health Care Data Committee and the State Department of Health review the laws related to the Health Care Data Committee and bring recommendations to the Health Services Committee for legislative changes that would make it possible to use data collected by the State Department of Health.

## COMMITTEE DISCUSSION AND STAFF DIRECTIVES

Chairman Lee said the next committee meeting will be Tuesday, January 10, 2012. She said a spring meeting may be scheduled in April 2012.

No further business appearing, Chairman Lee adjourned the meeting at 4:40 p.m.

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Sheila M. Sandness
Fiscal Analyst

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Allen H. Knudson
Legislative Budget Analyst and Auditor

ATTACH:29