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**AGENCY OVERVIEW****301 ND Department of Health**

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**Date:** 12/07/2012**Time:** 13:50:02**Statutory Authority**

North Dakota Century Code Titles 19, 23, 25 and 61.

**Agency Description**

- Works closely with the U.S. Environmental Protection Agency (EPA) to safeguard the quality of North Dakota's air, land and water resources through permitting, inspecting, sampling, analytical services and monitoring activities.
- Enables communities to promote healthy behaviors that prevent injury, illness and disease through various state and federal programs.
- Manages programs leading to the detection, diagnosis, analysis, reporting, intervention/referral and follow-up of diseases.
- Provides leadership and oversight for public health and medical emergency preparedness and response efforts in the state.
- Regulates and supports food and lodging establishments, emergency medical services and healthcare facilities including hospitals, home health agencies, nursing facilities, basic care facilities, intermediate care facilities for the mentally retarded, and clinical laboratory services.

**Agency Mission Statement**

To protect and enhance the health and safety of all North Dakotans and the environment in which we live.

GOALS: To accomplish our mission, the North Dakota Department of Health is committed to:

- Improving the health status of the people of North Dakota.
- Improving access to and delivery of quality health care and wellness services.
- Preserving and improving the quality of the environment.
- Promoting a state of emergency readiness and response.
- Enhancing capabilities to manage challenges such as oil impact, flooding and other emerging activities.
- Achieving strategic outcomes using all available resources.
- Strengthening and sustaining stakeholder engagement and collaboration.

**Agency Performance Measures**

Agency performance measures are included in each program narrative. They were developed through the Department's strategic planning process. Targets were typically established based on historical data and U.S. averages. Key measures are those addressing tobacco use, obesity, clean air and drinking water, immunization, emergency preparedness, and access to quality health care.

**Major Accomplishments**

1. Facilitated emergency response during the 2011 flood.
2. Received more than 8,000 calls to the Tobacco Quitline in FY 2011. Maintained more than 1,500 active accounts on QuitNet.
3. Received Gold Certification of the North Dakota Cancer Registry in 2011 and 2012 for data accuracy, completeness and timeliness of reporting.
4. Screened 62 North Dakotans as part of the state funded colorectal cancer screening initiative.
5. Worked with the North Dakota Cancer Coalition to revise the North Dakota Cancer Plan for 2011-16.
6. Exceeded the *Women's Way* Program screening goal of 3,200 women.
7. Developed and implemented a nurse aide registry.
8. Established a statewide worksite wellness program.
9. Completed enrollment of 35 out of 42 eligible hospitals in the State Stroke Registry Program.
10. Maintained a 90.0 percent rate of compliance in the air, waste, water discharge and public water supply programs.
11. Published "Chronic Disease in North Dakota: A Status Report for 2010".
12. Implemented a local public health regional network pilot project.
13. Implemented new Emergency Medical Services Grant Program.

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14. Obligated more than \$620,000 for projects in the Suicide Prevention Program.
15. Placed 26 health professionals in shortage areas.
16. Collaborated to secure a \$4.9 million grant for a mobile simulator training program.
17. Participated in implementation of the ST-Elevation Myocardial Infarction (STEMI) project.
18. Promulgated new state food code regulations.
19. Achieved a 77.6 percent primary series vaccination rate.
20. Investigated three foodborne outbreaks resulting in over 100 people reporting illness.

**Future Critical Issues**

- Enhance and maintain critical disease investigation and control infrastructure to address health care-associated infections; antibiotic resistance; food safety issues, including foodborne illness investigations; sexually transmitted diseases; and tuberculosis.
- Enhance capacity to handle increasing number of forensic examinations.
- Resources to assess and address environmental impacts (air, water, and waste), availability of primary care and infectious disease burden associated with increased energy development in western North Dakota.
- Remain current with increased plan reviews, pre-operational inspections, complaint follow-ups and routine inspections of new food and lodging establishments as a result of the increased oil activity.
- Availability of public health prevention and health-care programs to address disparate populations.
- Access to oral health services for the low-income and Medicaid populations.
- Lack of health services available to children in child-care and school settings.
- Addressing the need for a statewide, school-based dental sealant program for children.
- Resources to help North Dakotans make healthy choices to help prevent cancer, heart disease, obesity and Type 2 diabetes.
- Sufficient funding to develop and implement programs to reduce unintentional injuries, the leading cause of death to North Dakotans ages 1 through 44 from 2007-2011.
- Implementation of electronic benefit transfer (EBT) in the WIC Program.
- Ability to maintain staff in light of increases in the energy industry and competition with the market in general for a variety of positions including nurses, scientists, engineers, epidemiologists, and information technology.
- Public health workforce shortages.
- Resources to address emerging environmental protection regulations and implementation of associated federal and state laws.
- Level or reduced funding in most federal grants and increasing inflationary costs, leaving less money for operation of programs and funding of local public health service delivery.
- Funding strategies for immunizations provided at local public health units and consequences of federal vaccine no longer being available for insured children.
- Ability to increase electronic data exchange between electronic medical records and the North Dakota Immunization Information System and improve the quality of the data at the same time.
- Need for increased electronic laboratory reporting in North Dakota to improve timely disease reporting.

**REQUEST SUMMARY**301 ND Department of Health  
Biennium: 2013-2015

Bill#: SB2004

Date: 12/07/2012

Time: 13:50:02

Description	Expenditures 2009-2011 Biennium	Present Budget 2011-2013	Budget Request Change	Requested Budget 2013-2015 Biennium	Optional Budget Request
<b>By Major Program</b>					
Administrative Support	9,176,161	10,873,018	1,165,411	12,038,429	10,505,084
Medical Services	11,765,942	34,024,362	(18,562,548)	15,461,814	1,081,442
Health Resources	7,206,807	8,655,103	328,534	8,983,637	250,063
Community Health	53,309,872	64,521,624	270,705	64,792,329	2,345,586
Environmental Health	53,120,992	52,993,754	(6,203,488)	46,790,266	3,706,767
Emergency Preparedness and Response	21,165,877	18,696,444	(1,216,934)	17,479,510	8,169,600
Special Populations	4,084,582	5,062,599	46,036	5,108,635	2,002,121
<b>Total Major Program</b>	<b>159,830,233</b>	<b>194,826,904</b>	<b>(24,172,284)</b>	<b>170,654,620</b>	<b>28,060,663</b>
<b>By Line Item</b>					
Salaries and Wages	42,236,883	49,351,659	1,769,766	51,121,425	6,803,430
Operating Expenses	26,570,760	50,272,030	(15,198,036)	35,073,994	10,421,233
Capital Assets	1,593,821	1,998,073	(45,785)	1,952,288	734,000
Grants	55,528,571	58,528,038	(6,205,509)	52,322,529	9,947,000
Tobacco Prevention & Control	5,308,174	6,162,396	(637,873)	5,524,523	0
WIC Food Payments	17,915,331	24,158,109	501,752	24,659,861	0
Contingent Appropriation	0	864,371	(864,371)	0	0
Federal Stimulus Funds	10,676,693	3,492,228	(3,492,228)	0	155,000
<b>Total Line Items</b>	<b>159,830,233</b>	<b>194,826,904</b>	<b>(24,172,284)</b>	<b>170,654,620</b>	<b>28,060,663</b>
<b>By Funding Source</b>					
General Fund	24,739,222	33,878,151	(301,089)	33,577,062	22,626,035
Federal Funds	119,277,392	126,288,123	(5,456,210)	120,831,913	865,586
Special Funds	15,813,619	34,660,630	(18,414,985)	16,245,645	4,569,042
<b>Total Funding Source</b>	<b>159,830,233</b>	<b>194,826,904</b>	<b>(24,172,284)</b>	<b>170,654,620</b>	<b>28,060,663</b>
<b>Total FTE</b>	<b>343.50</b>	<b>344.00</b>	<b>0.00</b>	<b>344.00</b>	<b>14.00</b>

**REQUEST DETAIL**301 ND Department of Health  
Biennium: 2013-2015

Bill#: SB2004

Date: 12/07/2012

Time: 13:50:02

Description	Expenditures 2009-2011 Biennium	Present Budget 2011-2013	Budget Request Change	Requested Budget 2013-2015 Biennium	Optional Budget Request
<b>Salaries and Wages</b>					
Salaries - Permanent	29,665,824	33,674,579	377,460	34,052,039	1,515,134
Salaries - Other	0	0	0	0	3,650,000
Temporary Salaries	1,296,026	2,009,506	991,885	3,001,391	1,043,408
Fringe Benefits	11,275,033	13,667,574	400,421	14,067,995	594,888
Salary Increase	0	0	0	0	0
Benefit Increase	0	0	0	0	0
<b>Total</b>	<b>42,236,883</b>	<b>49,351,659</b>	<b>1,769,766</b>	<b>51,121,425</b>	<b>6,803,430</b>

**Salaries and Wages**

General Fund	11,758,920	14,515,638	55,417	14,571,055	5,518,929
Federal Funds	25,238,105	30,376,838	1,164,809	31,541,647	912,500
Special Funds	5,239,858	4,459,183	549,540	5,008,723	372,001
<b>Total</b>	<b>42,236,883</b>	<b>49,351,659</b>	<b>1,769,766</b>	<b>51,121,425</b>	<b>6,803,430</b>

**Operating Expenses**

Travel	1,995,831	2,528,380	522,097	3,050,477	172,675
Supplies - IT Software	614,127	408,677	106,019	514,696	415,750
Supply/Material-Professional	1,092,853	1,201,226	184,093	1,385,319	5,400
Food and Clothing	151,989	194,810	9,761	204,571	0
Bldg, Ground, Maintenance	386,560	219,402	14,369	233,771	0
Miscellaneous Supplies	7,436	6,870	(122)	6,748	168,000
Office Supplies	295,284	305,723	23,429	329,152	9,225
Postage	550,806	544,109	26,409	570,518	12,850
Printing	489,727	515,055	38,971	554,026	17,000
IT Equip Under \$5,000	318,470	330,395	8,975	339,370	20,750
Other Equip Under \$5,000	89,403	100,728	(71,028)	29,700	8,000
Office Equip & Furn Supplies	164,300	49,991	(14,041)	35,950	28,000
Utilities	500,358	474,872	25,522	500,394	0
Insurance	68,660	96,271	28	96,299	84,000
Rentals/Leases-Equip & Other	61,866	83,123	(12,817)	70,306	0
Rentals/Leases - Bldg/Land	1,529,194	1,712,713	77,342	1,790,055	81,000
Repairs	932,342	724,502	50,045	774,547	325,500
IT - Data Processing	1,264,742	1,236,426	218,839	1,455,265	105,199
IT - Communications	594,862	635,030	11,597	646,627	21,588
IT Contractual Srvcs and Rprs	1,353,383	2,006,625	257,025	2,263,650	1,321,764
Professional Development	495,011	537,156	41,628	578,784	115,900
Operating Fees and Services	364,351	619,801	30,896	650,697	40,194
Fees - Professional Services	7,238,029	10,335,588	2,637,988	12,973,576	7,166,250
Medical, Dental and Optical	6,011,176	25,404,557	(19,385,061)	6,019,496	302,188

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<b>Total</b>	<b>26,570,760</b>	<b>50,272,030</b>	<b>(15,198,036)</b>	<b>35,073,994</b>	<b>10,421,233</b>
<b>Operating Expenses</b>					
General Fund	4,502,474	5,762,722	620,994	6,383,716	6,474,106
Federal Funds	19,817,785	21,612,689	1,896,184	23,508,873	(201,914)
Special Funds	2,250,501	22,896,619	(17,715,214)	5,181,405	4,149,041
<b>Total</b>	<b>26,570,760</b>	<b>50,272,030</b>	<b>(15,198,036)</b>	<b>35,073,994</b>	<b>10,421,233</b>
<b>Capital Assets</b>					
Other Capital Payments	645,205	706,983	(64,295)	642,688	17,000
Extraordinary Repairs	71,953	316,329	3,021	319,350	0
Equipment Over \$5000	854,282	858,761	98,489	957,250	717,000
IT Equip/Sftware Over \$5000	22,381	116,000	(83,000)	33,000	0
<b>Total</b>	<b>1,593,821</b>	<b>1,998,073</b>	<b>(45,785)</b>	<b>1,952,288</b>	<b>734,000</b>
<b>Capital Assets</b>					
General Fund	340,750	357,220	205,688	562,908	686,000
Federal Funds	867,544	1,407,020	(297,803)	1,109,217	0
Special Funds	385,527	233,833	46,330	280,163	48,000
<b>Total</b>	<b>1,593,821</b>	<b>1,998,073</b>	<b>(45,785)</b>	<b>1,952,288</b>	<b>734,000</b>
<b>Grants</b>					
Grants, Benefits & Claims	53,562,470	57,545,800	(5,734,202)	51,811,598	9,947,000
Transfers Out	1,966,101	982,238	(471,307)	510,931	0
<b>Total</b>	<b>55,528,571</b>	<b>58,528,038</b>	<b>(6,205,509)</b>	<b>52,322,529</b>	<b>9,947,000</b>
<b>Grants</b>					
General Fund	8,137,078	12,878,200	(818,817)	12,059,383	9,947,000
Federal Funds	42,537,191	42,589,338	(4,881,192)	37,708,146	0
Special Funds	4,854,302	3,060,500	(505,500)	2,555,000	0
<b>Total</b>	<b>55,528,571</b>	<b>58,528,038</b>	<b>(6,205,509)</b>	<b>52,322,529</b>	<b>9,947,000</b>
<b>Tobacco Prevention &amp; Control</b>					
Salaries - Permanent	623,336	653,065	(72,529)	580,536	0
Temporary Salaries	37,959	25,000	(25,000)	0	0
Fringe Benefits	228,149	271,598	(32,090)	239,508	0
Travel	43,081	42,511	(13,265)	29,246	0
Supplies - IT Software	21,298	13,935	697	14,632	0
Supply/Material-Professional	2,531	1,576	79	1,655	0

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Description	Expenditures 2009-2011 Biennium	Present Budget 2011-2013	Budget Request Change	Requested Budget 2013-2015 Biennium	Optional Budget Request
Office Supplies	5,006	5,369	163	5,532	0
Postage	4,877	6,000	300	6,300	0
Printing	31,200	41,016	1,249	42,265	0
IT Equip Under \$5,000	9,424	5,100	900	6,000	0
Office Equip & Furn Supplies	14,178	25,180	(25,180)	0	0
Rentals/Leases-Equip & Other	869	1,512	0	1,512	0
Rentals/Leases - Bldg/Land	20,632	15,757	1,670	17,427	0
Repairs	247	330	17	347	0
Salary Increase	0	0	0	0	0
Benefit Increase	0	0	0	0	0
IT - Data Processing	23,468	21,768	1,794	23,562	0
IT - Communications	10,384	10,639	0	10,639	0
IT Contractual Srvcs and Rprs	351,398	12,039	(12,039)	0	0
Professional Development	31,141	31,686	1,584	33,270	0
Operating Fees and Services	24,186	3,922	196	4,118	0
Fees - Professional Services	2,848,128	3,651,393	(3,419)	3,647,974	0
Grants, Benefits & Claims	976,682	1,323,000	(463,000)	860,000	0
<b>Total</b>	<b>5,308,174</b>	<b>6,162,396</b>	<b>(637,873)</b>	<b>5,524,523</b>	<b>0</b>
<b>Tobacco Prevention &amp; Control</b>					
General Fund	0	0	0	0	0
Federal Funds	2,224,743	2,651,901	(347,732)	2,304,169	0
Special Funds	3,083,431	3,510,495	(290,141)	3,220,354	0
<b>Total</b>	<b>5,308,174</b>	<b>6,162,396</b>	<b>(637,873)</b>	<b>5,524,523</b>	<b>0</b>
<b>WIC Food Payments</b>					
Food and Clothing	17,915,331	24,158,109	501,752	24,659,861	0
<b>Total</b>	<b>17,915,331</b>	<b>24,158,109</b>	<b>501,752</b>	<b>24,659,861</b>	<b>0</b>
<b>WIC Food Payments</b>					
General Fund	0	0	0	0	0
Federal Funds	17,915,331	24,158,109	501,752	24,659,861	0
Special Funds	0	0	0	0	0
<b>Total</b>	<b>17,915,331</b>	<b>24,158,109</b>	<b>501,752</b>	<b>24,659,861</b>	<b>0</b>
<b>Contingent Appropriation</b>					
Fees - Professional Services	0	864,371	(864,371)	0	0
<b>Total</b>	<b>0</b>	<b>864,371</b>	<b>(864,371)</b>	<b>0</b>	<b>0</b>

**REQUEST DETAIL**301 ND Department of Health  
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Description	Expenditures 2009-2011 Biennium	Present Budget 2011-2013	Budget Request Change	Requested Budget 2013-2015 Biennium	Optional Budget Request
<b>Contingent Appropriation</b>					
General Fund	0	364,371	(364,371)	0	0
Federal Funds	0	0	0	0	0
Special Funds	0	500,000	(500,000)	0	0
<b>Total</b>	<b>0</b>	<b>864,371</b>	<b>(864,371)</b>	<b>0</b>	<b>0</b>
<b>Federal Stimulus Funds</b>					
Salaries - Permanent	838,888	4,694	(4,694)	0	0
Temporary Salaries	96,134	567,604	(567,604)	0	0
Fringe Benefits	323,140	190,351	(190,351)	0	0
Travel	34,014	23,304	(23,304)	0	0
Supplies - IT Software	1,683	1,086	(1,086)	0	0
Supply/Material-Professional	218	6,279	(6,279)	0	0
Bldg, Ground, Maintenance	0	57	(57)	0	0
Miscellaneous Supplies	0	10,000	(10,000)	0	0
Office Supplies	703	4,522	(4,522)	0	0
Postage	1,932	766	(766)	0	0
Printing	4,170	14,802	(14,802)	0	0
IT Equip Under \$5,000	1,550	0	0	0	0
Other Equip Under \$5,000	1,099	0	0	0	0
Office Equip & Furn Supplies	688	488	(488)	0	0
Rentals/Leases-Equip & Other	156	67	(67)	0	0
Rentals/Leases - Bldg/Land	3,213	400	(400)	0	0
IT - Data Processing	96	70,758	(70,758)	0	0
IT - Communications	3,466	4,197	(4,197)	0	0
IT Contractual Svcs and Rprs	497,360	320,604	(320,604)	0	0
Professional Development	2,673	1,101	(1,101)	0	0
Operating Fees and Services	119,401	110,000	(110,000)	0	0
Fees - Professional Services	152,135	157,826	(157,826)	0	130,000
Grants, Benefits & Claims	6,159,393	2,003,322	(2,003,322)	0	25,000
Transfers Out	2,434,581	0	0	0	0
<b>Total</b>	<b>10,676,693</b>	<b>3,492,228</b>	<b>(3,492,228)</b>	<b>0</b>	<b>155,000</b>
<b>Federal Stimulus Funds</b>					
General Fund	0	0	0	0	0
Federal Funds	10,676,693	3,492,228	(3,492,228)	0	155,000
Special Funds	0	0	0	0	0
<b>Total</b>	<b>10,676,693</b>	<b>3,492,228</b>	<b>(3,492,228)</b>	<b>0</b>	<b>155,000</b>

**Funding Sources**

**REQUEST DETAIL**

301 ND Department of Health

Bill#: SB2004

Date: 12/07/2012

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Description	Expenditures 2009-2011 Biennium	Present Budget 2011-2013	Budget Request Change	Requested Budget 2013-2015 Biennium	Optional Budget Request
General Fund	24,739,222	33,878,151	(301,089)	33,577,062	22,626,035
Federal Funds	119,277,392	126,288,123	(5,456,210)	120,831,913	865,586
Special Funds	15,813,619	34,660,630	(18,414,985)	16,245,645	4,569,042
<b>Total Funding Sources</b>	<b>159,830,233</b>	<b>194,826,904</b>	<b>(24,172,284)</b>	<b>170,654,620</b>	<b>28,060,663</b>

**CHANGE PACKAGE SUMMARY**301 ND Department of Health  
Biennium: 2013-2015

Bill#: SB2004

Date: 12/07/2012

Time: 13:50:02

Description	Priority	FTE	General Fund	Federal Funds	Special Funds	Total Funds
<b>Base Budget Changes</b>						
<b>One Time Budget Changes</b>						
A-E 2 Remove One Time Funding		0.00	(964,371)	0	(500,000)	(1,464,371)
A-E 8 Remove One Time ARRA Funding		0.00	0	(2,729,579)	0	(2,729,579)
<b>Total One Time Budget Changes</b>		<b>0.00</b>	<b>(964,371)</b>	<b>(2,729,579)</b>	<b>(500,000)</b>	<b>(4,193,950)</b>
<b>Ongoing Budget Changes</b>						
A-A 1 Costs to Continue Existing Programs		0.00	541,273	175,805	(18,483,355)	(17,766,277)
A-A 11 Cancer Registry Reduction		0.00	0	19,298	0	19,298
A-A 12 Coord Chronic Disease Program		0.00	0	979,076	0	979,076
A-A 13 School Health Program		0.00	0	34,300	0	34,300
A-A 15 Arsenic Trioxide		0.00	0	(3,450,000)	0	(3,450,000)
A-A 6 Add 2013-15 Bond Payments		0.00	221,088	18,848	0	239,936
A-A 7 Add 2013-15 Capital Assets		0.00	341,820	670,369	280,163	1,292,352
A-A 9 Reduce Hospital Preparedness Funding		0.00	0	(67,348)	0	(67,348)
A-F 3 Remove 2011-13 Bond Payments		0.00	(357,220)	(349,763)	0	(706,983)
A-F 4 Remove 2011-13 Extraordinary Repairs		0.00	0	(316,329)	0	(316,329)
A-F 5 Remove All 2011-13 Equipment > \$5000		0.00	0	(740,928)	(233,833)	(974,761)
Base Payroll Change		0.00	(83,679)	300,041	522,040	738,402
<b>Total Ongoing Budget Changes</b>		<b>0.00</b>	<b>663,282</b>	<b>(2,726,631)</b>	<b>(17,914,985)</b>	<b>(19,978,334)</b>
<b>Total Base Budget Changes</b>		<b>0.00</b>	<b>(301,089)</b>	<b>(5,456,210)</b>	<b>(18,414,985)</b>	<b>(24,172,284)</b>

**Optional Budget Changes****One Time Optional Changes**

A-D 100 State and Local Public Health Oil Impact Suppo	2	12.00	3,245,108	0	542,542	3,787,650
A-D 29 EPA Legal Fees	3	0.00	500,000	0	0	500,000
A-D 16 ARRA Continued Funding	12	0.00	0	155,000	0	155,000
A-D 27 Safe Sleep Campaign/Cribs for Kids	21	0.00	475,000	0	0	475,000
A-D 28 Senior Falls Prevention Program	30	0.00	122,675	0	0	122,675

**CHANGE PACKAGE SUMMARY**

301 ND Department of Health  
Biennium: 2013-2015

Bill#: SB2004

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Description	Priority	FTE	General Fund	Federal Funds	Special Funds	Total Funds
<b>Total One Time Optional Changes</b>		<b>12.00</b>	<b>4,342,783</b>	<b>155,000</b>	<b>542,542</b>	<b>5,040,325</b>
<b>Ongoing Optional Changes</b>						
A-C 17 Medical Examiner's Office	4	1.00	624,145	0	0	624,145
A-C 42 Public Health Emergency Preparedness - Voluntee	5	0.00	84,000	0	0	84,000
A-C 20 Universal Vaccine	6	0.00	1,000,000	0	0	1,000,000
A-C 100 Salary Equity Package	7	0.00	2,737,500	912,500	0	3,650,000
A-C 22 Healthy North Dakota	8	0.00	345,748	(174,664)	0	171,084
A-C 36 Physician & Mid Level Practioners Loan Repaymen	9	0.00	270,000	0	0	270,000
A-C 43 Nurse Telephone Triage	10	0.00	671,000	0	3,979,000	4,650,000
A-C 37 Dental Loan Repayment & Dental Non-profit Progr	11	0.00	360,000	0	0	360,000
A-C 25 Healthy Communities	13	0.00	1,364,911	0	0	1,364,911
A-C 32 Community Paramedic/Community Health Care Worke	14	1.00	276,600	0	0	276,600
A-C 39 Office of Health Equity	15	0.00	292,263	(27,250)	0	265,013
A-C 35 Leadership Training For Ambulance Service Direc	16	0.00	220,000	0	0	220,000
A-C 31 Trauma System	17	0.00	709,000	0	0	709,000
A-C 38 ND Early Hearing Detection and Intervention Pro	18	0.00	300,000	0	0	300,000
A-C 33 Rural EMS Assistance Fund for Grants	19	0.00	1,750,000	0	0	1,750,000
A-C 34 EMS Database Systems	20	0.00	480,000	0	0	480,000
A-C 23 Local Public Health Networks	22	0.00	4,000,000	0	0	4,000,000
A-C 40 CSHS Client Server Application	23	0.00	647,108	0	0	647,108
A-C 26 Stroke System of Care	24	0.00	383,000	0	0	383,000
A-C 18 NDIIS Analytical/Data Quality Support	25	0.00	254,609	0	0	254,609
A-C 24 Local Public Health Support State Aid Increase	26	0.00	1,500,000	0	0	1,500,000
A-C 21 Food & Lodging Licensing Management System	27	0.00	110,000	0	0	110,000
A-C 19 Maven Maintenance	28	0.00	80,000	0	0	80,000
A-C 41 Veterinarian Loan Repayment Program	29	0.00	135,000	0	0	135,000
A-C 30 New Lab Equipment & IT Domain Replacement	31	0.00	695,680	0	47,500	743,180
<b>Total Ongoing Optional Changes</b>		<b>2.00</b>	<b>19,290,564</b>	<b>710,586</b>	<b>4,026,500</b>	<b>24,027,650</b>

**CHANGE PACKAGE SUMMARY**301 ND Department of Health  
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Description	Priority	FTE	General Fund	Federal Funds	Special Funds	Total Funds
<b>Total Optional Budget Changes</b>		<b>14.00</b>	<b>23,633,347</b>	<b>865,586</b>	<b>4,569,042</b>	<b>29,067,975</b>
<b><u>Optional Savings Changes</u></b>						
A-G 14 LPHU Universal Vaccine	1	0.00	(1,007,312)	0	0	(1,007,312)
<b>Total Optional Savings Changes</b>		<b>0.00</b>	<b>(1,007,312)</b>	<b>0</b>	<b>0</b>	<b>(1,007,312)</b>

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<b>Change Group:</b> A	<b>Change Type:</b> A	<b>Change No:</b> 1	<b>Priority:</b>
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Costs to Continue Existing Programs

**Administrative Services**

Salaries and wages increased due to the continuation of the second year pay increase and retirement contribution. In addition temporary salaries increased \$69,721, which is primarily due to the addition of dollars to hire a temporary staff person to assist with the Community Transformation – Small Communities grant.

The operating line has increased as a result of inflationary projections averaging around 5%, with the exception of the following. Travel costs increased \$65,001 due in part to higher airline and hotel costs as well as funding for the new accounting manager and human resource director. In addition the travel costs for the Community Transformation grant increased \$20,000 to reflect funding for two years versus the one year in the current biennium. Finally, travel costs increased \$18,750 for the new Community Transformation – Small Communities grant requested for the 2013-2015 biennium. Several other operating costs increased reflect funding for two years versus the one year in the current biennium for the Community Transformation grant and the addition of the Community Transformation - Small Communities grant in the 2013-2015 biennium. These lines include professional supplies and materials, office supplies, professional development, and operating fees and services. The largest increase in operating expenses is in the professional services area, which represents contracts the department will enter into for the management of the Community Transformation and Community Transformation – Small Communities grants. The decrease in postage is a result of more activities being performed online versus through the mail and the decrease in IT-contractual services reflects the sharing of ongoing maintenance costs for the Program Reporting System with the Tobacco Center.

The grants line has increased \$200,000 to allow for grants to be issued for the Community Transformation grant.

**Medical Services**

Temporary salaries have increased due to the expansion of our current Ryan White program with federal funds in Disease Control, additional staff for the Immunization program, continuation of Healthcare Associated Infections program and the new BioSense program. All of the temporary salaries are federal funds. Other salary changes in the salaries and wages line item are for equity adjustments and legislatively approved raises.

The operating line has increased as a result of inflationary projections averaging around 5% with the exception of the following. IT software and supplies have increased \$6,848 for Microsoft Office software. Professional supplies and materials have increased by \$71,665 for the purchase of calibrated probe thermometers for the Immunization program. Office supplies have increased due to the additional temporary staff needed to operate the increase in federal programs. Postage has increased by \$27,490 for the reminder recall notices for the Immunization program. Printing has increased by \$18,135 for the Immunization program and \$1,200 for the BioSense program. Lease/Rentals on buildings has increased for field staff rent due to a change in billing for the field staff. This was previously billed in the grants and contracts and has been moved to operating. The IT data processing has increased due to additional work needed for the Immunization program. In the professional service line item fee contracts to local health units will increase for HIV Prevention, Ryan White, Tuberculosis, Immunization, and Epidemiology and Lab Capacity projects. The medical, dental and optical line item is decreasing due to removal of funding to purchase vaccine for the statewide universal immunization project.

In the grants line item grants to local health units has decreased due to a reduction in federal funds for the federal Immunization Program and moving activities for the VFC/AFIX program from the local health units back to Department of Health staff.

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**Health Resources**

The increase in the salaries and wages line item is for equity adjustments and legislatively approved raises.

The operating line has increased as a result of inflationary projections averaging around 5% with the exception of the following. In the operating line item increases in travel of \$172,419, of which \$160,267 is due to oil impact and \$12,152 is due to inflationary increases. IT software and supplies increased by \$20,300 for licenses for Microsoft office software as well as the 5% increase for toner and other supplies. IT Equipment <\$5,000 has increased \$12,855 for replacement computers and a replacement printer. Office Equipment < \$5,000 increased by \$5,614 for office furniture within the Health Resources section. IT data processing has decreased by \$57,749 due to startup costs for Nurse Aid Registry. Lease/Rentals on buildings have increased \$12,053 due to an increase set by OMB. Professional services have decreased by \$7,670 due to one-time activity in the current biennium.

The Equipment >\$5,000 has increased by \$10,000 to purchase a wide format digital scanner for the Life Safety Code and Construction program and a new copier for the Health Resources Section.

Federal funds have increased and are available to cover the increased costs in salaries and travel.

**Community Health**

Salaries, wages, and benefits line decreased a little over \$147,000. The main decrease was in the Cancer Registry program which has been transferred to the University of North Dakota and a decrease in the temporary salaries line for the Suicide Prevention program. Other changes in salaries and wages are for equity adjustments and legislative approved raises.

The operating line has increased as a result of inflationary projections averaging around 5% to 7% except for a few instances. IT Software and Supplies is increasing due to onetime software purchase needs. Professional Supplies and Materials have increased to purchase breast pumps for the Women Infants and Child (WIC) program. Other Equipment and Office Equipment has decreased due to onetime purchases in the 11-13 biennium that are not needed in the 13-15 biennium. Lease building rentals has increased \$22,089 due to an increase set by OMB. IT Data Processing has increased by \$29,024 for WIC Electronic Benefit Transfer (EBT) planning and increases set by ITD. IT contractual services have decreased by about \$82,000 for maintenance on the WIC system. Professional Services is increasing primarily for services in the Cancer Prevention and DentaQuest programs and for WIC EBT implementation.

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The Equipment greater than \$5,000 was decreased by \$30,200 due to one time purchases that are not needed in the 13-15 biennium.

The grants line item has decreased approximately \$1,209,695 which is primarily a decrease in the Safe Havens, RPE Capacity, and Cancer Prevention programs.

The WIC food payments line item is showing an increase is to cover anticipated inflationary costs and costs associated with the drought in the 13-15 biennium.

The Tobacco special line has several small changes in the salaries and operating lines. First, we have decreased salaries by 1.00 FTE as a result of a minor reorganization of the Community Health Section. Temporary salaries have also decreased by \$25,000 for additional help that is no longer needed. The most notable change in the Tobacco Special line item is a decrease of \$463,000 in the grants line due to less revenue being available from the Community Health Trust Fund.

**Environmental Health**

The salaries and wages increase of \$240,740 is a net of several adjustments. Temporary/overtime has increased \$143,150 for oil impact. There is an offsetting reduction of \$50,700 in temporary services in the Lab due to a reduction of federal funding. During the 2011-13 biennium there will be approximately \$482,000 charged to the Federal Stimulus line for salaries and wages - this has been removed. There has been turnover with hiring at lower levels. Other changes are for legislatively approved raises. An internal adjustment in this section included a reduction of an FTE in the Laboratory and an increase of an FTE in the Division of Municipal Facilities where it will be used for oil impact.

The operating line has increased as a result of inflationary projections averaging around 5% with the exception of the following. Travel has increased \$191,263 due to oil impact. IT – software/supplies have increased \$57,753 due to additional software needs. Buildings/Vehicle Maintenance Supplies have increased \$8,716 due to additional needs. IT equipment <\$5,000 has decreased \$17,475 due to a reduction in the equipment need. Other equipment <\$5,000 has decreased \$44,400 as a result of the environmental health section spending this current biennium. Office equipment <\$5,000 increased \$4,863 due to a copy machine to replace an outdated unit. Repairs have increased \$35,275 which is slightly above the inflation rate. IT – data processing increased \$43,902 which stems from increases from ITD. IT – contractual services increased \$263,024 for updates to various environmental data systems including radiation. Professional Services have increased \$719,820 due to legal fees increasing 39%, an increase in the courier service in the laboratory, LUST engineering fees, Targeted Brownfields Response for the Division of Waste Management, and Data Management for the environmental chief's office. Medical, dental, and optical increased by \$98,920 for lab supplies which is slightly above the inflation rate.

In the capital assets line item equipment >\$5,000 decreased \$61,150 which stems from the air quality program. IT equipment >\$5,000 decrease of \$65,000 occurred in the Laboratory, the environmental chief's office, and the Division of Municipal Facilities.

In the grants line item the 319 NonPoint grant is reduced \$352,423 due to a reduction in funding and also a reduction in the projects. Wetlands Protection pass through grants to universities decreased \$295,000 due to a reduction in funding and moved some money back to support the Department of Health staff

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**Emergency Preparedness and Response**

Salaries and wages increased \$131,386, which is due to the continuation of the second year pay increase of 3% and the retirement contribution. In addition temporary salaries increased \$37,916, which is primarily due to increased health insurance costs for temporary employees.

The operating line has increased as a result of inflationary projections averaging around 5%, with the exception of the following. Travel costs increased \$24,963 due to higher airline and hotel costs. The decrease in the various supplies, printing and professional supplies lines reflects the elimination of purchases of materials in the current biennium with carryover federal funding. The decreases in the equipment under \$5000 lines are due to the cyclical timing for replacement of equipment and current needs. Rental costs decreased due to the purchase from federal carryover funding of trailers for storage of medical cache. The department was renting the trailers during the current biennium. IT Data Processing has increased due to ongoing maintenance of system development at ITD. Professional fees were reduced due to the section performing the services with their staff that previously were contracted out. Medical, Dental, and Optical decreased \$531,604 due to one-time funding for Pandemic Flu Emergency Response (H1N1) carryover federal funds that are no longer available.

Equipment greater than \$5,000 is increasing due to the need to purchase two multi-point control units for the video conference equipment. The current system does not support high definition and it is causing problems when end users with high definition capability try to connect. In addition, the section plans on purchasing two emergency response health and medical tents which provide shelter and climate control for health professionals when responding to emergencies.

The grants line has decreased \$60,800 due to a reduction of federal funding for the city readiness program.

**Special Populations**

Salaries, wages, and benefits decreased a little over \$32,000. The Maternal and Child Health block grant decreased in temporary salaries \$47,496. Other changes in salaries and wages are for equity adjustments and legislative approved raises.

The operating line has increased as a result of inflationary projections averaging around 5% to 7% except for a few instances. Office Supplies has decreased by \$2,301 due to funds needed in the salary line item in the Health Disparities division. Office equipment has decreased approximately \$3,900 due to onetime costs for Herman Miller office furniture. Lease building rentals has increased \$5,043 due to an increase set by OMB. ITD data processing has increased \$52,668 for programming costs to

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update the CSHS Client Server application to change code from ICD9 to ICD10. Professional Services has increased \$35,246 to contract graphic design services and report and resource development.

The grant line has decreased by \$7,456. This is comprised of an increase of \$17,411 in the Maternal and Child Health block grant, a \$25,000 increase in catastrophic disease funding to address two possible new cases, an increase in federal funds of \$387,500 for loan repayments to physicians, a decrease of \$100,000 for the dental loan repayment program, a decrease of \$5,000 for the new dental practice grant, a decrease of \$113,212 for the medical personnel loan repayment program, and a decrease of \$95,000 for the veterinarian loan repayment program. The Primary Care ARRA funding of \$124,155 is removed.

<b>Change Group:</b> A	<b>Change Type:</b> A	<b>Change No:</b> 6	<b>Priority:</b>
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Add 2013-15 Bond Payments

Adjustment to add bond payments to the 2013-2015 biennium base budget request

<b>Change Group:</b> A	<b>Change Type:</b> A	<b>Change No:</b> 7	<b>Priority:</b>
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Add 2013-15 Capital Assets

Adjustment to add capital assets to the 2013-2015 biennium base budget request

<b>Change Group:</b> A	<b>Change Type:</b> A	<b>Change No:</b> 9	<b>Priority:</b>
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Reduce Hospital Preparedness Funding

The federal government reduced funding for the Hospital Preparedness Program. The 2013-15 request reflects a reduction in purchases for the medical cache of \$50,828 as well as a \$16,520 reduction in support provided to local hospitals and long-term care facilities for the purchase of medical supplies.

<b>Change Group:</b> A	<b>Change Type:</b> A	<b>Change No:</b> 10	<b>Priority:</b>
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Reallocate EMS Grants Manager Funding

The current biennium appropriation includes the addition of \$3,000,000 funding for ambulance operation areas, an emergency medical services advisory council, and state financial assistance for emergency medical services. The advisory council was tasked with providing recommendations for integrated emergency medical services in the state and developing emergency medical funding areas and criteria. Upon passage of the bill all funding authority was placed in the grants line. The change requested reflects the movement of a portion of the funding to cover the administration of the program. Projected expenses include the temporary salaries and fringes for a grants manager as well as ongoing operating costs for the manager for phone, data processing and supply costs. The request also includes funding for the grants manager to perform site visits and audits. In addition travel costs are included for reimbursement to advisory council members and to emergency service personnel to attend meetings relating to the implementation of the advisory council's recommendations.

<b>Change Group:</b> A	<b>Change Type:</b> A	<b>Change No:</b> 11	<b>Priority:</b>
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## Cancer Registry Reduction

This is a federal program that was transferred to the University of North Dakota effective July 1, 2012. The program was funded in the 11-13 base budget for \$538,315. A total of \$257,613 was removed in the 11-13 base budget and the remaining balance of \$280,702 was removed in the 13-15 biennium's budget.

<b>Change Group:</b> A	<b>Change Type:</b> A	<b>Change No:</b> 12	<b>Priority:</b>
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## Coord Chronic Disease Program

This new federal program focuses on collaborative activities to address major risk factors for chronic disease such as physical inactivity, obesity, poor nutrition and tobacco use. Heart disease, stroke, cancer, diabetes, and arthritis are chronic diseases that are specifically targeted in this grant.

This package includes temporary salaries for a program coordinator. The operating line item includes travel, software, equipment under \$5,000, operating costs for staff and professional services of \$933,006 for contracts for public awareness, training for partners, an evaluation and communication consultant, and a quality improvement contractor.

<b>Change Group:</b> A	<b>Change Type:</b> A	<b>Change No:</b> 13	<b>Priority:</b>
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## School Health Program

Coordinated school health (CSH) is recommended by CDC as a strategy for improving students' health and learning in our nation's schools. The North Dakota Department of Public Instruction (DPI) has received CSH funds since March 1, 2003. As a requirement of the grant award, the DPI must award funds to the Department of Health (DoH) to support CSH leadership positions; hence the CSH funding supports key positions and activities both within the DPI and DoH.

The North Dakota CSH Program works with schools, local public health units, multiple state partners, and statewide organizations to reduce priority health risks among youth, especially those risks that contribute to chronic diseases – specifically to (1) reduce tobacco use and addiction, (2) improve eating patterns, (3) increase physical activity, and (4) reduce obesity among youth.

The North Dakota CSH Program is currently in Year 5 of a five-year CDC Cooperative Agreement; ending February 29, 2013. CDC has communicated that new CSH Program funds may become available with a start date of August 1, 2013. CDC has also communicated that States may apply for a no-cost extension, although no specific guidance has been released.

There has not been communication from CDC indicating what the new CSH Funding Opportunity Announcement (FOA) will include; however, informal communication has suggested that new funding may be directed to Health Departments.

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This package includes temporary salaries for a program director. The operating line item includes travel and operating costs for staff and professional services of \$13,000 for profile surveys and evidence based training. The grants line includes \$181,240 for a grant to the Department of Public Instruction to support coordinated school health staff and program activities.

<b>Change Group:</b> A	<b>Change Type:</b> A	<b>Change No:</b> 15	<b>Priority:</b>
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Arsenic Trioxide

The grants line item has been reduced \$3,450,000 due to completion of the arsenic trioxide project.

<b>Change Group:</b> A	<b>Change Type:</b> C	<b>Change No:</b> 17	<b>Priority:</b> 4
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Medical Examiner's Office

**Medical Examiner's Office - \$624,145**

Since 2004, the number of autopsies performed by the Medical Examiner's Office (ME) with the North Dakota Department of Health has increased 64.8%, from 196 to 323 autopsies per year. In addition, the number of consultations has increased 48%, from 83 to 123 from 2010 to 2011. Accreditation standards indicate that one forensic examiner should perform only 225 to 250 autopsies per year.

The number of forensic autopsies being performed in North Dakota continues to increase and the Medical Examiner's office with the Department of Health has exceeded the number of autopsies recommended by the National Association of Medical Examiners, by more than 50 in 2011. Not funding this project would result in a continued heavy workload for the ME's office and potentially having to refuse cases or conduct only external exams, even though a full autopsy may be indicated.

Two different options are presented here to address the growing forensic pathology workload occurring in North Dakota. For both options stakeholders include families of lost loved ones, law enforcement and county coroners. This funding does not now qualify as a match for other funding but could potentially in the future. This would be a project that continues into future biennia. Both options allow for the NDDoH State Forensic Examiner to devote more time to administrative duties and prepare testimony and testify for court cases.

**Option 1 – Grant to University of North Dakota School of Medicine (UNDSM) \$640,000**

One option is to contract with UND School of Medicine to conduct Medical Examiner Services for counties in the eastern part of North Dakota. Under this plan the deaths occurring in counties along the eastern border of North Dakota and in the northeastern part of North Dakota needing forensic autopsies would be referred to UNDSM. This is approximately 100 per year plus the forensic autopsies done for Grand Forks County, which is about 60 autopsies per year. UND School of Medicine currently performs Grand Forks County autopsies through an arrangement with Grand Forks County. UNDSM has informed NDDoH that if the state pays UNDSM for autopsies, Grand Forks County would expect the state to pay for their cases as well. UNDSM indicates it costs about \$2,000 per autopsy, so \$640,000 is the estimated total cost for the biennium. No FTE's are being requested with this option.

Possible advantages to this option include

- making use of existing forensic expertise and existing mortuary facilities at UND
- increased academic/educational opportunities at UND in forensic pathology
- avoiding developing additional capacity (FTE) at the NDDoH – it would be almost impossible to hire a part time forensic examiner when currently that is all that is needed

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**Option 2 - Adding a second pathologist to the NDDoH Medical Examiner's Office \$653,884**

This option includes adding a second pathologist (1 FTE) in the Medical Examiner's (ME) Office at the NDDoH and autopsy support in the form of two assistants and laboratory testing. Of the requested amount, \$26,000 is one-time expense. Funding this position will allow the ME's office to handle all forensic autopsies for all areas of the state and would allow for some succession planning as well. The second forensic examiner could provide 225 to 250 autopsies per year so would be able to cover further anticipated growth.

If funding is not provided, accommodating the workload may require cutting back on the number of autopsies performed by the ME's Office. The NDDoH is receiving a few complaints about the timeliness of autopsies and in some cases failing to conduct an autopsy when a full autopsy is indicated. UNDSM has indicated that they will not provide assistance without compensation.

The following is the budget breakdown by line item for option 2.

Salary	\$369,984
Temp Salaries	\$ 44,114
Benefits	\$ 86,747
Travel	\$ 3,500
IT Equipment	\$ 1,500
Other Equipment	\$ 3,500
Office Equipment	\$ 4,000
IT/Phone	\$ 1,800
Professional Service	\$ 67,000
Medical Supplies	\$ 25,000
Equipment > \$5000	<u>\$ 17,000</u>
Total	\$624,145

Of the total cost to implement this option, one time start-up costs total \$26,000.

There are several advantages to this option which include but are not limited to:

- Prepares the Department's Medical Examiner's Office for long term operations by providing an additional pathologist for succession planning. Allowing for a planned transition when the lead pathologist resigns or retires will help ensure uninterrupted operations during this period of transition.
- Builds infrastructure to handle an increasing case load. Even though initially the forensic examiner would be conducting only 170 autopsies per year (or 110 if Grand Forks continues to send theirs to UNDSM), NDDoH would have the capacity to conduct an additional 225 to 250 autopsies per year. At 340 autopsies per

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biennium, cost (net of one-time costs) is \$1,847per autopsy; at 200 autopsies per biennium, cost is \$3,139 per autopsy; when at full capacity of (at a minimum) 225 per year or 450 per biennium, cost drops to \$1,400 per autopsy. The number of autopsies performed by the ME's Office has continued to increase steadily and may continue to do so, especially with development and the influx of people in the western part of North Dakota.

- Builds infrastructure into the ME's office for the two pathologists to cover for each other when they take personal or educational leave. Right now, the ME's Office pays UNDSM \$2,000 per autopsy to perform autopsies when the Medical Examiner is on leave. An additional \$48,000 to \$60,000 per biennium could be saved when the ME is on leave.
- Eliminates any problems with continuing normal operations if UNDSM were to suddenly discontinue forensic pathology services leaving the ME's office to cope with a sudden surge in workload.

Regardless of which option is implemented, ongoing evaluation of the number of forensic autopsies performed in North Dakota and the geographic distribution of these autopsies, along with any associated costs, will be evaluated on an ongoing basis.

<b>Change Group:</b> A	<b>Change Type:</b> C	<b>Change No:</b> 18	<b>Priority:</b> 25
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NDIIS Analytical/Data Quality Support

**NDIIS Analytical and Data Quality Support, NDIIS Maintenance and vaccine level de-duplication - \$252,564**

This funding will employ a full-time temporary epidemiologist to monitor and coordinate data quality in the North Dakota Immunization Information System (NDIIS). Funding would also support the development of vaccine level de-duplication within NDIIS and help support NDIIS maintenance. In the event that federal grant dollars become available for any component of this optional package, the following dollar amounts could be backed out of this package:

1. \$92,075 for vaccine de-duplication.This cost is based on an estimate from Blue Cross and Blue Shield of North Dakota, the entity that hosts and provides the technical support for NDIIS.BCBS proposes to build vaccine level de-duplication into the NDIIS.
2. \$40,000 for NDIIS maintenance.This cost is based on the annual maintenance fee for NDIIS.In 2012 the maintenance fee was \$168,530 and the fee for 2013-15 biennium is estimated at \$354,091. This maintenance contract has a cost of living increase of 3% per year.This amount represents about 11% of the total amount for the 2013-2015 biennium.
3. \$120,489 for a full-time temporary epidemiologist with health benefits and other support.This cost is based on hiring a Grade K full time temporary employee with a 3% salary increase and offering health benefits.

Interoperability, the exchange of data between electronic medical records and NDIIS, has resulted in the need for further personnel support in data quality issues, mainly patient duplicate records and vaccine level duplicate records. Interoperability also requires interaction between BCBS, the NDDoH, Healthcare facilities and EMR vendors for on-boarding and meaningful use testing. There has been an increase in data requests from universities, public health and private providers for provider level data. The vaccine ordering module will be added which will require additional oversight. Data integrity is important to ensure that children, adolescents and adults have a valid vaccine history, to help reduce missed opportunities to provide vaccinations and to avoid double-vaccinating.

Funding in the amount of \$92,075 is being requested to develop vaccine level de-duplication in NDIIS. This process would automatically flag any potential duplicate records at the level of the vaccine dose for each patient. Obvious duplicates would be fixed automatically, the other potential duplicates would be both reviewed and fixed manually.

Maintenance costs of \$40,000 represent about 11% of the total maintenance costs for the NDIIS system. The remainder of the maintenance is paid from federal grant dollars. Maintenance costs continue to increase as the technical complexity of NDIIS increases. Most recently interoperability between NDIIS and electronic health records and the health information network has added to the technical complexity of NDIIS. The addition of vaccine level de-duplication will also increase the complexity of maintaining this system. Maintenance is important in order to be able to provide un-interrupted service to healthcare providers who are searching for their patients' immunization records. Often times the patient is in the office receiving care when a provider needs to access NDIIS to determine vaccine needs for the patient. Real-time access to patient records is critical for not missing an opportunity to vaccinate a patient.

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Although many of the improvements to NDIIS have been made with federal funding, much of that funding was one-time funding. With the improvements came increased complexity of maintenance but the ongoing federal support for this increased maintenance does not exist.

Stakeholders include medical providers, local public health, and families. This funding does not count as match for any existing programs but could potentially be used as a match for federal grants concerning immunizations and emergency preparedness.

This position would help to reduce vaccine preventable diseases by helping to ensure the integrity of the data in NDIIS thus allowing for timely completion of vaccinations.

<b>Change Group:</b> A	<b>Change Type:</b> C	<b>Change No:</b> 19	<b>Priority:</b> 28
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Maven Maintenance

**Maven Maintenance - \$80,000**

This funding will be used for the maintenance of the electronic disease surveillance system (MAVEN) used by the Division of Disease Control. This system is used to collect infectious disease data in North Dakota. It is HL7 ready allowing for the exchange of information in a standard format and is receiving electronic laboratory reports from the Division of Laboratory Services, ARUP and Mayo Laboratories. This system is the basis for disease surveillance, which is used to determine disease control program objectives and measure disease control program impacts.

Maintenance also includes upgrades and new builds and minor adjustments requested by Disease Control. Stakeholders include local public health, the Department of Health's Emergency Response Section, Medical Providers and Laboratories and, during larger events such as Pandemic Influenza, the Department of Emergency Services.

This funding would help in achieving the goal of reducing infectious and toxic diseases in North Dakota. If not funded Disease Control would stop receiving automatic upgrades and would start paying an hourly rate for software fixes. Furthermore, without a maintenance agreement we would not have a service agreement that allows for emergency fixes and any response from the vendor for servicing our product would be at their convenience. This software is new enough, where suggestions by the user group often result in significant improvements to the software.

Our software vendor indicates the following proposed price schedule would apply without the maintenance agreement. Otherwise these are covered by the annual \$100,000 maintenance fee.

- The first incidence of support would cost \$20,000
- The second incidence of support would cost \$15,000
- Service releases would cost \$10,000 (2-3 per year)
- Feature releases would cost one-half the cost of the original software license. For North Dakota this would be \$170,000.
- Professional services would cost \$150 per hour

The general funds being requested represent 40% of the total maintenance costs with the remainder coming from federal funding sources. We will monitor the total number of upgrades and minor fixes we receive over the biennium and compare that to the potential cost if we were to pay an hourly rate of \$150 per hour for fixes, upgrades and updated versions of the software.

<b>Change Group:</b> A	<b>Change Type:</b> C	<b>Change No:</b> 20	<b>Priority:</b> 6
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Universal Vaccine

**Universal Vaccine - \$1,000,000**

**BUDGET CHANGES NARRATIVE**

301 ND Department of Health

Bill#: SB2004

Date: 12/07/2012

Time: 13:50:02

During the 2011 legislative session, a bill was passed that allowed for free vaccine for the immunization of children at any participating local public health unit, regardless of insurance status. Federal section 317 vaccine is to be used first in this program. When that is exhausted \$1.5 million of general fund dollars was appropriated to cover the remaining costs. In 2012, the Department of Health received approximately \$1,000,000 in vaccine through the federal 317 program. At this time all but six of the local public health units are participating in the universal vaccine program.

Starting in October 2012, federal 317 vaccines will no longer be able to be used to immunize insured individuals. Based on immunization registry information, if uptake of vaccine remains constant, vaccine inflationary costs do not exceed 5% and no new vaccines are introduced into the recommended immunization schedule, the estimated general fund increase needed to offset the lost 317 vaccine is \$797,327. However several factors may increase the amount of funding needed. The increasing influx of people into western North Dakota along with the unknown number of children in that part of the state, the uncertainty of vaccine pricing and the potential for additional vaccines to be added to the recommended immunization schedule would increase the need for additional funding. Furthermore, if additional local public health units decide to participate in the universal vaccine program more funding would be needed. To make sure this mandate is fully funded \$1,000,000 is being requested.

Stakeholders include local public health, citizens with limited access to healthcare and insurers who would otherwise be billed for the vaccine. This project will help to reduce vaccine preventable diseases by lowering or maintaining the low incidence of specific vaccine preventable diseases found in the outcome indicators of the Department's strategic plan. Funding will be used by the NDDoH to purchase vaccine on behalf of the local public health units at federal contract rates. No funding will be passed on to LPHUs. This funding would not qualify for matching funds for any existing program.

<b>Change Group:</b> A	<b>Change Type:</b> C	<b>Change No:</b> 21	<b>Priority:</b> 27
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Food &amp; Lodging Licensing Management System

**Food and Lodging Licensing Management System - \$110,000**

The Division of Food and Lodging is requesting additional general fund dollars to replace our current licensing management system. The current system is approaching 20 years old and does not offer the capabilities for more efficient and effective report generating, license renewals, and being able to electronically accept inspection reports generated by the field staff. With a new licensing management system, we are interested in being able to conduct electronic inspections in the field and send them electronically to the office immediately after completion or on a daily basis. A considerable amount of time and money would be saved by eliminating the need to send hard copies of the inspection reports in daily and having the results of those inspections manually entered into the current data management system. This new system would also allow our field inspection staff to generate criteria for scheduling inspections, generate overdue work lists, obtain a stylus signature from the person in charge of each inspected facility, and be able to generate an inspection report on site. We also hope this new system will allow us to accept credit card payment for annual license fees which would save considerable time and money. The regulated community has requested the ability to pay online electronically for years and hopefully having this capability will reduce our need to send hard copy second notices on late renewals.

During the last several audits of our division, we received an audit recommendation to have the inspection results of certain restaurant or other food service facilities available through our department's website so the general public could readily access that information. Our current system does not have the capabilities to report electronically. A new licensing management system would allow us to report results on the website and save the office time and effort in copying and sending hard copies out to the consumers who request information through the open records provisions.

With the heavy workload increases facing our division because of the oil impact in western North Dakota, having a new licensing management system will reduce the time our field staff has to prepare and send daily hard copy reports in the mail which will allow for more time in the field conducting routine inspections and conducting follow up or complaint investigations.

<b>Change Group:</b> A	<b>Change Type:</b> C	<b>Change No:</b> 22	<b>Priority:</b> 8
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Healthy North Dakota

**BUDGET CHANGES NARRATIVE**

301 ND Department of Health

Bill#: SB2004

Date: 12/07/2012

Time: 13:50:02

**Healthy North Dakota - \$171,084**

In North Dakota, there is growing recognition that collaborative arrangements are important for addressing rural health access issues and as a means to improve population health. North Dakota has a long history of working cooperatively and collaboratively with categorically funded programs and multi-sector partners for chronic disease prevention and health promotion. Healthy North Dakota (HND), a dynamic, statewide partnership for prevention with over 400 members serving on 14 active coalitions, has demonstrated success in working together and finding solutions for healthier living since its launch in 2002.

Healthy North Dakota uses the Community Engagement model, and HND personnel coordinated the planning and application for a successful CTG grant for capacity building in October 2011. Community engagement is the powerful vehicle that can bring about changes in policies, systems, and environments to reduce behaviors that lead to the development of chronic diseases. Through the community engagement process, a community identifies the nature and magnitude of its health problems and designs and implements interventions to create health change. Sustainable community change is unlikely to occur from the outside; rather, it requires the investment of its own leadership, skills and resources. Under development in the current CTG capacity building grant activities is community engagement trainer curricula and courses by State Health Officer Dr. Terry Dwelle offered through the University of Minnesota School of Public Health, the development of a Masters of Public Health (MPH) program offered jointly through NDSU and UND that will include a certificate in community engagement, and a community engagement course that is culturally specific for American Indians under development. Those trained in community engagement will be able to better help their communities implement policy, systems and environmental changes in chronic disease management projects identified by communities.

Challenges to implementing policy, environmental, programmatic and systemic changes include a conservative social and political climate; the fast rate of change due to oil and gas development in Western North Dakota; lack of recognition of the importance in investing in prevention; changes in the state's healthcare system including consolidation of health systems and lack of services and personnel to provide them in rural areas and also in rapidly expanding Western North Dakota. Healthy North Dakota is needed to help bring the prevention and health care perspective to these serious challenges, and to convene the groups who are able to move initiatives forward to address our challenges.

Without HND, there will be no one to bring together the statewide coalitions, voluntary health organizations and other interested parties to work together where possible, to reduce duplication of effort, and serve as a leadership and connecting point for statewide efforts including the Coordinated Chronic Disease Program. There will be no one to bring together hospitals, nursing homes and other health care and insurance organizations – the Statewide Vision and Strategy for a Healthier North Dakota (SVS) convened by the HND director– is the only effort that is working to keep these groups connected during these times of rapid change in our state.

Without HND, local, state, federal and non-profit leaders and citizens would have much less access to information on the benefits of prevention, healthy living, healthy communities, food access and food deserts; a liaison between the ND Department of Agriculture and the NDDoH would be lost; there would not be a coordinator for the Creating a Hunger Free North Dakota Coalition or the Patient-Centered Medical Home Coalition; there would be much less applied research shared about new developments in childhood and adult obesity, employment, socio-economic status and health statistics, nutrition and physical activity research, hunger and poverty effects on obesity, policy and environmental change; and there will be less technical and grant-writing assistance to community and public health organizations.

Healthy North Dakota is currently funded through the Preventive Health Block Grant. This grant has been consistently excluded from the President's budget but added back by Congress. Healthy North Dakota cannot continue to survive on an uncertain funding source. Our goal is to provide general funding for the basic infrastructure and use Preventive Health Block funding for projects if it continues.

<b>Change Group:</b> A	<b>Change Type:</b> C	<b>Change No:</b> 23	<b>Priority:</b> 22
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Local Public Health Networks

**Local Public Health Networks - \$4,000,000**

**BUDGET CHANGES NARRATIVE****301 ND Department of Health****Bill#: SB2004****Date:** 12/07/2012**Time:** 13:50:02

The Office of Local Public Health requests \$4,000,000 to provide funding to encourage and allow local public health units to form and operate networks to share services within the core public health activities.

Seventy-five percent of the North Dakota local health units serve single county, city or combined city/county jurisdictions, while the other 25 percent serve multi-county jurisdictions. According to the National Association of County and City Health Officials National Profile of Local Health Departments, 54 percent of North Dakota's local public health units serve a population of less than 10,000. These health units have an average of 3 FTE for all staff, 1.5 FTE being a nurse, and an average budget or expenditures of \$115,000. As a result of the various structures, and workforce expertise and capacity, and because funding sources and amounts differ for local public health units, there is a wide variety in the levels of services they provide and in their capacity to provide comprehensive services. Therefore, North Dakotans cannot expect equitable public health services throughout the state.

Local public health units (LPHUs) are the foundation of North Dakota's public health system and the lead organizations providing community based programs and services that assure and protect the health of our citizens. Local public health is operating in an ever changing environment where expectations have grown for expertise and action in new areas such as chronic disease and injury reduction; community organizing; national accreditation with its prerequisites of community health assessments and improvement plans, and strategic plans; clinical prevention; and health information technology without revenue streams to support the work. As local public health administrators and their governing bodies are faced with these growing expectations and challenges, they recognize the need to collaborate and share services, resources and functions for a more effective and efficient local public health delivery system.

The 2009 Legislative Assembly authorized LPHUs to form collaborative networks through joint powers agreements (JPA) and provided funds for a pilot project. A bill will be introduced by the interim Health Services Committee in the upcoming legislative session to allow for flexibility and provide some standardization by requiring networks to create a work plan that includes activities around the core public health activities identified by a national steering committee for "Public Health in America". The core activities include; 1) Prevent epidemics and spread of disease; 2) Protect against environmental hazards; 3) Prevent injuries; 4) Promote health behaviors; 5) Respond to disasters; and 6) Assure the quality and accessibility of health services. Identified work plan activities should also meet the community needs or reflect a community health assessment.

Networks will be required to serve a minimum population of 15,000 or comprise at least three local public health units. The \$4,000,000 requested is based on \$6 per capita and was derived in part from the successful results of the regional pilot project conducted in 2009 in which \$275,000 (\$6 per capita) state funding was appropriated for the five counties in Southeast Central region. LPHUs feel that this is a reasonable and effective per capita amount needed to serve all North Dakotans through regional networks. The funding will be appropriated to networks that have an effective JPA approved by the state health officer.

Public Health Networks will address nearly all of the health department's key objectives. By improving the effectiveness of the public health delivery system, local public health units will better aid in reducing and preventing infectious and vaccine preventable diseases, chronic diseases, tobacco use, and intentional and unintentional injuries, and better promote and protect against environmental hazards.

<b>Change Group:</b> A	<b>Change Type:</b> C	<b>Change No:</b> 24	<b>Priority:</b> 26
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Local Public Health Support State Aid Increase

**Local Public Health Support State Aid Increase - \$1,500,000**

The Office of Local Public Health requests \$1, 500,000 to support local public health operations to carry out the core public health activities and essential services. The core activities include the following:

- Prevents epidemics and the spread of disease
- Protects against environmental hazards
- Prevents injuries
- Promotes and encourages healthy behaviors
- Responds to disasters and assists communities in recovery

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- Assures the quality and accessibility of health services

Local public health units (LPHU's) are the foundation of North Dakota's public health system and the lead organizations providing community based programs and services that assure and protect the health of our citizens. Local health departments serve as the primary organizing and mobilizing forces for public health practice in most communities and are critical to protecting the health of the community. The state Department of Health generally maintains responsibility for implementing public health policies and programs through relationships with local health departments. A strong local infrastructure is needed for a prompt response to public health issues.

LPHU's are expected and often required to provide services and reach people that private and other governmental agencies fail to adequately serve. In this context LPHU's are regarded as the residual guarantor for essential services. They are also required by state law to provide services to North Dakota citizens regardless of ability pay. Services are often rendered without reimbursement either by insurance or client payment.

LPHU funding sources are generally from local government, state government and federal pass-through funds. As indicated in the 2012 National Association of City and County Health Officials (NACCHO) Profile Survey of Local Health Departments, the largest source of LPHU revenue is from local government at 34% of the total budget, state direct is 9% with only 5% from state aid, federal pass through is 28% and other sources 24%. The majority of the flexible funding source is from local governments to respond to community needs. However, there is a barrier to generate additional local tax dollars as 19 of the 28 LPHUs are health *districts* whose budgets may not exceed the amount that can be raised by a levy of five mills as mandated in state statute. Four of the 19 district LPHUs are at the maximum mill levy and another 6 are at or above 4.5 mills; the average of the 19 LPHU districts is 4.2. However some of these values may change with higher property valuations in oil impacted areas.

With federal programs either decreasing or holding even, LPHUs are seeing cuts to local programs. Trust for America's Health 2012 and 2011 reports indicate North Dakota Department of Health per capita funding from CDC has decreased for core service programs such as infectious disease, emergency preparedness and response, vaccines for children, 317 immunization program, influenza, injury prevention and control, and others. These cuts to NDDoH alone total \$1,488,350. The total impact to local public health units is uncertain, but a \$438,370 cut in emergency preparedness and response dollars has already been determined. Combined with the other decreases in federal pass through funding, core services are at risk of extensive cuts.

In addition, LPHU's are having difficulty recruiting and retaining qualified and experienced public health workers to meet the needs of North Dakota's changing environment and to effectively provide the core public health activities. Southwestern District Health Unit has had 8 staff leave in the last 1.5 years. Three of these positions which are public health nurses have not been filled due to no or limited qualified applicants. The other positions took three to six months to fill. Upper Missouri District Health Unit has had 5 staff resign in 2012 alone. The Executive Officer position has been unfilled for two years and an environmental health practitioner (EHP) position remains unfilled. The other positions have taken six to nine months to fill. First District Health Unit has had 3 public health nurses and 2 EHPs resign in the past 6-12 months. One EHP position remains unfilled and the other took 4 months to fill. The ability to provide competitive salary and benefits is the largest challenge in hiring and retaining staff. In order for LPHU to sustain current level of core services and retain qualified employees, an additional **\$1,000,000** in state aid is needed.

The core public health activity of protecting against environmental hazards has been identified by the local public health administrators as a priority area of need to increase capacity to better meet the environmental health demands of their communities. An effective environmental health infrastructure throughout the state is imperative in our response to public health threats. Public Health threats may include food borne outbreaks, water supply contamination or natural disasters such as floods and tornados and other hazards such as train derailments that impact air quality. Only eight of the larger multi-county local public health units have environmental health practitioners (EHPs). Only \$400,000 per biennium of the current state aid is earmarked for the provision of environmental health services. This is only \$.59 per

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capita or an estimated six hours a month of services provided to counties outside of the EHP's jurisdiction. Many of the smaller health units do not have the financial means to contract for additional services which results in many unmet needs and unfulfilled community expectations. State aid funding appropriated for regional environmental health services has not changed since 2007. LPHU's are requesting an additional **\$500,000** in state aid funds to increase and enhance the capability to protect against and to respond to environmental hazards.

Financial support for local public health operations will address nearly all of the health department's key objectives. By improving local public health resource capacity, local public health units will better aid in reducing and preventing infectious and vaccine preventable diseases, chronic diseases, tobacco use, and intentional and unintentional injuries, and better promote and protect against environmental hazards.

<b>Change Group:</b> A	<b>Change Type:</b> C	<b>Change No:</b> 25	<b>Priority:</b> 13
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Healthy Communities

**Healthy Communities- \$1,364,911****Optional Budget Request for 2013-2015 and 2015-2017 Biennium.**

The Division of Chronic Disease, Division of Nutrition and Physical Activity, Division of Family Health and Division of Cancer request \$1,364,911 for the next biennium to implement a statewide comprehensive Healthy Communities Program. This request supports the following for the next biennium:

\$364,911 for State-Level Support (including salaries and wages and operating expenses)

\$600,000 for professional services (evaluation, local training, health communications, etc.)

\$400,000 for local community support (and another \$900,000 for the 2015-2017 biennium)

The Chronic Disease, Nutrition and Physical Activity and Cancer Divisions are requesting funds to establish a Healthy Communities Program to reduce the burden of chronic diseases. The goal will be to assist communities across the state, as they work to change the places and organizations that touch people's lives every day in schools, worksites, health care sites, and other community settings. Funds will support local communities in their efforts to positively impact health as individuals, communities, businesses and as a state.

Prevention measures such as appropriate screening and control of risk factors are important steps to save lives, reduce disability and lower healthcare costs. The initiative encourages individuals to practice four key healthy behaviors: maintain a healthy weight; engage in regular exercise; participate in regular health screenings and avoid tobacco use and exposure. The campaign will invite focus on four key health measures (body mass index or BMI; blood pressure; cholesterol and blood glucose level) to help individuals be healthy and productive. Implementation of the initiative will require a collaborative approach among state, tribal and local governments, business, industry and other private sector partners, schools and community organizations and families. It will also take leadership at the state level to provide technical assistance and support to the communities. The technical assistance will come in the form of suggested principles from the social ecological model where interventions for individuals and environments are used. The grants and technical assistance will provide a springboard for community action in the areas of health-related environmental change. Strategies include a health communication/awareness campaign (with targeted health messages) and support of community partnerships in their efforts to reduce chronic diseases including heart disease, stroke, cancer, diabetes kidney disease and dementia.

The Division is requesting funding for two specialists to lead and support the work of Healthy Communities and for grants to support local health partnerships (four grants the first year and eight the next year). The staff will come from existing FTE's, provide the Divisions some much needed resources and position the Department as a leader and a resource in efforts to reduce chronic disease

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The NDDoH program will deliver training and technical assistance to increase the skills of these partners. At the same time, systems will be created to gather and use data for program planning and evaluation. With the completion of a review of surveillance data, specific program activities that target populations affected by disparities can be designed, implemented and evaluated.

Specifically Healthy Communities will assist in mobilizing local communities in an effort to create healthier environments. Communities will be trained and assisted in performing their community assessment, with a broad representation of partners. Once the assessment is completed Healthy Communities staff will assist them in developing a plan that reflects the needs for their community and assist in the prioritizing the needs and what can be done, using best and promising practices. The technical assistance provided to each community will help them implement their plan, offering on-going support as they continue to evolve with the plan and activities that encourage their residents to maintain a healthy weight, engage in regular exercise; participate in regular health screenings and avoid tobacco use and exposure. Finally the technical assistance offered by Healthy Communities will help them evaluate their efforts by identifying existing surveillance and survey data (like BRFSS) to identify indicators for chronic disease that may be helpful for their at-risk populations. Healthy Communities staff may also help local communities assess gaps in needed data and plan for how those may be filled. The training Healthy Communities will be based on the community's identified need plus suggestions based on national guidance (like some of the CDC trainings on affecting policy, system and environmental change). Our intent is to make it easier for communities to establish environments that will in the long term help reduce chronic disease.

With competing priorities and limited funding, communities do not have the resources to implement this kind of an initiative. That is why the local grant to support staffing is a critical component to the initiative. Local communities need partners and resources. Our intent is to start with grants for four communities willing to participate in the initiative using best and promising practices (like the ACHIEVE Program). Once established we plan to use the model communities successes and lessons learned to expand to a total of eight communities. One of the advantages of state level technical assistance is the ability to consolidate available resources. For example, the Community Transformation Grant (CTG) may offer tools on using community engagement to identify needs. The community may or may not select chronic disease prevention as one of their CTG priorities. If they do, they may likely need assistance in their next steps and Healthy Communities could help. We've seen recent examples as the NDDoH conducted sessions on using health indicators for local planning. In a number of cases the local partners identified obesity prevention as a high priority, but they don't know where to go for the next steps. Again, Healthy Communities would be in a position to support their efforts with the right resources. The Healthy Communities funding could also be helpful in administering streamlined funding for the local communities by consolidating funds like Healthy Communities, CTG or other programs like Cancer or Diabetes who all would like to see successful health initiatives in the local communities.

Regarding the evaluation plan, we have identified a number of healthy behaviors that influence health indicators such as BMI, blood pressure, cholesterol and blood glucose levels. Clearly we will not be in a position to change those indicators in the short period of time this initiative covers. We understand that it will take a number of years to recognize any movement in health behaviors, which could be recognized in the BRFSS for example. Our best evaluation indicators for the four year period will likely be in process indicators. These will come in the form of system, policy or environmental changes that are yet to be defined (and would of course be driven by the community needs assessment). Measuring process changes that make it possible to allow residents to make easy healthy choices will be our short term measures, with the understanding that eventually we may see those healthy behavior changes evident in the decreases in BMI or cholesterol in the years ahead.

The budget supports two FTEs at the Health Department. A large share of the budget will be grants to local communities. Awards will be made through a competitive application process to a variety of community based organizations including Local Public Health, Extension, non-profits, advocacy organizations, etc. and awarded based on their interest in the initiative, their ability to convene a diverse local stakeholder group, past experience, etc. There are also a large amount of funds under the professional services lines. The majority of these funds (\$153,000 per year based on a recent NPA media contract promoting physical activity in child care) will go to a media contractor to develop and distribute media messages promoting healthy weights, daily exercise, and regular health screening. We feel that consistent messaging will help support the work of the communities. We have requested funds for an evaluation coordinator (\$35,000 per year, based on contractor currently working with the Diabetes Program) since we do not have the resources in-house. Knowing that much of our population receives health information via the web, we also have funds for website development with information, messages and links to other peer reviewed resources (\$40,000). We are requesting funds to support the BRFSS questions related to Chronic Diseases and healthy behaviors. We use the BRFSS as one of our major data sources and with funding reductions; the program will be requesting support for questions. Note we are not clear what the cost will be since the cost will be driven by the program funding levels for the year, but we have set aside \$12,000 per year.

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We are also looking to help support the MediQ Home disease management initiative with Blue Cross/Blue Shield (\$80,000 per year). Along with module guidance in managing disease with their patients, MediQ Home provides the Health Department with important chronic disease data.

Professional fees summary FY13-15

Healthy Communities Media campaign	\$306,000
Evaluator contract	\$ 70,000
Website development and maintenance	\$ 40,000
BRFSS chronic disease and health behavior question support	\$ 24,000
Blue Cross/Blue Shield Disease management liaison support	\$160,000
Total	\$600,000

Funding is requested for the next two bienniums but will continue into the future if successful.

Preventing and managing chronic diseases is the top health challenge of the 21<sup>st</sup> century. Today, Chronic diseases affect almost 50% of Americans and account for 7 of the 10 leading causes of death in the US. Chronic diseases and conditions such as heart disease, stroke, diabetes, cancer, obesity and arthritis cause suffering and limitation to daily function. Preventable health risk factors such as tobacco use and exposure, insufficient physical activity, and poor nutrition contribute greatly to the development and severity of many chronic diseases.

The facts point to North Dakota having a public health crisis when it comes to obesity and chronic illness. Twenty-eight percent of adults are obese (BMI greater than 30) and 11 percent of youth are obese. Obesity is the root cause of most chronic illness. Addressing obesity will help control blood pressure, cholesterol and blood sugar/ glucose levels which altogether will greatly reduce chronic illness in our population.

North Dakotans enjoy a quality of life second to none. However, like every state in the nation, North Dakota is also experiencing rising rates in overweight and obesity in children and adults. While many partners in the state are working to address improving eating habits and increasing physical activity levels, North Dakota does **not** have a comprehensive program to address the problems of poor nutrition and physical inactivity on a state or community level. With a small population and limited fiscal resources, North Dakotans have always recognized the value gained by strong partnerships. North Dakotans hold a deep-seated sense of community, and our people and communities are exceptionally well-connected. Because of these straightforward connections, the possibility of creating real changes is promising.

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North Dakota has had success working collaboratively on many projects and programs to improve healthful eating and physical activity to prevent and control obesity. Working together with partners has helped us leverage our limited resources. However, the prevalence of overweight and obesity in North Dakota adults and children has risen steadily.

- Between 1995 and 2010 the percentage of North Dakotans considered obese (BMI >30) increased 70 percent (from 16% to 28%). (BRFSS)
- The percentage of North Dakota high school students who were obese (at or above the 95th percentile for body mass index, by age and sex) increased from 7.2 percent in 1999 to 11.0 percent in 2011. (YRBS)

The continued increases in the percentages of North Dakotans who are overweight and obese highlight the fact that these piece-meal efforts have not had the desired impact. There is sound science illustrating best practices to serve as guides, but translating these best practices for North Dakota residents is yet to be done. Funding will help allow North Dakota to implement a focused and more comprehensive plan to help residents achieve and maintain healthy weights, monitor progress, and share that information across North Dakota communities and with other states.

**Department goals and objectives this proposal addresses are as follows:**

- Goal: *Improve the Health status of the people of ND*

#2: Achieve health weights throughout the lifespan, and

#3: Prevent and reduce chronic diseases and their complications- both explained the need for the project.

- Goal: *Improve access to and delivery of quality health care and wellness services*

#3: Enhance the Quality of Health Care Services (screenings and use of tools like MediQ Home. We would assume that assessing the needs and skills of health care providers and offering training specific to those needs would be a part of the community service, and

#4: Improve health equity. We assume that all populations will be impacted in all of the planned activities.

**Outcome measures applicable to the project are as follows:****Department indicators. (Those developed during the strategic planning process.)**

By 2015, reduce the rate of diagnosed diabetes among adults to 3.

By 2015, increase the percentage of adults with diabetes who received at least two HgA1c tests during the year to 72.

By 2015, decrease the coronary heart disease death rate among people age 0 to 64 to 25.

By 2015, decrease the cerebrovascular disease death rate to 35.

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By 2015, decrease the preventable cancer death rate to 90.
By 2015, decrease the asthma death rate to 0.7.
By 2015, increase the percentage of ND children age 10-17 with a Body Mass Index (BMI) in the normal weight range to 80.
By 2015, decrease the percentage of ND adults who are overweight or obese to 60.
By 2015, decrease the incidence of low birth weight to 6.0%.
By 2015, decrease the percentage of ND youth grades 9-12 who are overweight or obese to 20.

Without funding there will be no coordinated effort to address the prevention of chronic disease, with a strategic direction and consistent messages for local partners across the state who are interested in investing in disease prevention. North Dakota does not have a comprehensive program to address the preventable risk factors leading to the development of chronic disease. Without funding, the Department will not be able to provide fiscal and technical support to the communities. We would also not be able to measure and evaluate the need for the support nor the success of the initiative. We currently have a very limited ability to identify and evaluate the impact of this kind of disease prevention initiative in the state.

Given the forecasted federal funding picture, we anticipate that by the time this state funding would come into place we will likely have the two FTE's available. One example is the positions currently funded through the CDC Coordinated Chronic Disease grant which is slated to end in August of 2013.

<b>Change Group:</b> A	<b>Change Type:</b> C	<b>Change No:</b> 26	<b>Priority:</b> 24
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Stroke System of Care

**Stroke System of Care - \$383,000**

The Division of Chronic Disease requests \$191,500 per year for the next biennium or \$383,000 to increase funding for continued implementation of the statewide coordinated and integrated stroke system of care. This request supports the following:

\$35,000 per biennium for Statewide Technology

\$8,000 per biennium for Data Entry (at the hospital level)

\$150,000 per biennium for Regional TA support and 2 aphasia pilot projects

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\$50,000 per biennium for training of EMS and other responders

\$140,000 per biennium for Health Communication Interventions

**Description.**

The North Dakota Stroke System of Care Task Force (SSCTF), working as charged under HB 1339 and through its appointment by the state health officer, developed recommendations and strategies to direct the de-fragmentation of stroke related care in our rural state. The significant and primary purpose of the SSCTF recommendations are to create and maintain an inclusive and coordinated, statewide system of care and education that continuously improves the knowledge, diagnosis, treatment and rehabilitation of stroke patients and reduces the overall stroke risk for all North Dakota citizens.

This budget request supports several recommendations for the continued implementation of a statewide coordinated and integrated stroke system of care. The first recommendation is additional dollars needed to support statewide technology related to the registry system. Due to increased costs from the vendor as well as continued on-boarding of hospitals, the stroke registry is currently underfunded in this current biennium by approximately \$25,000. With past experience; the increase of the technology will continue to rise, therefore an additional \$35,000 for the 2013-2015 is requested.

One critical element of the stroke system is the hospital-based acute stroke team. This is the component of the stroke system that is prepared to handle the hyperacute phase of diagnosis and treatment of acute stroke events. The availability of providers capable of diagnosing and treating all aspects of acute stroke remains critical. According to the American Stroke Association, a stroke system should ensure that all patients having signs or symptoms of stroke be transported to the nearest primary stroke center or hospital with an equivalent designation, given the available acute therapeutic interventions. Hospitals not possessing these capabilities should enter into pre-event-negotiated transfer agreements with primary stroke centers or hospitals possessing acute therapeutic interventions. HB 1339 stipulates that the Department can designate hospitals as primary stroke centers if they meet current certification criteria. The SSCTF Recommendation 1.6 – to promote the designation and certification of Primary Stroke Centers – is important for the successful implementation of a stroke system of care. The Division of Chronic Disease is requesting an additional \$8,000 to offer certification assistance grants to those hospitals seeking primary stroke center designation. Local hospitals seeking this designation would need to match funds granted.

The ongoing assistance for the hospitals for training and technical assistance continues to be needed due to the limited time of the Chronic Disease Division- Heart Disease and Stroke program staff. With assistance in this area from a contractor, the hospitals will be receiving continued support to ensure training needs are being identified (such as hospital staff being able to identify the signs and symptoms of stroke and how to respond accordingly), continuing education is being provided regarding chart entry into the state stroke registry, and other technical assistance issues that arise from the hospitals, are able to be resolved in a timely manner. The total amount for the technical assistance from a contractor to work with hospitals statewide would be an additional \$100,000 for the biennium.

An element of the stroke system of care is also the rehabilitation/quality of life of the survivors of stroke. Therefore an additional \$50,000 is requested to assist with two pilot projects related to aphasia. Aphasia is an acquired communication disorder that impairs a person's ability to process language, but does not affect intelligence. Aphasia impairs the ability to speak and understand others, and most people with aphasia experience difficulty reading and writing. The dollars would be granted to universities in the state that have speech pathology to work with persons that are recovering from a stroke. The in-kind resources provided by the students will assist the projects to maximize the dollars granted.

In developing recommendations for a statewide coordinated and integrated stroke system of care, the SSCTF focused on North Dakota citizens and individuals as one of the target audiences. The task force identified strategies that advance public awareness of stroke risk factors, assist individuals in identifying their own risks and move them to action to build healthier lifestyles and prevent strokes; to educate the public to recognize the signs and symptoms of a stroke and take appropriate action by calling 911; and to utilize disease management initiatives to reduce the risks of stroke or recurrence of stroke. To this end, the Division of Chronic Disease is requesting an additional \$140,000 to implement statewide health communication interventions to advance public awareness of stroke risk factors, signs and symptoms of stroke and the

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urgent need to call 911 for appropriate and timely medical care (SSCTF Recommendation 1.2). The primary target population is citizens age 55 and older. The secondary target population is the general public and family members.

The SSCTF also identified recommendations and strategies for agencies and professionals as well as facilities that directly influence and impact the implementation of a statewide coordinated and integrated stroke system of care. SSCTF Recommendation 1.4 supports the establishment of statewide EMS standardization and implementation of stroke training, assessment (tool), treatment and transportation protocols. SSCTF Recommendation 1.5 supports establishment of statewide standardization and implementation of rapid deployment of appropriate EMS resources. In its efforts to support these two recommendations, the Division of Chronic Disease is requesting an additional \$50,000 to provide training on the task force recommendations for EMS standardization prior to the implementation of regulation and licensing changes as well as training for 911 dispatchers and operators for improved response times and survival rates. EMS operators and dispatchers play a critical role in recognizing stroke and determining the timing and type of the EMS response to stroke. In the absence of ongoing stroke-specific training and feedback, EMS operators and dispatchers may fail to identify a significant percentage of potential strokes, even when callers spontaneously use the word "stroke" in communicating with the dispatcher. Establishing programs that provide ongoing education for dispatchers and field EMS personnel to facilitate the accurate and rapid recognition of patients with acute stroke is essential to promote making appropriate decisions involving the treatment, transport and destination of patients suspected of having a stroke. These dollars will enhance the ability to provide stroke specific training to both EMS and 911 dispatchers as well as educate them on the by-pass protocols that are being developed by the SSCTF to ensure that the person experiencing a stroke receives timely services that are most appropriate for the situation. Note that with this request, in addition to the already funded program, the budget amounts would be as follows:

1. Statewide Technology	\$110,324
2. Data Entry	\$100,000
3. Regional TA Support	\$310,000
4. Super User Fee	\$ 3,775
5. Training	\$100,000
6. Public Education	<u>\$236,000</u>
TOTAL	\$860,099

Eighty-three percent or 35 of the 42 eligible hospitals participating in the State Stroke Registry

North Dakota Hospitals Currently Participating in the State Stroke Registry Program:

Tertiary (Non-CAH) Hospitals Participating in State Stroke Registry (6)

Altru Health System-Grand Forks

Essentia Health-Fargo

Medcenter One-Bismarck

Sanford Health-Fargo

St. Alexius Medical Center-Bismarck

Trinity Hospitals-Minot

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CAH Facilities Participating in State Stroke Registry (29)

Ashley Medical Center

Carrington Health Center

Cavalier County Memorial Hospital-Langdon

Langdon

Community Memorial Hospital-Turtle Lake

Cooperstown Medical Center

First Care Health Center-Park River

Garrison Memorial Hospital

Heart of America Medical Center-Rugby

Hillsboro Medical Center

Jacobson Memorial Hospital Care Center-Elgin

Jamestown Regional Medical Center

Lisbon Area Health Services

McKenzie County Healthcare Systems-Watford City

Mercy Hospital of Valley City

Nelson County Health System-McVille

Northwood Deaconess Health Center

Oakes Community Hospital

Presentation Medical Center-Rolla

Sakakawea Medical Center-Hazen

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Sanford Medical Center-Mayville

Southwest Healthcare Services-Bowman

St. Aloisius Medical Center-Harvey

St. Andrew's Health Center-Bottineau

Tioga Medical Center

Towner County Medical Center-Cando

Trinity Kenmare Community Hospital

Unity Medical Center-Grafton

West River Health Services-Hettinger

Wishek Hospital Clinic Association

CAH Hospitals **Not** Participating in State Stroke Registry (7)

Linton Hospital

Mercy Hospital Devils Lake

Mercy Medical Center-Williston

Mountrail County Medical Center-Stanley

Pembina County Memorial-Cavalier

St. Joseph Hospital-Dickinson

St. Luke's Hospital-Crosby

**Need for Project.** Major advances have been made during the past several decades in stroke prevention, treatment and rehabilitation. And yet, stroke continues to be a significant cause of morbidity and mortality. Stroke also remains a leading cause of serious, long-term disability. Despite successes in delivering effective new therapies, significant obstacles remain in ensuring that scientific advances are consistently translated into clinical practice. In many instances, these obstacles can be related to a fragmentation of stroke-related care caused by inadequate integration of the various facilities, agencies and professionals that should closely collaborate in providing stroke care.

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Building stroke systems is the critical next step in improving patient outcomes in the prevention, treatment and rehabilitation of stroke. Increasing the funding for the SSCTF recommendations is an excellent step to create linkages and coordination among the fundamental components of stroke care. Directing resources to these recommendations will make significant contributions to reducing the devastating effects of stroke by working to promote coordinated systems that improve patient care.

These funds will directly relate to the State's ability to improve the quality of stroke care and help ensure optimal prevention and timely identification, transport, treatment and rehabilitation of stroke patients. In addition, the establishment of a statewide coordinated and integrated stroke system of care is critical in North Dakota since our state has many rural and neurologically underserved areas. Collaboration with other stroke system of care members to ensure access to all of the core components of a primary stroke center, as well as access to the broader services that are required to provide stroke patients with the most appropriate treatments will be crucial to establishing a meaningful system for stroke prevention, treatment and rehabilitation. Many important issues will need to be addressed at the local and regional level. It is imperative that the Department provide leadership, organization and governance as the structure for the stroke system is identified, established and implemented.

**Department goals and objectives and how this will help meet them.**

Goals: Improve Health Status of the People of North Dakota

- Prevent & Reduce Chronic Diseases and their complication
- Improve access to & Delivery of Quality Health Care & Wellness Services
- Enhance the quality of Health-Care
- Improve Health Equity

**Outcome Measures (Strategic Plan of DoH)**

- Decrease the percentage of North Dakota adults who are current smokers.
- Increase the percentage of North Dakota smokers who have made a quit attempt within the past year.
- Decrease the percentage of adults who report not having a cholesterol test in the last five years.
- Decrease the percentage of Native Americans age 18 and older who report current smoking.
- By 2015, decrease the coronary heart disease death rate among people age 0 to 64 to 25.
- By 2015, decrease the cerebrovascular disease death rate to 35.

The Stroke System of Care is comprised of grant programs including training grants and primary stroke center certification assistance grants. The training grants will be available to 911 dispatch operators and local EMS operators. The primary stroke center certification assistance grants will be available to those hospitals eligible for this designation.

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New Lab Equipment &amp; IT Domain Replacement

**New Lab Equipment & IT Domain Replacement - \$743,180**

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The North Dakota Department of Health Laboratory Services Division is requesting funding to purchase a Liquid Chromatograph tandem mass spectrometer (LC/MS/MS) and software. In addition, funding for travel and tuition for training, instrument service contracts / extended warranties, and a conversion to the ITD sponsored domain is requested.

Environmental and clinical sample analyses are facing increased demands due to emergencies (both one-time such as the Missouri River floods and on-going such as the Devils Lake flooding). There are also increased demands for a wider range of environmental analyses (e.g. new pesticides and herbicides).

This project includes the purchase of a liquid chromatograph tandem mass spectrometer (LC/MS/MS) which opens new analytical methods to us (many of which have been requested by the Department of Agriculture).

Funding is also requested to replace the existing IT domain (EASTLAB) with the ITD sponsored NDGOV domain while maintaining the redundancy and COG/COOP capabilities of the existing EASTLAB domain and make necessary physical changes to reduce or eliminate single points of failure that are inherent to ITD network design on the lab campus. The project involves ITD locating NDGOV domain controllers (both Active Directory and DNS) into the laboratory building. These will replace the existing EASTLAB domain that is maintained and supported internally.

While researching this project in conjunction with ITD, several single points of failure were identified. These include the single fiber pathways that exist between the laboratory building wire closets (there are two of them) and the ITD operated connectors in the Environmental Training Center (ETC); the lack of direct connection between the two wiring closets in the laboratory building; and the lack of redundant power for the wiring closet in the ETC (much of the laboratory building, including its IT infrastructure, are connected to an emergency generator). In effect, the laboratory is connected to the metro ring with a single path to the ring and no alternatives if that path is broken in any manner.

Sample analysis (public health, environmental, and BT) must be able to be performed on a 24 x 7 basis, especially in emergency situations. These points of failure produce an unacceptable level of risk to the laboratories achieving their mission.

The project will provide a network design within the laboratory building that could, if necessary, function completely without interaction with the ITD connecting capabilities in the Environmental Training Center (ETC) (e.g. during periods of power outage or other failures within the ETC wiring closet) or with other ITD resources available on the metro ring (e.g. during failures elsewhere on the ring or associated with components of the ring).

This project involves both one-time expenses and on-going expenditures. The one-time expenses would be the purchase of the LC/MS/MS, travel, and software; the on-going expenditures into subsequent bienniums would be the supplies and repair services / service agreements.

The budget request has a number of components associated with it. These are as follows.

- Equipment over \$5000. \$445,000 for the LC/MS/MS
- IT equipment under \$5,000. \$4,000. This is the data system (hardware and software) that operates the LC/MS/MS and processes the resultant data. It is provided by the instrument manufacturer and configured to integrate with the instrument.
- IT – Contractual Services. \$51,080 is to replace the existing IT domain (EASTLAB) with the ITD sponsored NDGOV domain while maintaining the redundancy and COG/COOP capabilities of the existing EASTLAB domain. At the same time, make necessary physical necessary changes to reduce or eliminate single points of failure that are inherent to ITD network design on this campus.
- Medical, Dental, and Optical Supplies. \$19,500 is an estimate that includes: \$13,000 for the consumables used by the LC/MS/MS and 6,500 for supplies and standards for the LC/MS/MS.
- Repair Services. \$220,000. This includes: \$14,000 for StarLims - Requested funding supports about 50% of the maintenance contract costs. This service contract supports Microbiology's Laboratory Information Management System (LIMS). This system supports all aspects of sample receipt, specimen processing, test tracking and reporting, billing, accounts receivable, electronic reporting and email notifications to other state programs; \$72,000 for Perkin Elmer – this service contract supports all of the hardware and software for the metals testing instruments in Chemistry; \$42,000 for Agilent –this contract supports all of the

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GC's and GC/MS instruments both hardware and software in Chemistry; \$12,000 for Atlas Chromatography software –The Atlas Chromatography Data System collects the data from our multiple gas chromatographs and liquid chromatographs and permits the chemists to perform timely and accurate analysis of the raw data. The service contract supports the software associated with the CDS (providing solutions to technical problems, analytical assistance, implementation assistance) and the interface hardware that sits between the instruments and the CDS software; \$12,000 for Getinge - This service contract provides preventative maintenance coverage for 3 steam sterilizers. These instruments are used to sterilize media, glassware, biological waste, prepare reagents to support laboratory testing and ensure safe disposal of biohazard waste materials; \$18,000 for the FT-IR – contract supports the FT-IR which is used to assist in identifying white powders and other unknown substances that may be submitted to the lab in responding to a potential incident; \$50,000 for the LC/MS/MS - This is a two year on-site service contract for the repairs and maintenance.

- Travel. \$3,600. This is travel for the training for the operator(s) of the LC/MS/MS and associated data system.

The IT contractual project involves both a one-time expense (the physical network changes) and on-going expenditures. One time expenses include the initial deployment of the Active Directory and DNS servers by ITD and fiber installation between the two wiring closets in laboratory building to build a pathway between the wiring closets that does not involve the ETC wiring closet. On-going expense includes ITD charges for each use of the Active Directory and the DNS server on a monthly basis

Potentially, any entity that uses our analytical results (environmental, public health, or BT) would be considered a stakeholder in this project. We are not certain how many of these would be willing to participate on behalf of this project for us. However, the Department of Agriculture has consistently expressed interest in and support for our expansion in the analytical areas that the LCMS will open up for the Laboratory. Also, the State Water Commission relies heavily on our analytical results for the operation of the Devils Lake Outlet.

Identify the need for the project.

Sample analysis (public health, environmental, and BT) must be able to be performed on a 24 x 7 basis, especially in emergency situations.

These new instruments will add redundancy as well as some new technologies that will improve the testing process. The project also includes supplies for both the increased testing and the new instruments.

To meet these needs the Laboratory needs to move into new analytical areas (the LC/MS/MS).

The existing domain on this campus (EASTLAB), which was left in place to provide the local capabilities and redundancy needed by the critical nature of our analytical environment, needs to be upgraded to an active directory model. It is ITD's preference (based on several meetings with them), that we eliminate EASTLAB at this time and replace it with ITD's NDGOV. In order to have confidence in the reliability and performance in emergency situations that we have with EASTLAB, we need to have local domain controllers.

The proposed LC/MS/MS acquisition will increase the capacity of the laboratory in terms of both the pesticides that can be detected and increased sensitivity to the pesticides (lower levels can be detected).

The LC/MS/MS, service contracts, and IT services are critical to maintain the quality of health and the environment in North Dakota. They facilitate the laboratory's ability to rapidly identify environmental contamination.

If not funded, it could slow the department's response to emergencies that the state may be faced with. We will be at increasing risk of not being able to keep up with the increasing demands being placed on the Laboratory for analyses. We would not be able to move into new analytical areas that the LC/MS/MS would permit us to.

With regards to the IT requests, our choices would be to continue with our existing out-dated domain environment for as long as we keep it operation or to accept the greatly increased risk of failure during critical operations by joining the NDGOV domain without the protections implemented by this project.

All dollar amounts requested are based on conversations and discussions with, or projections by, ITD.

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Trauma System

**Trauma System - \$709,000**

DEMST requests an optional package for the support of the current trauma system in North Dakota.

In 2007, the American College of Surgeons Committee on Trauma quoted "North Dakota is poised to take the trauma system to the next level and has the potential to become a showcase for an inclusive rural trauma system". Since 2007 critical advancements have been made to the trauma system such as a system wide approach to performance improvement and trauma designations for all hospitals in the state.

The state system has been functioning for many years with minimal resources and heavy reliance on the level II trauma centers for support. As the demographics of our state are changing due to the oil activity and the numbers of injured patients steadily increasing, maintaining the system at its current function has proven to be very challenging.

Our system priorities and needs are focused around outreach and education to our rural hospitals and EMS providers especially in the western part of the state. The resources needed are as follows:

**Appropriations for the State Medical Director, trauma designation visits, and ATLS Training**

In the 2011 legislative session appropriations were passed for the biennium in the amounts of \$50,000 for a contracted State Medical Director, \$30,000 for trauma designation visits and \$20,000 for Advanced Trauma Life Support (ATLS) training for the rural hospital providers.

1. The State Medical Director has proven to be a huge resource in providing education and outreach to our rural providers on the standards of care for injured patients in North Dakota as well as leadership at the national level. The expertise that this position has added to the state has been proven instrumental to the trauma system performance improvement process and is believed to provide better outcomes for the trauma patients within the state. With the current appropriations the contracted position is limited to an average of 20 hours per month and the funding must also cover all other expenses with the position.
2. In the 2009 legislative session trauma designation for all hospitals providing emergency services was mandated. On average 30 designation site visits are conducted a year. Each visit takes a full day and includes a 3 person team consisting of the state trauma coordinator and a trauma medical director and trauma program manager from our level II trauma centers. The current budget falls short of covering the cost for the level II trauma centers for allowing their trauma medical director and trauma coordinator to conduct the site visits. It is crucial to have adequate funding for trauma designation site visits to be in compliance with the regulation that was set forth in 2009.

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3. The ATLS training for all providers is also a requirement in regulation to be a designated trauma center. It is a two day course that must be completed every four years and the cost per provider to take the course is \$750. With the current appropriations the state has been able to reimburse a portion of the hospitals when their providers have successfully completed the course. The current funding is not adequate to reimburse all the providers from the level IV and V trauma centers that take the course and it is distributed on a first come first serve basis. This funding is very important as it helps to alleviate some of the financial burdens for the hospitals. Often times there are additional costs for the hospital associated with the course such as travel and hiring a locum provider to cover their hospital while their provider is taking the course.

**Additional Needs to Sustain the ND State Trauma System****1. Rural Trauma Team Development Course**

In the process of visiting all the rural hospitals around the state it has become apparent that there is need for additional education in enhancing our rural trauma system. With the leadership of our State Medical Director, the opportunity for another course called the Rural Trauma Team Development Course has become available in the state. This course focuses on a team approach to treating the trauma patient including providers, nurses, EMS, radiology, lab, etc. The course is taken out to the rural hospitals to help them utilize the resources that they have available in the most efficient way to resuscitate and stabilize the injured patients that they treat.

The trends we are seeing with constant turnover in staff in the rural hospitals and the hiring of locum providers to accommodate the increased number of trauma patients has proved to be challenging when it comes to using a uniform approach to treatment and transfers. There is also a change in the types of trauma patients that are being treated with more penetrating and burn injuries being seen. In other states with rural trauma systems, this course has been proven to be very beneficial to providers and staff that may be unfamiliar with the trauma system and the standards of care within the system.

The level II trauma centers are willing to take the lead in coordinating the course and providing instructors. Each course will require 3-4 physicians and two nurses from the level II facilities to travel out to the rural hospitals. The goal is to do 8 courses (30 participants /course) a year and the cost of each course would be \$ 6,250 (\$50,000/8 courses). Additional funding is requested to conduct this course.

**2. Support for the Department of Health, Division of EMS and Trauma**

In the 2009 and 2011 legislative session, additional FTE support within the Division of EMS and Trauma has been sought, but due to compromise and prioritization it was not appropriated. The program is currently managed with 1.5 FTE and the work load has substantially increased with trauma center designations, education and outreach, and system performance improvement.

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The State Trauma Coordinator is responsible for all the logistics and management of the trauma system. Some of which includes organizing and attending all of the trauma designation site visits, regional and state meetings, orientating new trauma coordinators in the rural hospitals to which there is constant turnover, and the trauma system performance improvement process. The work load has increased extensively and the trauma system has been very challenging for one person to sustain at its current level. The level II trauma centers have been very supportive and will continue to support and promote the trauma system. But with the increase in the number of injured patients they are seeing and stricter requirements by the American College of Surgeons for trauma center verification requiring more trauma medical director and trauma program manager time, there are fewer resources to provide the education and outreach that has been done in the past.

**3. State Trauma Registry Support**

Regulations require that all hospitals submit trauma data to the state trauma registry in order to be trauma designated. Clinical Data Management is the vendor for the trauma registry and all hospitals use the same program for data submission. The annual cost for trauma registry maintenance is \$600 for the level IV and V trauma centers (40), \$2,700 for the level II trauma centers (6), and \$17,000 for the state trauma registry. This again adds an additional financial burden on hospitals.

The trauma registry is a crucial component of the state's performance improvement process. Data is reviewed on a monthly basis to improve outcomes, reduce severity of injuries, and identify system issues as they occur. To maintain the registry and retrieve meaningful data, yearly training and updates are required. There is also a constant turnover in trauma coordinators and trauma registrars who work with the trauma registry which requires additional training to maintain a functional trauma registry.

**2013-2015 Proposed appropriations to support North Dakota State Trauma System:**

\$114,000	Contracted Associate Statewide Trauma Coordinator
\$158,000	Contracted Medical Director
\$ 25,000	Medical Director expenses for education and travel
\$100,000	Implementation of the Rural Trauma Team Development Course (16 courses)
\$ 80,000	Advanced Trauma Life Support Training
\$ 72,000	Level IV and V site visit designations
\$160,000	Trauma registry support for state and hospital registries and training
<b>Total</b>	<b>\$709,000</b>

Change Group: A

Change Type: C

Change No: 32

Priority: 14

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Community Paramedic/Community Health Care Worker Pilot Project

**Community Paramedic/Community Health Care Worker Pilot Project - \$276,600**

The Division of Chronic Disease and the Division of Emergency Medical Services and Trauma request an optional package for the pilot project of establishment of a Community Paramedic/Community Health Care Worker educational pilot project. There appears to be significant overlap of the Community Health Care Worker and Community Paramedics, therefore, it seems natural for these two divisions to work in concert on a new health care delivery system in both rural and urban areas. Not only has this been a major effort in healthcare circles of other states but also internationally. We have held a statewide stakeholder meeting asking for input of those in the health care arena to introduce the concept of patient centered medical home or in some cases seeking a decrease of chronic use of ambulance transport or unnecessary utilization of emergency departments.

This model is currently being utilized in some surrounding states, Minnesota and Montana, as well as rural areas (Eagle County, Colorado) utilizing both the urban and rural focus of this concept. We believe this concept would be the first to marry the Community Health Worker and Community Paramedics and effectively use the workforce that currently exists with significant down time between ambulance calls or transports.

There are many efforts being made throughout the country for an alternative to the existing healthcare delivery system. Many of these programs are looking at a Medical Home model or a transition model of care. We believe this model can accomplish the same aims but do it for less money. Most of the new models require a workforce that needs to be found and compensated. In EMS the workforce already exists and can possibly survive on a fee for service basis. The added benefit to this concept is that it can assist in keeping ambulance services sustainable.

The project time period is ongoing, however, it is expected that most of the cost would be in the first fiscal year of the biennium with the exception of the FTE. In order to train the current workforce and reinforce the dwindling number of volunteers this project could inject some paid staff for the ambulance services while filling the needs of the community.

This is a request to begin a pilot project within North Dakota. We are asking for \$276,600 as a combination of one-time funding for the educational start up and continued funding for the FTE. The FTE cost for the biennium is \$135,000 and the educational start up cost is \$141,600. The FTE portion of this funding is to coordinate the ongoing Community Health Care providers and to establish the training program for this project and coordinate STEMI.

A curriculum already exists for the training of the providers. There may be a need to change existing rules and statutes to make this program fully functional. There will be many other changes in addition to changing rules and statutes to make this program fully functional.

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There exists a need to change portions of the rural and urban health care delivery system. This program can reinforce the system's change so people can be treated by the appropriate providers at the appropriate time to ensure there is a smooth transition between the clinical systems into the community. This program presents an opportunity to increase the quality of health care within the underserved communities. Other programs similar to this have been shown to decrease health care costs especially in the urban areas. The climate in the EMS arena is at best challenging, with the lack of volunteers and the EMS workforce aging. Whatever we can do to attract and retain EMS personnel is essential to continue the EMS system throughout the state. If training and education become a financial burden for the individual as well as the ambulance service the likelihood exists for significant erosion of the system which could result in areas of decreased coverage or decreased quality. In the state there has never been an equivalent level of challenges as what we currently face.

There is also a need in the state to help transition patients from the clinical system into the community. As part of the healthcare continuum, the transition for patients from the clinical system back into their home environment has been not up to par. With continued chronic disease readmissions into the clinical systems, the financial and personal wellbeing continues to be sacrificed.

**Department Goal and Objective the project addresses:**

Goal: Improve Access to and Delivery of Quality Prehospital Health Care

Objectives: Promote and maintain statewide emergency medical services.

Enhance the quality of health care services.

This request addresses the above goal and objectives by ensuring there are adequate resources to assist ambulance services and personnel in lowering the cost of education and training. We need to make education and training less of a financial burden rather than an increased burden or the result will be a smaller number of personnel to staff ambulance services and ultimately the potential closure of some critical access ambulance services.

This program is popular around the country and provides the opportunity to establish a new method of healthcare. This program has the real potential to save healthcare dollars in a number of areas, and those gains would be sacrificed if funding is not available. Without the program we would lose the potential of cross training existing EMS personnel and the flexibility of adding additional services to the citizens of North Dakota such as Occupational Health and Wellness.

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Rural EMS Assistance Fund for Grants

**Rural EMS Assistance Fund for Grants - \$1,750,000**

Additional funds are requested to maintain the current fiscal year funding at the \$3,000,000 level or above for future years. With the passage of House Bill 1044 in the last legislative session the dollar amount for the current biennium is \$1,250,000 for the first fiscal year of the current biennium and \$3,000,000 for the second fiscal year of this

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biennium. These amounts totaling \$4,250,000 are stated as the baseline for grant funding for the 2013 – 2015 biennium, \$2,125,000 per fiscal year for the Rural EMS Assistance Fund. In the current fiscal year there was approximately \$2,900,000 available for distribution after administrative costs were subtracted. Grant applications totaling approximately \$7,365,000 were received and the amount requested was 253% of the amount available.

One conclusion that can be drawn from this experience is that there is a much greater need in the funding areas than what we were able to provide. In the testimony before legislative committees the North Dakota EMS Association had asked for funding for the current biennium at \$12,000,000 and the legislative action made \$4,250,000 available for the biennium. The legislation also included a requirement that there needed to be a \$10.00 per capita match to receive state funds. This requirement was based on raising approximately \$12,800,000 at the county or local level for the biennium.

There is no mandate for Emergency Medical Services in North Dakota at the state, county or local level. As a result, there is no one entity charged with the financial support of ambulance services in North Dakota. Until there is a mandate for financial support of ambulance services there needs to be a balance of funding sources from state, county and local levels. While we do not feel that it is appropriate for the state to support every ambulance service in the state to a financially sustainable level, state funds help with overall sustainability of services. Currently we provide funding by grants awarded to funding areas through the Rural EMS Improvement Fund. The staffing grant of the past has played an integral part in sustaining volunteer ambulance services through partially paid staff for volunteer ambulance services. The funding area grants are geared toward collaboration of services within a funding area. We have a long history of ambulance services operating independently with no true statewide system in effect. The goal of the funding area grants is to promote collaboration between services with the long term goal of building a true system of EMS within the state. Unfortunately DEMST is the only agency that looks at the state as a whole and can incentivize services to work together.

Since the DEMST is part of the Emergency Preparedness Response section these monies may well be used as matching funds. Support for this program comes from all stakeholders of the EMS industry in North Dakota.

**Need:** There are many factors affecting the delivery of pre-hospital care: shrinking volunteer workforce, some communities impacted by the oil boom with increasing population, an increase in the severity of patients, an increase in the cost of equipment and the generational difference in volunteers make a case for increasing financial commitment to retain the high level of pre-hospital care that is enjoyed by our citizens. As the majority of ambulance services in the state are volunteers, the funding area grant plays a large role in sustaining the level of service within the state. Taking into account all of the financial support an ambulance service receives through fee reimbursement, local tax levies, and monies from the state, by far and away the single largest contributor or subsidy an ambulance service receives is the volunteer time spent by the thousands of volunteer EMS personnel. It has been estimated that to fully fund ambulance services for the volunteer subsidy it would take approximately \$31,000,000 per year.

**Department Goal and Objective the project addresses:**

Goal: Improve Access to and Delivery of Quality Prehospital Health Care

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Objectives: Promote and maintain statewide emergency medical services.

Enhance the quality of health care services.

Enhance sustainability of critical access ambulance services

If the state is unable to provide the necessary resources for ambulance services we may see a reduction in the numbers and quality of the ambulance services across the state. It is inevitable that we will have a decrease in the number of services that currently exist within the state. The fear is certain critical access services may close as well and this may result in large geographical areas of the state that are left uncovered or a reduction in the quality of care rendered in the prehospital arena.

<b>Change Group:</b> A	<b>Change Type:</b> C	<b>Change No:</b> 34	<b>Priority:</b> 20
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EMS Database Systems

**EMS Database Systems – \$480,000**

The Division of Emergency Services and Trauma (DEMST) requests an optional package for the replacement of the current database systems within the division. The current systems are cumbersome and we could dramatically improve the efficiency of staff time and communication with those we serve. The improvements would be single entry of information by EMS providers that is then used for patient record information by the hospitals, billing information on the fiscal side and system monitoring and description by our office.

On the communication side it would be ambulance run status being automatically conveyed to dispatchers and hospitals receiving notice of patients en route and approximate estimated time of arrival (ETA). Based on the above information we are not just replacing an existing system, we are developing additional capabilities with a new system.

We currently have two database systems within the Division that are outdated and both of the systems lack company support. The purchase of the systems dates back to 2004 and before, with little hope of upgrading to the present needs much less consideration of future needs.

With the advances in technology and medical equipment we can no longer tolerate proprietary systems that aid in the establishment of segregated information technology. It is essential that whatever technology systems we put in place must work together in order to achieve the synergy of a true system, not exclusive systems that isolate themselves from interconnectivity of multiple components. This destroys the possibility allowing for multiple opportunities for these components to form an integrated technology platform.

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The components of this platform include but are not limited to run status of ambulances, patient care records that can be uploaded to the run reporting requirements of the state, a registry for the licensure of individuals and services, a database which can aid in the quality improvement of emergency healthcare, and a common platform by which services can automatically transmit various data points for physician input during the transport phase. This system would also increase the transparency of the Division by allowing members of the general public, employment agencies and third party payers to view current public information regarding current status of licensure therefore increasing public safety. The system currently in use does not have those capabilities.

**Project time period:** The project time period is ongoing. It is imperative that the EMS data program has enough lead time to train ambulance services on run reporting data, and users within the office. Data base maintenance and reporting will continue in future bienniums. By our office continuing with upgrading the database we at the Division level we will be able state to insure consistency with established rules and expectations across the state.

**Funding:** The funding for the replacement database will occur in this biennium at a level of \$400,000 for the biennium and continued funding in the second year of the biennium and beyond at a level of \$80,000 per year for a service contract.

**Matching funds:** Since the DEMST is part of the Emergency Preparedness Response section these monies may well be used as matching funds.

**Need:** A dire need exists to upgrade our system into a more modern system not only for ease of use but also for accommodation of new technology in the EMS arena. Currently we have two proprietary systems within the Division that do not interact with each other and certainly do not have the robust capabilities to keep pace with technology. With current economic activity that is occurring within the State of North Dakota the demand on the Division has increased dramatically. This system will allow the Department to provide these services that the citizens of North Dakota demand and deserve without increasing costs of staff to the Department. Federally we are also required to submit certain data points to the National EMS Information Systems database and this product will accomplish these mandates.

**Department Goal and Objective the project addresses:**

Goal: Improve the database system in North Dakota for ease of use and greater flexibility

Objectives: Assemble statewide ambulance run report date

Promote the capabilities in all forms of communication within our realm

**Outcome measures:** The outcome measures will the improvement of accuracy and time in run reporting. Currently it may take as long as three to six month for an ambulance reports to be filed. This is not tolerable and the new system will alleviate this gap

<b>Change Group:</b> A	<b>Change Type:</b> C	<b>Change No:</b> 35	<b>Priority:</b> 16
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Leadership Training For Ambulance Service Directors

**Leadership Training For Ambulance Service Directors - \$220,000**

The Division of Emergency Medical Service and Trauma (DEMST) requests an optional package of \$220,000 for the 2013 – 2015 biennium for the establishment of ongoing leadership training of ambulance service directors. It is apparent many of the service directors are ill prepared to lead the ambulance services in the current crisis

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or the many future challenges that are going to occur. For the past 40 years or so the focus has been on the medical education and training needed to respond to emergency calls. Few ambulance services have been operated as a true business and the pressures within this industry for the present and future can only be met by focused and prepared leadership. It is our belief that this training is the single highest priority for ameliorating some of the woes that face sustainability of ambulance services within the state for the long run.

As part of the Rural Emergency Medical Services Improvement Project (REMSIP) conducted by SafeTech Solutions in the 2009 – 2011 biennium one component introduced leadership training for service directors. These sessions became very popular and often the comments associated with the leadership seminars were nearly universal in their praise for the content of the seminar. There are four levels of leadership training and we were only able to host five Level 1 courses and one Level 2 course. Since that time we have been struggling with supporting leadership training within the state. There have been a few additional leadership sessions put on by the ND EMS Association after they have received small grants from other agencies.

For the 2011 – 2013 biennium our training grant funds were cut by \$300,000 to make up the shortfall in operational funds for DEMST. During this time we have partnered with the ND EMS Association to try and complete additional leadership training but that has been a less than successful approach. The training grant funds stand at \$940,000 per biennium and this amount will be exhausted by the ongoing medical education and recertification educational opportunities.

There is one common denominator in the most successful ambulance services within the state, and that is adequate and prepared service directors. With leadership training we are finding that those people who are most interested in becoming a leader do attend at least one leadership level and most would attend more if we were to offer continuous leadership training opportunities.

Approximately one half of the ambulance services within the state have had at least one person attend a leadership session. However, we have been only able to offer a handful of Level 1 and even a smaller number of Level 2 trainings. We have not offered a single Level 3 or a Level 4 session. These dollars would allow us to put on five leadership training opportunities per year and would allow us to offer all 4 levels during each year. This appears to be the only sustainable opportunity for the continuous leadership training.

We are asking for \$220,000 to allow for five leadership training sessions per year. Since the DEMST is part of the Emergency Preparedness Response section these monies may well be used as matching funds. Support for this program comes from all stakeholders of the EMS industry in North Dakota. With changing patterns in the ambulance services, such as workforce demands and complexities of business practices, leadership is a key factor for the establishment of solid, sustainable services.

While approximately one half of the ambulance service directors attend a Level 1 leadership training session, significantly fewer attend a Level 2 training. It would be the goal to train 100% of all service directors in all four levels of leadership training with an ongoing reinforcement or continuing education format to continuously keep abreast of the rapidly changing EMS world.

**Department Goal and Objective the project addresses:**

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Goal: Train 100% of ambulance service directors in all four levels of training

Objectives: Promote and maintain statewide leadership training.

Enhance the sustainability of the needed ambulance services

All ambulance services by the end of this biennium will have a leader representative that has been trained in Level 1 and 50% will have attended a Level 2 training session, 25% attended a Level 3 program and 10% will have attended a Level 4 session. This project will have to continue in future bienniums if we are to attain 100% in all levels and be able to offer the complete set of leadership training because of turnover and continuous reinforcement.

<b>Change Group:</b> A	<b>Change Type:</b> C	<b>Change No:</b> 36	<b>Priority:</b> 9
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Physician & Mid Level Practitioners Loan Repayment

**Physician and Mid Level Loan Repayment - \$270,000**

The loan repayment programs for physicians and mid level practitioners (nurse practitioners, physician assistants and certified nurse midwives) are intended to attract health professional workers to serve in North Dakota's areas of need and workforce shortage areas. Physicians may receive \$90,000 for two years of service in a selected community and mid level practitioners may receive \$30,000 awards for two years of service in a selected community. Half of the awards are paid by the community (usually by a hospital or clinic) and half is paid by the state. The State Health Council may select any number of recipients and communities each year as participants in the programs subject to the availability of funding.

The state general fund and the Community Health Trust Fund were used in the 2011-2013 biennium to support the loan repayment programs. In order to support the health professionals currently participating in the loan repayment programs and to allow three new physicians and three new mid level practitioners into the programs each year of the 2013-2015 biennium, \$270,000 of General Funds is requested.

North Dakota Health Care Association, North Dakota Medical Association, North Dakota Hospitals, North Dakota Clinics, North Dakota School of Medicine and Health Sciences all support this program.

Funding for physicians and mid level practitioners under contract for repayment during the 2011-13 biennium is included in the base budget. Additional general fund dollars are needed to pay the educational loans of health professionals and of new health professionals who will enter the program during the 2013-2015 biennium.

**Department Goal and Objective the project addresses:**

Goal: Improve access to and delivery of quality health care

Objectives: Enhance the quality of health care services

**Outcome Measures:** The number of health professionals receiving loan repayment awards and serving in areas of need.

<b>Change Group:</b> A	<b>Change Type:</b> C	<b>Change No:</b> 37	<b>Priority:</b> 11
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Dental Loan Repayment & Dental Non-profit Programs

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301 ND Department of Health

Bill#: SB2004

Date: 12/07/2012

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**Dental Loan Repayment and Dental Non-profit Programs - \$360,000**

The Dental Loan Repayment Program is designed to attract dentists to North Dakota to practice in areas of need. The focus of the program is to encourage new dental school graduates to practice in North Dakota. Each dentist selected may receive up to \$80,000 in exchange for providing four years of service in a selected community or communities. Three new dentists may enter the program each year. Preference is given to dentists who will serve in rural underserved areas.

The Dental Non-profit Program allows for awards of \$60,000 to dentists who work in non-profit/public health dental clinics that bill patients on a sliding fee schedule. The purpose of this program is to provide oral health services to low-income populations. Three dentists may be selected for awards over the 2013-2015 biennium. The dentist must work at the non-profit clinics for three years. The award is paid over a two year period.

Funding for dentists under contract for repayment during the 2011-13 biennium is included in the base budget. Additional general fund dollars are needed to pay the educational loans of dentists who will enter the program during the 2013-2015 biennium. Additional general fund dollars (\$180,000) are requested to support the dentists in the Dental Loan Repayment Program that will be added over the 2013-2015 biennium.

An Additional \$180,000 of general fund money is requested to support three new dentists who will work in non-profit/public health clinics who serve low income populations.

The ND Office of Oral Health, ND Dental Association, North Dakota Oral Health Coalition support this program.

**Department Goal and Objective the project addresses:**

Goal: Improve Access to and Delivery of Quality Health Care

Objectives: Enhance access to and utilization of health services

Enhance the quality of health care services

<b>Change Group:</b> A	<b>Change Type:</b> C	<b>Change No:</b> 38	<b>Priority:</b> 18
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ND Early Hearing Detection and Intervention Program

**ND Early Hearing Detection and Intervention Program - \$300,000**

The ND Early Hearing Detection and Intervention (EHDI) program is currently administered by the North Dakota Center for Persons with Disabilities (NDCPD) at Minot State University utilizing federal grant funds. Without state support to sustain it, ND's EHDI program may come to an end effective March 31, 2014 when the current federal grant funding ends. The ND EHDI program's goals are: 1) To screen newborn infants for hearing loss before one month of age, 2) To complete diagnostic evaluations on infants who don't pass the screening before three months of age, and 3) To enroll infants in early intervention services before six months of age. These goals are endorsed by the Joint Committee on Infant Hearing, the American Academy of Pediatrics, and the US Preventive Services Task Force.

The ND EHDI program has received on-going support from a variety of stakeholders, many of whom have participated on the ND EHDI Advisory Group. These individuals or organizations have assisted the grants management team in developing a strong infrastructure. A state contracted EHDI program will continue to improve on this initial success. Stakeholders include: North Dakota Center for Persons with Disabilities, ND Chapter of the American Academy of Pediatrics, ND Chapter of the March of Dimes, ND Department of Public Instruction, ND Department of Human Services, ND Department of Health, ND Hands and Voices, ND Family Voices, National Center

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for Hearing Assessment and Management, ND Sertoma Club, Audiologists, Otolaryngologists, Families of children with hearing loss, Hospital Staff, Tribal representatives, ND Healthcare Association, and the ND Medical Association.

Studies show that children who have a hearing loss often have developmental delays. Children with a hearing loss may lag behind their peers in language, cognition and social-emotional development. Such delays may result in lower educational and employment levels in adulthood. Given the serious ramifications of late identification of hearing loss, it is important to perform timely newborn hearing screening, diagnosis, and intervention.

**Department Goals and Objectives**

- Improve Access to and Utilization of Health Services
- Prevent and Reduce Chronic Diseases and Their Complications
- Enhance the Quality of Health Care Services
- Reduce Health Disparities

**Outcome Measures:**

Outcome measures have been used to evaluate the EHDI process. With the use of the web-based tracking system known as OZ, the ND EHDI program has the ability to track the following measures on a statewide basis as well as on an individual hospital basis.

1. **The percent of infants that have been screened for hearing loss before hospital discharge.** In 2011, 99% of the births received a hearing screening prior to discharge.
2. **The percent of infants that received a referral for additional screening at hospital discharge.** In 2010, the average referral rate was 10%. Current 2011 data indicates a referral rate of 9.4%. National targets for this measure are less than 5%. Newer screening equipment or two stage screeners (OAE and ABR combination screeners) may be able to impact this percentage.
3. **The percent of infants requiring additional hearing screening that return for an outpatient screen.** In 2011, 81% of infants that failed the initial birth screen returned to complete the outpatient screening. This is up from 59% in 2007. The goal is that 100% of infants that failed the initial hearing screening complete the outpatient screen.
4. **The percent of infants that are referred for a diagnostic evaluation.** In 2011, 5.7% of the infants that were referred from the initial birth screen and from the outpatient screening were referred for a diagnostic evaluation with an audiologist. This indicator is down from the 8.8% that was achieved in 2009. The national benchmark for this measure is <4%.
5. **The number of infants that were referred for a diagnostic hearing evaluation that complete the diagnostic hearing evaluation.** Of the 36 infants that were referred for a diagnostic evaluation, 24 (67%) of them had results reported in OZ. The goal for this measure is 100%.
6. **The number of infants that are diagnosed with a hearing loss.** In 2011, eleven infants were identified as having a hearing loss on the OZ system. Based on national incidence levels, 2-3 infants per 1000 are expected to have a hearing loss.

The first two measures are near or exceeding the national benchmarks. The remaining measures show a need for continued support. Improvement of these outcomes is dependant on many aspects of the community-based system (e.g., families, birthing hospitals, audiologists, physicians, early interventionists, family support agencies, etc.) to achieve set targets and benchmarks. The ND EHDI program has worked well with these community partners, and as a result, over time has seen an improvement in these measures.

Without funding, it is unlikely a statewide program that addresses hearing screening, diagnosis, and intervention could be maintained. Although community support has been strong throughout the life of the EHDI grant program, state infrastructure is needed to sustain the EHDI system, especially if federal grant funding ends

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Office of Health Equity

**Office of Health Equity - \$265,013**

Health disparities in North Dakota are significant and exist across the life span. While Native Americans make up 5.4 percent of the population in North Dakota, they account for 51 percent of Infant Mortality (IMR) in the state. In 2009, the ND IMR was 5.4 per 1,000 live births for the general population, and it was 16.7 for Native Americans. In addition, the mortality rate for children ages 15 – 18 years due to unintentional injury in 2008 was 1,327 per 100,000 people for Native Americans, but it was only 495 for the white population. As a result, the mortality rate for age 0 – 44 years in ND 282.1 per 100,000 people for Native Americans, but it is 82.4 for the white population.

The rate of diabetes among Native American adults (11.3 percent) is significantly higher than that of whites (7.6 percent). Although the prevalence of diabetes is nearly double for Native Americans, the mortality rate from diabetes is nearly six times greater (144.2 per 100,000 for Native Americans versus 25.4 for whites). Native Americans living in North Dakota experience death due to cardiovascular disease at twice the rate of death for whites; stroke mortality is also higher for Native Americans than for whites.

The upstream socio-economic conditions that build health conditions are also unequal in our state. About 11.7 percent of North Dakotans live in poverty (ND State Data Center, 2009); the poverty rate for children ages 0 to 17 was estimated at 14.1 percent. It is striking that the poverty rates in counties in which tribal reservations are located have poverty rates that are more than double the statewide rate; the poverty rate in Sioux County was 39.9 percent, 30.1 percent in Benson County, and 28.1 percent in Rolette County. Approximately 50,200 North Dakotans are food insecure. Again the rates of food insecurity are significantly higher in counties that contain tribal reservations within their boundaries. (2011, Feeding America). In ND, 56 percent of Native Americans have not completed education beyond high school compared to 36 percent of the white population.

Approximately 23,557 Native Americans live in reservation areas in the state (ND State Data Center, 2010). Tribal governance and tribal health administration structure vary greatly within each of the five federally recognized Indian tribes, and tribal nations, not state/local public health jurisdictions, have sovereign authority in reservation areas.

The NDDoH Office for the Elimination of Health Disparities plays a key role in linking and coordinating programs and plans among North Dakota's tribal nations; the director is a member of the HND Coordinating Committee. A blanket one-size-fits-all policy or plan does not work for every tribal nation; each has its own people, culture and priorities that must be considered on an individual basis. The large disparities that exist amongst people in our state, especially the large differences between health status in Native Americans and Whites needs time, attention and access to resources, which can be facilitated through the OEHD.

Without the OEHD, it is expected that fewer linkages and less coordination will occur between tribal nations, and also that there will be less opportunity to find and direct resources to the people in our state who need them most. It may follow that the large health disparities gap will continue to grow rather than to shrink.

The Office of Health Equity is currently funded through a federal grant that ends in the fall of 2013. We are uncertain of future federal funding of this effort. Our goal is to provide general funding for the basic infrastructure for Health Equity and use Health Equity federal funding for various projects if it continues.

<b>Change Group:</b> A	<b>Change Type:</b> C	<b>Change No:</b> 40	<b>Priority:</b> 23
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CSHS Client Server Application

**CSHS Client Server Application - \$647,108**

The Children's Special Health Services (CSHS) database is a client server application that was developed in 1999. It is used to support a variety of programmatic and reporting functions within the Division. The client server application was designed with the following needs in mind: 1) to address federal, state, and ad hoc reporting requirements, 2) to provide information to guide administrative decision-making, and 3) to increase integration and functionality of various CSHS programs administered at

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the state-level. As services and administrative needs have evolved, computer programming has been required to support ongoing functionality of the system over the last decade.

CSHS has identified the need for a new web-based system that would achieve or support the following: 1) link with local level service providers who provide eligibility and care coordination services for children and their families, 2) move from paper files to an electronic medical record, 3) achieve data integration where possible and assure communication with various health care providers (e.g., MMIS, Health Information Exchange, etc.), and 4) continue functionality of the current client server application.

Costs to sustain the web-based system, once developed, would be needed in subsequent bienniums.

County social service staff that help administer the CSHS program at the local level would likely support the project. Other health care providers and payers would also likely benefit. Needs assessment data generated from the CSHS web-based system would also be important to Title V MCH stakeholders.

The client server application, with identified enhancements that transform it into a web-based system, would be an essential business tool for the CSHS division. The current client server application was developed over a decade ago. Long-term ITD support for dB2 Powerbuilder applications is questionable.

**Department Goals and Objectives**

- Improve Access to and Utilization of Health Services
- Prevent and Reduce Chronic Diseases and Their Complications
- Enhance the Quality of Health Care Services
- Reduce Health Disparities

A new web-based system would support essential public health functions, including assessment, public information/education, linkage to services/enhancing system capacity, and evaluation among others. The web-based system would provide data for federal performance measures, state performance measures, strategic planning, and internal CSHS quality assurance measures. If not funded reporting capabilities and communication could be jeopardized. Efficiencies through use of up-to-date technology would not be realized.

<b>Change Group:</b> A	<b>Change Type:</b> C	<b>Change No:</b> 41	<b>Priority:</b> 29
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Veterinarian Loan Repayment Program

**Veterinarian Loan Repayment Program - \$135,000**

The loan repayment program for doctors of veterinary medicine is a state financed and administered loan repayment program designed to attract new food animal veterinarians to North Dakota to practice in areas of need. The focus of the program is to attract new graduates of veterinary schools although any veterinarian may apply if he or she has an outstanding educational loan and is licensed to practice in North Dakota. Three new veterinarians may receive loan repayment awards each year. Each veterinarian selected may receive up to \$80,000 to repay educational loans. Each veterinarian that receives an award must enter a contract with the North Dakota Department of Health. The contract states the length of the service obligation and the amount of the award. The contracts require a minimum of two years of service for \$30,000 and four years of service for \$80,000.

Funding for veterinarians under contract for repayment during the 2011-13 biennium is included in the base budget. Additional general fund dollars of \$135,000 are needed to pay the educational loans of veterinarians who will enter the program during the 2013-2015 biennium.

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Three new awards are added each year and three complete their service obligation each year.

The North Dakota University System, North Dakota Stockman's Association, North Dakota State Veterinarian, North Dakota Veterinary Association, North Dakota Board of Animal Health all support the program.

North Dakota's University System does not offer a doctorate in veterinary medicine. This means that North Dakota students must go out of state to obtain this advanced degree. The loan repayment program is an incentive designed to attract the students back to North Dakota and to serve in areas of need.

<b>Change Group:</b> A	<b>Change Type:</b> C	<b>Change No:</b> 42	<b>Priority:</b> 5
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Public Health Emergency Preparedness - Volunteer Coverage through WSI

**Public Health Emergency Preparedness (PHEP) - Volunteer Coverage through WSI - \$84,000**

The PHEP program is responsible for preparing, planning and responding to health and medical emergencies in North Dakota. A major component of the response element is the activity of health and medical volunteers from health and medical agencies across the state. The North Dakota Legislature tasked our ESAR VHP (Emergency System for the Advanced Registration of Volunteer Health Professionals) program with credentialing and data collection for the professional medical volunteers in North Dakota. Additionally, the legislature enacted legislation that re-calculated a fee schedule for WSI coverage for the volunteers needed annually.

Prior to this legislative change, total WSI annual coverage for volunteers agreeing to respond to an event came to an amount less than \$1,000. Now that the fees for WSI coverage are calculated differently as mandated by state law, the annual amount for these medical professional volunteers comes to approximately \$42,000 per year.

If this amount is passed to the local stakeholders, a different fee schedule would be developed for each local entity based upon their population and associated risk. If the state were to request these volunteers for an event, the fees would vary from one local entity to the other. It is preferred that the state take on this expense to provide relief to local stakeholders and to create unity within the state.

Due to a 19% decrease in federal program funding, the PHEP program is not able to take on this fee increase. The funds would be paid directly by the Department of Health to WSI, resulting in coverage for all ESAR VHP members.

<b>Change Group:</b> A	<b>Change Type:</b> C	<b>Change No:</b> 43	<b>Priority:</b> 10
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Nurse Telephone Triage

**Nurse Telephone Triage \$4,650,000 (\$671,000 general fund; \$3,979,000 special funds)**

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The project will implement a telephone triage system within the North Dakota Department of Health. The system will be useful during large scale emergencies and reduce unnecessary emergency department visits resulting in an overall reduction of emergency department expenditures by at least 15%. A contractor would be secured to staff the system 24 hours a day, seven days a week with nurses who will receive the calls, provide the caller with assistance in deciding if medical care or emergency room care should be sought, provide advice for self care, if appropriate, and collect data to measure the system's efficacy and analyze disease data. It is estimated that three major North Dakota payment providers, the Public Employee Retirement System, Blue Cross and Blue Shield of North Dakota and Medicaid incur costs for about 90,000 emergency department calls annually totaling about \$66.4 million each biennium. A 15% reduction in those costs would be \$9.6 million each biennium.

This request would provide funding to oversee and manage the system, cover the costs of software and protocol licensing and provide reimbursement for the Medicaid share of the call staffing contract. The project will be ongoing to future biennia with the intention of shifting all of the costs to the payment providers.

Failure to implement the project will result in losing the opportunity to substantially reduce health care costs.

**Budget and Justification:** \$4,650,000

Blue Cross/Blue Shield and North Dakota PERS will provide funding for their share of the nurse triage calls estimated at \$3,979,000. State general funding is requested for the Medicaid portion of the estimated number of calls. This funding will cover \$144,000 of administrative costs at the state level and the remainder will be contracted to an entity to provide the nurse coverage for the calls. Administrative costs at the state level include \$10,000 of administrative oversight, \$110,000 for the telephone triage medical protocol, ITD hosting fees and telephone costs. The contract with an organization to provide 24/7 telephone coverage and response is \$4.5 million calculated as \$25.40 per call for 90,000 calls.

The following is the budget breakdown by line item:

Temp Salaries	\$ 9,091
Benefits	\$ 909
IT/Data Processing	\$ 24,000
IT/Contractual	\$110,000
Professional Services	\$4,506,000

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Salary Equity Package

**Salary Equity Package \$3,650,000 (\$2,737,500 general fund; \$912,500 federal funds)**

The North Dakota Department of Health is requesting a salary equity package because of the severe compression caused by instituting the Hay classification system and large number of our staff that are paid significantly less than employees in other state agencies.

The chart below shows the compression caused by the new system.

**Department of Health Employees by Salary Quartile**

	<u>Old System (June 1<sup>st</sup>, 2012)</u>		<u>New Hay System (July 1<sup>st</sup>, 2012)</u>	
<u>1<sup>st</sup> Quartile</u>	114 employees-	34.9%	224 employees-	64.9%
<u>2<sup>nd</sup> Quartile</u>	132 employees -	40.4%	99 employees-	28.7%
<u>3<sup>rd</sup> Quartile</u>	79 employees -	22.0%	21 employees-	6.1%
<u>4<sup>th</sup> Quartile</u>	9 employees -	2.8%	1 employee-	0.3%

While still clustered toward the bottom of the salary range in the previous classification system (75% in 1<sup>st</sup> and 2<sup>nd</sup> quartiles), the Department of Health salary structure did allow for some spreading across the salary range based on longevity and performance. The new system offers almost no spreading in the range as over 93% of all employees are currently being paid below their market policy point (formerly midpoint) of their range. Almost 65% of all employees are now compressed in the 1<sup>st</sup> quartile. Over 55% of this percentage (124 out of 224 employees) is made up of employees who have over five years of experience working in state government. In the Hay system, almost no separation exists between new employees and experienced employees. This creates a significant morale issue for longer termed employees and significantly limits starting salary flexibility in hiring new employees.

Additionally, the Department of Health is paid considerably lower than other state agencies and the market. As revealed by the Hay Study, Department of Health employee pay lags the market by 12% which is significantly higher than the 7% state agency average. Using data available from Human Resources Management Services, the department identified several of its classifications where the average salaries lagged at least 5% behind similar classes in state government. Analysis of the average salaries of other state classes and/or the average salaries paid other state employees in the same grade revealed that 50 of 75 Department of Health classifications are at lower rates of pay than other state departments and agencies in classified service. Increases would vary significantly, however the 212 employees are, on the average, 15 percent behind state employees in similar classifications and grades. This is an increase of 26 percent more employees over our request for the 2011 session when 168 employees were 5 percent or more below and only 9 percent behind on average.

These figures were compiled using as direct comparisons as possible, for example comparing the average for Administrative Assistant Is in the Department of Health to average of Administrative Assistant Is in classified service. In some cases such as environmental engineers, comparisons were made with other engineering classes, e. g. Transportation Engineers, because they are at the same grade and we are the only agency with Environmental Engineers. When a classification could not be compared directly, e.g. no other agencies employ autopsy technicians, the difference between the average salary for Department of Health employees in the classification and the average salary for state employees in the same grade was used.

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An equity increase is required for the department to alleviate the severe compression caused by implementation of the new classification system. This equity increase would increase employee salaries and also reach a compensation level that is closer to the current level paid in other North Dakota state agencies.

The department will be able to match some of the requested general funds with federal or special funds for the increases.

**compa**

monthly	\$127,806	\$152,089
annual	\$1,533,672	\$1,825,070
biennial	\$3,067,344	\$3,650,139

**w/fringe****Employees within the 1<sup>st</sup> quartile**

	<b>Employees</b>	<b>Percent</b>
<b>Yrs Srv</b>	19	8.5%
Vacant	28	12.5%
< 1yr	22	9.8%
1-3 yrs	31	13.8%
3-5 yrs	55	24.5%

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5-10 yrs	21	9.4%
10-15 yrs	15	6.7%
15-20 yrs	14	6.3%
20-25 yrs	19	8.5%
25+ yrs	<b>224</b>	<b>100.0%</b>

<b>Change Group:</b> A	<b>Change Type:</b> D	<b>Change No:</b> 16	<b>Priority:</b> 12
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ARRA Continued Funding

**ARRA NDIIS Interoperability - \$130,000**

This federally funded project is the projected carry-over from the 2011-2013 biennium into the 2013-2015 biennium for a project that allows for real-time, two-way communication between the North Dakota Department of Health's Immunization Registry (NDIIS) and provider electronic health records. This is a one-time expenditure. This project helps the department reduce the rates of vaccine preventable diseases such as measles, mumps, polio, influenza, pertussis and others. Funds are awarded to major healthcare providers who want to exchange electronic health information with NDIIS. If the project is not funded, some of the interoperability costs of these providers will not be covered. This requires no new FTE.

**ARRA National Health Services Corps - \$25,000**

The purpose of this project is to document a baseline for the retention of National Health Service Corps (NHSC) clinicians and develop strategies to retain these clinicians in service to the underserved. Funds will be used to provide continued support for NHSC activities to aid in the retention of health care providers for the state's underserved areas. Activities include providing opportunities for NHSC scholars to rotate through our delivery systems where appropriate; provide networking opportunities for loan repayors and scholars; and provide retention workshops. A survey is being conducted in partnership with the Sheps Center in North Carolina to study retention rates among the NHSC clinicians. The carry-over funds will be used to continue that work to include the clinicians in the State Loan Repayment and J-1 Visa Waiver program. Trend analysis of the state's health care vacancies is an ongoing activity as are quarterly surveys to site administrators to determine vacancy rates.

The project will be completed by September 29, 2013

Alumni within the National Health Service Corps have never had a formal network that included clinicians serving the underserved specifically and this program is trying to create such a network to aid in provider retention. In order to better understand our baseline retention data, current studies are needed. Improving access to health care services and personnel will help improve the health status of North Dakotans. A sub-contract is in place for these activities with the University of North Dakota.

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Change Group: A	Change Type: D	Change No: 27	Priority: 21
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Safe Sleep Campaign/Cribs for Kids

**Safe Sleep Campaign/Cribs for Kids - \$475,000**

The North Dakota Sudden Infant Death Syndrome (SIDS) program is requesting a \$475,000 general fund appropriation to the State Department of Health, Community Health Section, Division of Family Health, for the purpose of providing cribs to families in the state through the Cribs for Kids program, updating educational materials to reflect current national safe sleep recommendations and developing a media campaign to raise safe sleep and SIDS awareness in North Dakota. This is a request for one-time biennium funding. There is great stakeholder support for this program including many local public health units, tribes, and state programs.

Sudden Infant Death Syndrome/Sudden Unexpected Infant Death (SIDS/SUID) occurs in North Dakota each year. Data from the Division of Vital Records indicates there have been 41 SIDS/SUID deaths in North Dakota from 2007 through 2011, with 16 of those deaths occurring in the American Indian population. By creating awareness of this problem and providing families opportunities to provide a safe sleep environment to their children, we can reduce these numbers in North Dakota.

North Dakota Century Code 23-01-05 states that North Dakota will “establish a program to provide information to the surviving family of a child whose cause of death is suspected to have been the sudden infant death syndrome.” This funding is needed to update the materials that are sent to families to reflect current national recommendations.

North Dakota has been a partner in the Cribs for Kids program since 2010. Since that time, 701 crib kits have been distributed to partner sites throughout the state. These crib kits include a pack-n-play crib, tight-fitting crib sheet, Halo SleepSack and pacifier. According to some of the partner sites, these crib kits have been a huge success with some sites reporting a waiting list for the crib kits, especially in the American Indian population sites.

The Cribs for Kids program is being implemented as a strategy to support the “Back to Sleep” national campaign to reduce the risk of SIDS. Since the start of this campaign in 1994, SIDS rates in the nation have fallen by over 50 percent. This campaign is due to be updated to the “Safe to Sleep” campaign in the fall of 2012. This funding is needed to keep North Dakota program activities current with the national campaign and updated recommendations.

North Dakota has seen an increase in population due to the growing oil field development. With this influx of people, there has been an increased need for housing. Limited housing opportunities may result in not having an appropriate safe sleep environment for infants. Cribs for Kids will help provide crib kits to these families to decrease the risk for SIDS.

With healthcare costs rising, prevention needs to be a priority. By educating families on the risks of SIDS and by providing them with a safe sleep environment for their child, health care costs can be reduced.

In June of 2011, the State Health Officer signed ASTHO’s 2012 President’s Challenge to improve birth outcomes by reducing infant mortality in the state. This project will have a direct effect on helping North Dakota achieve this goal.

**Budget Justification**

Travel - \$2,500

- Travel to Cribs for Kids sites to provide education to staff and for delivery of materials.

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Miscellaneous Supplies - \$160,000

- Purchasing crib kits for Cribs for Kids sites. 2,000 crib kits at \$80/each = \$160,000 (to be distributed between the 14 ND Cribs for Kids partner sites based on client numbers).

Postage - \$1,500

- Mailing of educational materials to families and sites.

Printing - \$11,000

- Printing of updated educational materials.

Professional Services - \$300,000

- Development of Safe Sleep media campaign.

***Priority should be given to the purchase of crib kits for the Cribs for Kids program. If funding does not allow, the media campaign can be taken out of the purposed project/budget.***

**Department Goals and Objectives:****Goal: Improve the Health Status of the People of North Dakota****Objectives:**

1. Prevent and Reduce Intentional & Unintentional Injury
2. Prevent & Reduce Tobacco Use & Support Other Substance Abuse Prevention.

Note: An increase risk of SIDS with tobacco use and exposure will be addressed through the educational materials and the media campaign.

**Goal: Improve Access to and Delivery of Quality Health Care****Objectives:**

1. Improve Access to & Utilization of Health & Wellness Services
2. Improve Health Equity

**How the project will meet goals and objectives:**

Project goals and objectives will be met by the following scopes of work:

SIDS program:

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- Support families and communities following the loss of a child to SIDS/SUID by providing educational material that is current with national recommendations and offering support through their local public health unit.
- Develop a SIDS database to identify trends and target populations for education on reducing the risk of SIDS.
- Develop a current media campaign to coordinate with national awareness efforts
- Develop new educational material for families and childcare providers with information that coordinates with national efforts and updated recommendations.
- Serve as a recourse to child care providers, families, local public health providers, home visiting programs, etc.
- Provide targeted education and information to American Indian populations (as well as other populations across the state).
- Provide education on the risk of SIDS and second-hand smoke.

**Cribs for Kids:**

- Provide crib kits to partner sites across the state to distribute to families with a need for safe sleeping environment for their infant.
- Provide training to existing Cribs for Kids sites and potential new sites.
- Update all educational material to reflect the current national SIDS campaign and recommendations.

**Outcome Measures and Indicator Impact:**

1. Decrease the number of Sudden Infant Death Syndrome/Sudden Unexplained Infant deaths in North Dakota.
2. Increase the number of crib kits distributed by Cribs for Kids.
3. Increase the access by families and professionals to safe sleep educational materials that are current with national recommendations.
4. Increase access to community health resources.

Implementation of the SIDS program, along with the Cribs for Kids program, will assist with strategies targeted to impact the following department indicators:

- By 2015, decrease the death rate among persons age 0-24 caused by unintentional injuries.
- By 2015, decrease the infant death rate to 5.5.
- By 2015, increase the percentage of pregnant women who receive first trimester prenatal care to 88.
- By 2015, increase the percentage of women who have Adequate or Adequate Plus prenatal care.
- By 2015, decrease the percentage of ND adults who are current smokers to 17.

**Consequences if Project Not Funded:**

The Cribs for Kids program was started by a small grant in 2010 from Ronald McDonald House Charities and has continued operating with funds from the Early Childhood and Comprehensive Systems (ECCS) grant and the Title V/MCH grant. Funds are no longer available through ECCS and MCH due to slight funding decreases every year. If additional funding is not secured, the current Cribs for Kids sites will not be able to keep up with demand and no new partner sites will be added.

SIDS is a problem that can be reduced with efforts to educate the public, and hopefully change behavior on infant sleep practices. There are many risk factors associated with SIDS that families may not be aware of. Because they are not informed, they place their babies at risk every time they put them to sleep in an incorrect position and may not even know that they are causing potential harm to their infant. MCH has limited funding for the purchase of and/or the development and printing of educational materials. No funding is currently available to develop a media campaign. If additional funding is not secured, efforts to educate the public and health care providers on new safe sleep recommendations will be greatly limited.

<b>Change Group:</b> A	<b>Change Type:</b> D	<b>Change No:</b> 28	<b>Priority:</b> 30
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Senior Falls Prevention Program

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**Senior Falls Prevention Program - \$122,675**

The Division of Injury Prevention and Control is requesting approximately \$122,675 in one-time general funding for the 2013 - 2015 biennium. This funding will create a foundation of trained professionals across the state to reduce injury and deaths due to falls. If received, the requested state general funding could provide matching funds for other appropriate ND Department of Health programs.

In North Dakota, falls remained the third leading cause of injury related fatalities behind motor vehicle crashes and suicides. According to statistics from the North Dakota Department of Health's Division of Vital Records a total of 446 North Dakota residents died due to fall related injuries from 2007 through 2011, an average of 89 people per year. Ninety four percent of those residents that died from a fall related injury were over the age of 50. The census from 2010 shows that 34% of the total ND population is over 50 years of age. Facing an aging population in North Dakota we want to take a proactive approach to fall prevention in order to provide residents with a better quality of life and a longer life span.

Falls are not an inevitable consequence of aging, but falls do occur more often among older adults because fall risk factors increase with age and are usually associated with health and aging conditions. These risk factors include: biological, behavioral, and environmental risk factors. Falls can result in moderate to severe injuries such as bruises to fractured bones to traumatic brain injuries. Falls occur in residential homes, community settings, work places, health care facilities, and during recreational activities. The goal of a Senior Falls Prevention Program is to reduce the number of injuries and fatalities by educating the general public and professionals on how to prevent injuries due to falls.

The Stepping On Falls Prevention Program is a program proven to reduce falls and build confidence in older people. The program is effective because classes are highly participative, where mutual support and success build the participants' confidence in their ability to manage their health behaviors to reduce the risk of falls and to maintain active and fulfilling lives. Subjects covered include improving balance, strength, home environmental safety, vision, and medication review.

The program is facilitated by trained Community Leaders who provide a safe and positive learning experience at local community-based workshops that seniors attend once a week for seven weeks to develop specific knowledge and skills to prevent falls. The program empowers older adults to carry out healthy behaviors that reduce the risks of falls, improve self-management, and increase quality of life. Participants gain specific knowledge and skills to prevent falls in community settings. It is designed specifically for people who are: 1) at risk of falling, 2) have a fear of falling, or 3) who have fallen one or more times.

The goal of the Senior Falls Prevention Program would be to increase the number of trained facilitators for the Stepping On Falls Prevention Program in North Dakota.

Funds requested would be used to:

- Contract with Wisconsin Institute for Healthy Aging to train 20 professionals in ND to become Community Leaders and four Master Trainers
- Provide training, resources and technical support for four Community Leaders to become Master Trainers for the Stepping On Falls Prevention Program
- Provide funding for Master Trainers to train Community Leaders for two trainings
- Provide grants to the Community Leaders to do 20 or more Stepping On Community workshops in local communities across ND
- Contract with an evaluator to collect and analyze fall related injury data from communities implementing the Stepping On Falls Prevention Program

Injury is a public health issue for all ages. It is vital that we act now to keep seniors safe by helping to live independently, stay active members in their communities and be the role models for generations to come. Without funding to implement a Senior Falls Prevention Program North Dakotans will continue to experience the current rate of deaths due to these injuries that are preventable.

<b>Change Group:</b> A	<b>Change Type:</b> D	<b>Change No:</b> 29	<b>Priority:</b> 3
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EPA Legal Fees

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**Legal Fees – Air Rules and Additional Environmental Legal Work - \$500,000**

During the 2011 legislative session, the Department was appropriated \$1 million for the purpose of defraying expenses associated with legal action against the U.S. Environmental Protection Agency (EPA). Of the \$1 million dollars appropriated to the Department, \$500,000 was provided out of the general fund with the remaining sum of \$500,000 to be borrowed from the Bank of North Dakota. Through June 30, 2012, the Department has spent a total of \$427,042.38 from the general fund to pursue legal action against the EPA as part of actions taken under the Clean Air Act (CAA). At this time, we have not started to use the Special Fund Line of Credit (\$500,000).

The Department is currently working with the North Dakota Attorney General's Office and Moye White, LLP, of Denver to continue addressing the following federal air rule legal challenges: 1) Sulfur Dioxide (SO<sub>2</sub>) 1 hour standard, and 2) Federal Implementation Plan (FIP)/State Implementation Plan (SIP) issues. We have reviewed EPA's most recent decision regarding the Regional Haze SIP and a proposed FIP and with concurrence from the Attorney General's Office have notified the court of our intention to challenge specific aspects of the federal decision.

We anticipate additional environmental legal work beyond the air program/rule legal challenges including ongoing national legal challenges by various states and entities of EPA's various rules and continuing increased oil field impact legal work.

We request \$500,000 in general funds for legal expenses to continue this work during the 2013 – 2015 Biennium.

<b>Change Group:</b> A	<b>Change Type:</b> D	<b>Change No:</b> 100	<b>Priority:</b> 2
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State and Local Public Health Oil Impact Support

**State and Local Public Health Oil Impact Support- \$3,787,650; 12 FTE**

The top oil-producing counties in North Dakota are within three multi-county health districts: Upper Missouri District Health Unit (Williston), Southwestern District Health Unit (Dickinson) and First District Health Unit (Minot). A great deal of inspection, monitoring and enforcement activities are required of the oil production industry to minimize the environmental impact and protect the public from environmental hazards. The state's workforce directly employed in the oil industry has risen to more than 35,000, paying an average wage of \$90,000 which is 117 percent above the statewide average of \$40,914. The workforce demands have brought an influx of people to the state further creating a demand for infrastructure such as housing and food establishments. As a result of the oil boom, local public health units and the North Dakota State Department of Health's Environmental Section and Food and Lodging Division need additional workforce, along with financial resources to recruit and retain qualified staff to meet current public health demands and to protect North Dakota's environment and the health of its people.

**The Division of Air Quality** consists of two major programs - Air Pollution and Control Program and Radiation Control and Indoor Air Quality Program. Field activities supporting the programs include inspecting facilities to ensure compliance, enforcing laws, investigating air pollution complaints and statewide ambient air quality monitoring (network).

Expanded activity in the oilfield has increased the workload in the Division of Air Quality due to the number of licensing/permitting and inspection activities. Air quality industrial construction permit applications have exceeded 100 per year, up from a historical average of about 20. All producing oil wells are required to go through a

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permit/registration process with the Division of Air Quality. Well permit registrations have risen from 3,000 to approximately 6,000 and are expected to increase with continued oilfield development. Similar increases have been seen in the number of crude oil storage tanks, compressor stations and gas plants.

In addition, many companies in the oil field use instrumentation technologies containing radioactive material, and there has been a large increase in the number of companies actively using such materials. Several operators have been identified as improperly using these materials, potentially placing members of the public at risk. Licensing requirements adopted by the U. S. Nuclear Regulatory Commission have become more complex due to increased control tracking.

**The Division of Laboratory Services** has two principal support programs: Chemistry and Microbiology. The chemistry laboratory provides analytical chemistry data to environmental protection, public health, agricultural and petroleum regulatory programs in the state. The laboratory also maintains a certification program for North Dakota laboratories that provide environmental testing services. The department's environmental protection programs use laboratory data to monitor and/or regulate air quality; solid and hazardous waste; municipal wastewater; agricultural runoff; surface, ground and drinking water quality; petroleum products; and other media of environmental or public health concern. The microbiology laboratory (i.e., the public health laboratory) performs testing in the areas of bacteriology, mycology, parasitology, immunology, virology, molecular diagnostics, bioterrorism response, and dairy and water bacteriology. The laboratory is responsible for providing rapid, accurate detection and identifying organisms that may threaten public health.

Microbiology laboratory workload has drastically increased. Private health sector testing done at the state public health laboratory increased by 2083 samples, likely due to an increasing number of medical providers in western North Dakota and in Bismarck and Minot. Public health sector testing conducted at the state laboratory decreased by 743 samples. This decrease is assumed to be caused from instituting rapid HIV screenings in many public health facilities in the area, eliminating the need to send samples to the state laboratory. Combined private and public tests steadily increased over the five-year period from 22,670 to 24,010 samples.

Chemistry's workload has also drastically increased. Since the beginning of 2012, 63 samples have been collected by Environmental Health Section personnel. A total of 55 samples also were received from other agencies or private entities. These numbers represent an increase over previous years. Tests requested for most of these samples were for complete chemistry, benzene, toluene, ethylbenzene, xylene (BTEX), diesel range organics (DROs), semi volatile organic compounds (VOCs), etc. Samples also were received for six new public drinking water systems associated with temporary housing in the oilfield. These systems are mandated by law to conduct specific chemical and microbiological testing.

**The Division of Municipal Facilities** administers three programs: Public Water Supply Supervision (PWSS), Drinking Water State Revolving Loan Fund (DWSRF), and Clean Water State Revolving Loan Fund (CWSRF). Field activities supporting the above programs include: (1) inspecting about 400 public water and wastewater systems to ensure compliance with all public health standards, (2) inspecting State Revolving Loan Fund construction projects to ensure they meet state and federal requirements, and (3) investigating complaints.

An ever-expanding challenge is keeping pace with new drinking water and wastewater facilities in oil-impacted areas. The total number of public water systems (PWS) significantly increased in 2010 and 2011, 93 percent of which are in oil-impacted counties. The total number of safe drinking water violations also significantly increased in 2010 and 2011. Most of this increase is due to new PWS in oil-impacted counties. Implementation of new and revised rules further impacts workload and compliance rates, both compounded by the increasing number of PWS which has resulted in an increased inspection workload. Local public health unit inspections of non-community PWS have decreased in oil-impacted counties, while division inspections have increased. In addition, under state law (NDCC 23-26), all persons operating water and wastewater systems, with some exceptions, must be certified by the department. Additional new systems have increased the workload of the division's operator certification and training program. In oil-impacted counties, the primary need has been for water distribution operators because most new systems obtain drinking water from other regulated sources (no treatment required) and either haul wastewater to another permitted system or provide on-site wastewater disposal. Compliance with operator certification requirements for water treatment and wastewater collection/treatment will likely decrease if more systems choose to develop/treat their own drinking water sources or treat/discharge wastewater.

There has also been a large increase in plans and specifications submittals/approvals, largely due to projects in the oil field. Many have been submitted by out-of-state engineering firms (38 to date) unfamiliar with North Dakota requirements, resulting in extended review time. Mechanical wastewater treatment and/or large on-site

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disposal systems require additional time for review/approval. As-built situations require more time to resolve design and construction issues. The division has spent considerable time developing new design policies and standards to address issues primarily related to projects in the oil field. A memorandum of agreement has been executed with the Upper Missouri District Health Unit for division review of on-site wastewater disposal systems serving 25 or more people, further increasing workload in an area not historically addressed by the division.

**The Division of Waste Management** works to safeguard public health through four programs: Hazardous Waste Program, Solid Waste Program, Underground Storage Tank Program and Abandoned Motor Vehicle Program. The Solid Waste Program regulates the collection, transportation, storage and disposal of nonhazardous solid waste. Resource recovery, waste reduction and recycling are promoted. The program helps individuals, businesses and communities provide efficient, environmentally acceptable waste management systems. There are 417 facilities regulated under this program and 531 permitted waste transport companies. The Underground Storage Tank Program regulates petroleum and hazardous substance storage tanks, establishes technical standards for the installation and operation of underground tanks, maintains a tank notification program, establishes financial responsibility requirements for tank owners, and provides for state inspection and enforcement. The program works with retailers and manufacturers to ensure specifications and standards for petroleum and antifreeze are met. There are 914 facilities regulated under this program. Field work for the programs includes compliance assistance, sampling, training and site inspections.

Oilfield activity has significantly increased the workload, from facilities directly operated by oilfield-related businesses and from peripheral businesses supporting the increasing general population. There are more oilfield service companies generating large quantities of hazardous waste and other support businesses, such as tank manufacturers, generating more hazardous waste. New gas stations and truck stops are being built or expanded. Both municipal landfills and oilfield special waste landfills are dealing with new types and greatly increased volumes of waste.

**The Division of Water Quality** protects water quality through four programs: North Dakota Pollutant Discharge Elimination System Permit Program (NDPDES); Nonpoint Source Pollution Management Program, Surface Water Quality Monitoring and Assessment Program, and Ground Water Protection Program. Field activities supporting the programs include inspecting wastewater treatment facilities and septic tank pumpers, and compliance audits/sampling to ensure permit requirements are met; inspecting construction site storm-water controls; meetings with local/state entities to assess nonpoint source project goals; ambient monitoring of lakes and rivers; evaluating domestic water sources for potential contaminant sources; annual collection/analysis of samples from vulnerable aquifers; overseeing remediation of spills with potential to reach water sources; and responding to complaints.

This division is primarily responsible for responding to oil spills with the potential to impact waters of the state and following up on appropriate remediation. With increased oilfield activities, there has been a large increase in number of spills reported and response by staff. In addition, within the NDPDES Program there has been an increase in the number of federally required permits issued. This increase in permits has resulted in additional inspections of septic tank pumpers, crew camp wastewater treatment facilities and stormwater controls on construction site. Increased commercial development in the oil patch has resulted in a 300 percent increase in inspections to evaluate on-site disposal of wastewater (e.g., industrial solvents/cleaners etc.). There also has been a considerable increase in office work associated with site reviews for landfills, water appropriation reviews and public inquiries from private well owners.

The four staff members primarily responsible for inspections in the oilfield area conducted 68 days of inspections in the first six months of the past year. Inspection days during the second six months will likely be higher as more are conducted in the summer. Further impacting workload this past year were two resignations, one retirement and one deployment

**The Division of Food and Lodging** is responsible for protecting public health through licensing and inspection of restaurants, bars, lodging facilities, mobile home parks, campgrounds, bed and breakfast facilities, retail food stores, meat markets, bakeries, schools, salvage food establishments, small food manufacturers/ processors, tanning facilities, tattoo and body art facilities, electrologists and assisted living facilities.

The Division of Food and Lodging has seen a dramatic increase in the numbers of new facilities needing plan reviews and pre-operational inspections which also results in more unannounced routine inspections and corresponding enforcement and complaint follow-up activities. Most of the new facilities being constructed and now needing inspections are RV parks, campgrounds, man camps, lodging establishments and mobile food vendors.

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This substantial increase in workload impacts the other activities of the division by reducing the number of inspections that can be conducted at high-risk food establishments. One of the major goals of any food safety program is to ensure risk-based food safety inspections are conducted and at a frequency to effectively reduce the incidence of foodborne illnesses. The division has been able to train staff in completing risk-based inspections, but the frequency of inspections does not come close to the recommended frequency as set forth in the national program standards as established by the Food and Drug Administration. In Standard 8 of those standards, a program budget should provide the necessary resources to develop and maintain a retail food safety program that has the staffing level of one FTE devoted to every 280 to 320 inspections performed. In addition, every high risk food service establishment should be inspected a minimum of three times per year. Each of the division's EHP's is responsible for more than 750 establishments, not all being food establishments. By North Dakota statute, the mandated statutory inspection frequency is limited to at least once every two years. Current staffing levels only allow the division to inspect food establishments one time per year. Support for an additional FTE in the division would help combat the drastic increase in workload and allow for a much needed and increased inspectional presence in each high risk food establishment and hopefully reduce the frequency of foodborne illness outbreaks.

In addition, the decreased inspection frequency of high-risk food establishments has resulted in a higher number of critical violations noted during inspections. This is reflected in the division not meeting its measurable strategic planning indicators (goals/objectives). With another FTE, the division would be able to provide more frequent inspections of high risk food establishments, which would result in fewer critical violations and less potential for foodborne outbreaks.

**Request Amounts:****Division of Air Quality**

To meet the increased workload demands, the division requests to add one full-time employee (FTE) (environmental scientist) to the Radioactive Materials Branch. Funding for such a position can be met with fees that are being generated and no general fund support is needed. Due to the increasing complexity of the air pollution regulations, it is imperative that additional funding be provided to retain experienced staff. The Air Quality Permitting and Compliance Branch include staff that is in demand for similar work with consultant companies who are working on applications on behalf of the oil and gas industry. The division has lost staff to these companies, and there are several openings at this time. Staff members with the department for three to five years remain within \$100 per month of the bottom of their pay range, in spite of significant experience and workload.

**Division of Laboratory Services**

Additional funds are being requested to address the increase in workload due to activities in the oil field. One FTE (Administrative Assistant II/Lab Tech IV) is needed to help with the administrative support functions in the laboratory. Responsibilities will include sample receipt and log-in, as well as data entry, proofing, helping with telephone calls and some sample preparation. In addition to the FTE, the division is requesting new instruments that include a Gas Chromatograph - Mass Spectrometer (GC/MS); Purge and Trap (P&T); Gas Chromatograph (GC); Ion Chromatograph (IC); and a Luminex multi-plex system to add redundancy, as well as some new technologies that will improve the testing processes. Additional funds are being requested for supplies for the increased testing and new instrumentation. Funds are also being requested to purchase instrument support agreements crucial to the continued operation of laboratory instruments.

**Division of Municipal Facilities**

An ongoing challenge is the implementation of new and revised Safe Drinking Water Act requirements and policies for the State Revolving Loan Fund Programs. This impacts workload and compliance rates/activity for the PWSS Program, a problem compounded by the increasing number of public water systems. In addition, there is heightened community interest in using the DWSRF and CWSRF Programs for financial assistance. The ability of the division to maintain state delegation for its programs could be significantly impacted, if not totally compromised, by future cuts in federal funding. These challenges are not short-term but long-term challenges. To better address these challenges, four additional FTEs are needed (two environmental engineer positions and two environmental scientist positions). Due to pending reductions in federal funding, these positions will need to be funded using state general funds.

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**Division of Waste Management**

The Division of Waste Management has received 15 pre-applications (as of June 8, 2012) for oilfield waste landfills. This increase requires additional staff for inspections and permitting activities. Two FTEs are needed (Environmental Scientist II).

**Division of Water Quality**

The Division of Water Quality has experienced a considerable increase in work load from oil activities. These impacts include responding to a 500 percent increase in spills and complaints regarding infrastructure shortfalls. The division needs to add four additional environmental scientists to meet the growing need for oversight of wastewater treatment and spill cleanups.

**Division of Food and Lodging**

The Division of Food and Lodging is requesting financial resources to support a vacant position transferred to the division which was filled as an environmental health practitioner (EHP) in 2012. The primary reason for requesting the financial support is to assist in handling the increased workload affiliated with the oil activity in the northwestern part of North Dakota. The funding for this position could be offset with an across-the-board increase in all license fees and an increase in general fund support. License fees were last increased effective April of 2008. Any fee increases would have to be adopted through the administrative rule process. That would make the next license fees effective around January 1, 2014, about six years from the last license increase.

**Local Public Health Description and Need:**

Local public health units (LPHUs) are the foundation of North Dakota's public health system and the lead organizations providing community-based programs and services that assure and protect the health of state citizens. Local health departments serve as the primary organizing and mobilizing forces for public health practice in most communities and are critical to protecting the health of the community. LPHUs are expected and often required to provide services and reach people that private and other governmental agencies fail to adequately address, including clinical prevention services. They are required by state law to provide services to North Dakota citizens regardless of ability to pay. Services are often rendered without reimbursement either by insurance or client payment. Local health departments operate on relatively small budgets.

The mission of local public health is to make a positive impact on the health and welfare of the community through public health nursing and environmental services, education, prevention and collaborative activities. The nursing services typically offered include child health and nutrition, STD (sexually transmitted diseases) and AIDS/HIV testing, family planning, child and adult immunizations, foot care, women's health, child car seats, tobacco prevention and more. The environmental health services include restaurant licensing and inspection, water testing, issuing sewer permits and more.

Western North Dakota local public health's capacity to provide comprehensive services is diminished due to worker shortage and other competing, high-paying jobs in the region. Local public health units are not able to compete with private healthcare for nursing or the oil industry for environmental health practitioners (EHPs) employment. Many job seekers learn about local public health wages and decline to submit an application for consideration because the wage cut would be too dramatic. This is during a time when there is an increased demand for many health services, including what local public health offers. Consequently, Upper Missouri District Health Unit is contracting for nursing and environmental services.

Southwestern District Health Unit's (SWDHU) current base pay for a registered nurse and environmental health practitioner is \$15 an hour, which is what fast food restaurant employees are typically making. As a result, two vacant nursing positions have not been filled in the Adams and Hettinger county offices. Upper Missouri District Health Unit's director of nursing recently resigned to work for the oil industry, leaving another open professional position. The local public health units need the financial ability to pay competitive wages to hire and retain qualified public health professionals.

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The population served in each LPHU has increased substantially with a shift in community demographics. A capacity of more than 10,000 crew camp units exists within Williams County alone. Along with an increased population, the need for public health nursing services has drastically risen. A projection for Williston School District #1 estimates nearly 2,000 new students to school enrollment (only one of 18 schools' records reviewed). As a result, there has been an increase in the number of immunization records reviewed and provision of vaccinations to new students. Birth rates have also doubled, which increases the demand for immunizations and services for high-risk pregnancies and sick babies. This is all occurring at the same time local clinics are cutting back on providing childhood immunizations. The Upper Missouri District Health Unit has already increased the number of clinic days and added immunizations in Tioga.

Also affecting nursing hours is the doubling of chlamydia cases and other infectious diseases. Tuberculosis (TB) testing has doubled, from 109 to 238, for students from Williston State University who are being employed in communities for oil-support positions. Minot and Dickinson State Universities are also experiencing TB-related issues. In oil country, there has been an observed increased volume of people from states with higher rates of TB, increasing the risk of an outbreak from an active case of TB. This would result in a tremendous impact on the public's health and workload for local public health units. In addition, current funding sources do not cover the amount of case management time.

The increased need and demand for environmental health services has also caused staff workload challenges. There has been an 800 percent increase in septic permits and about a 400 percent increase in non-community water inspections in the Williston area. All oil impact counties have seen a substantial increase in RV licensing, mobile food vendors, complaints of illegal sewage dumping, food and lodging issues, illegal tattoo operations and illegal trade waste burning.

An increased demand for nursing and environmental health services, coupled with the difficulties of employee recruitment and retention, creates the potential for a negative impact on public health.

Finally, there is a need to inform the public about the services LPHUs provide, where they are located and their website URLs. It is essential to have a public education budget, especially to reach people new to the area. This helps create a good relationship with local media as local public health seeks to inform, educate and empower community members about health issues.

**Request:**

Local public health is requesting financial resources to supplement operational expenses. Additional funding is necessary to respond to community needs and to address the emerging oil impact issues. Additional funding would be used to support the increased demand for nursing and environmental health services in western North Dakota. The funding will enhance the local public health units' (First District Health Unit, Southwestern District Health Unit and Upper Missouri District Health Unit) capacity to protect against environmental impacts and disease outbreaks, and to assist in helping residents and new workers to the area and their families live healthy lives. The funding will be used for nurse and environmental health FTEs, to retain staff with more competitive wages, and for public education.

The three local public health units serving western North Dakota request a total of \$1,184,000 to help protect and provide for the health and safety of community members.

Upper Missouri District Health Unit is (UMDHU) is a 4-county health unit serving Williams, Divide, Mountrail and McKenzie counties. UMDHU is requesting **\$364,000** for 3 FTE and public education materials. With the need for increased nursing services for immunizations, STD checks, Chlamydia cases and high risk pregnancies and births a total of 1 nurse FTE will be needed in the oil impact area. Also, Due to an increase in septic permits, non-community water inspections, RV licensing, mobile food vendors, complaints of illegal sewage dumping, food and lodging issues, illegal tattoo operations and illegal trade waste burning an increase of 2 environmental health practitioner FTE in the oil impact area will be needed. More public education is needed to inform the public of what services LPHU's provide so funding is needed for media and brochures.

Southwestern District Health Unit (SWDHU) serves eight counties in southwestern ND, including Stark, Dunn, Golden Valley, Billings, Bowman, Slope, Adams, and Hettinger. SWDHU does not have the capacity to generate local revenue to fund the increased need in services. Currently, local government contributes 4.75 mills to the budget with there being a 5 mill cap in state law. Their biggest struggle is to fill open positions at competitive wages. Two nursing positions remain open in Stark

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and Hettinger offices. Salaries need to be raised in order for public health to compete for employment. SWDHU is requesting **\$520,000** to increase existing salaries to retain staff and to fill 2 FTE in order to fulfill the increased need for nursing and environmental services.

First District Health Unit (FDHU) provides public health services to seven counties in north central North Dakota. Offices are located in Bottineau County, Burke County, McHenry County, McLean County, Renville County, Sheridan County, and Ward County. FDHU is requesting **\$300,000** for two additional FTE, one public health nurse and one environmental health practitioner. FDHU is also in need of funding for public education materials to inform their growing population and for travel to the rural counties.

<b>Change Group:</b> A	<b>Change Type:</b> E	<b>Change No:</b> 2	<b>Priority:</b>
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Remove One Time Funding

**Environmental Health-**

Funding for EPA legal fees has been removed from the budget as it was a one-time appropriation.

**Emergency Preparedness & Response-**

One time funding of \$600,000 was provided for the purchase of 12 lead monitor/defibrillators for ambulances. This funding is removed for the 2013-15 request.

<b>Change Group:</b> A	<b>Change Type:</b> E	<b>Change No:</b> 8	<b>Priority:</b>
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Remove One Time ARRA Funding

Remove all ARRA funding from the base budget. The continuation of this grant will be included in the optional request.

<b>Change Group:</b> A	<b>Change Type:</b> F	<b>Change No:</b> 3	<b>Priority:</b>
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Remove 2011-13 Bond Payments

Remove current biennium bond payments

<b>Change Group:</b> A	<b>Change Type:</b> F	<b>Change No:</b> 4	<b>Priority:</b>
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Remove 2011-13 Extraordinary Repairs

Remove current biennium extraordinary repairs

<b>Change Group:</b> A	<b>Change Type:</b> F	<b>Change No:</b> 5	<b>Priority:</b>
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Remove All 2011-13 Equipment &gt; \$5000

Remove current biennium equipment &gt; \$5,000

<b>Change Group:</b> A	<b>Change Type:</b> G	<b>Change No:</b> 14	<b>Priority:</b> 1
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## LPHU Universal Vaccine

The 3% optional general fund reduction consists of \$1,007,312 from the \$1,500,000 appropriation for the Local Public Health Unit Universal Vaccine program. This program was initiated through Senate Bill 2276 in the 2011 Legislative Session. It requires the Department of Health to provide childhood vaccines to LPHUs using \$1.5 million from the general fund and vaccines provided through the Section 317 federal Vaccine Program for those LPHUs that want to participate. The department is able to purchase vaccines off of a federal contract at a discount. LPHUs then bill insurance for the administration of the vaccines. This option is selected since there is an alternative funding source; LPHUs could purchase vaccine and bill insurance companies for the vaccine, as they bill for the administration. As in the current system, children without health insurance are covered through the Vaccines for Children federal program. This option would leave the remaining \$492,688 of general funding to be granted to LPHUs based on child population to use for uncollectible accounts such as cases where the vaccination is provided out of network (where the LPHU is not a network provider for the insurance company of the client). Implementing this option would require a change in law. LPHUs are not in favor of the option as they are concerned about changing the childhood vaccination system once again after multiple previous changes. In fact restoring the lost federal Section 317 vaccine through general funding, and keeping the system as it is, is a high priority for LPHUs.

<b>Change Group:</b> R	<b>Change Type:</b> A	<b>Change No:</b> 1	<b>Priority:</b>
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## Oil Related FTE

Provides funding for 9.00 FTE and grants to local public health units in the Williston, Dickinson and Minot areas for workload related to oil.

<b>Change Group:</b> R	<b>Change Type:</b> A	<b>Change No:</b> 3	<b>Priority:</b>
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## Autopsies Contract - Medical School

Provides \$640,000 from the general fund, to assist with the increasing number of autopsies. The Department of health will contract with the University of North Dakota Medical School to conduct autopsies for counties in the eastern part of the state. This will also provide increased academic and educational opportunities at UND in forensic pathology.

<b>Change Group:</b> R	<b>Change Type:</b> A	<b>Change No:</b> 4	<b>Priority:</b>
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## Universal Vaccine

Provides an additional \$1.0m for universal vaccines. With the new limitations on the use of 317 vaccines, additional population and increasing number of required vaccines, the currently appropriated funding will not be sufficient.

<b>Change Group:</b> R	<b>Change Type:</b> A	<b>Change No:</b> 5	<b>Priority:</b>
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## Medical Loan Repayment

Continues the Medical Loan Repayment Program with \$270,000 from the general fund.

<b>Change Group:</b> R	<b>Change Type:</b> A	<b>Change No:</b> 6	<b>Priority:</b>
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## Dental Loan Repayment

Provides \$180,000 to continue the Dental Loan Repayment Program.

<b>Change Group:</b> R	<b>Change Type:</b> A	<b>Change No:</b> 7	<b>Priority:</b>
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## Community Paramedics

Provides funding of \$276,600 for a pilot Community Paramedic and Community Healthcare Worker program, of which \$141,600 is one-time funding for educational startup costs. The program would coordinate workers to utilize the down time of paramedics between ambulance calls in order to assist Community Health workers.

<b>Change Group:</b> R	<b>Change Type:</b> A	<b>Change No:</b> 8	<b>Priority:</b>
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## Rural EMS Grants

Increases funding for rural EMS grants by \$1.75m from the general fund, for a total of \$6.0m to be distributed for the biennium.

<b>Change Group:</b> R	<b>Change Type:</b> A	<b>Change No:</b> 9	<b>Priority:</b>
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## Local Public Health State Aid

Increases state aid for local public health with \$750,000 from the general fund to be distributed to public health units in non-oil producing counties.

<b>Change Group:</b> R	<b>Change Type:</b> A	<b>Change No:</b> 11	<b>Priority:</b>
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## Veterinary Loan Repayment

Provides \$135,000 to continue the Veterinary Loan Repayment Program.

<b>Change Group:</b> R	<b>Change Type:</b> A	<b>Change No:</b> 13	<b>Priority:</b>
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## Public Health Emerg Preparedness WSI Rates

Provides \$84,000 additional funding for statutory changes in WSI rate recalculations for volunteer workers.

<b>Change Group:</b> R	<b>Change Type:</b> A	<b>Change No:</b> 14	<b>Priority:</b>
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## Colorectal Cancer Screening

Provides additional funding of \$125,000 for colorectal cancer screenings.

<b>Change Group:</b> R	<b>Change Type:</b> A	<b>Change No:</b> 100	<b>Priority:</b>
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## Executive Compensation Package Adjustment

This budget change provides funding for recommended 2013-15 compensation adjustments. Compensation adjustments for each agency were calculated following the recommendations of the Hay Group developed through the 2011 study of the state's classified employee compensation system. Pursuant to those recommendations, compensation adjustments were calculated to provide funding to allow for both performance-based salary adjustments and market-based salary adjustments. This funding allows for increases of 2% to 4% for employees in the first quartile of the pay range and 1% to 2% for those in the second quartile of the range. For employees in the third and fourth quartiles, which are above the market policy position, no market policy increase is funded. Performance-based increases are assumed to be 3% for employees meeting performance standards and up to 5% for employees exceeding performance standards. No performance-based increases are provided for employees that fail to meet performance standards.

<b>Change Group:</b> R	<b>Change Type:</b> B	<b>Change No:</b> 2	<b>Priority:</b>
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## EPA Legal Fees

Provides an additional \$500,000 from the general fund to continue legal challenges with the EPA.

<b>Change Group:</b> R	<b>Change Type:</b> B	<b>Change No:</b> 10	<b>Priority:</b>
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## Food and Lodging Licensing Mgmt System

Replaces the current Food and Lodging licensing management system with \$110,000 general funding. The new system will provide on-line license renewals and electronic submitting of field inspection reports

<b>Change Group:</b> R	<b>Change Type:</b> B	<b>Change No:</b> 12	<b>Priority:</b>
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## ARRA Immunization Registry

Provides authority for \$155,000 of remaining ARRA funding for Interoperability of the immunization registry system.