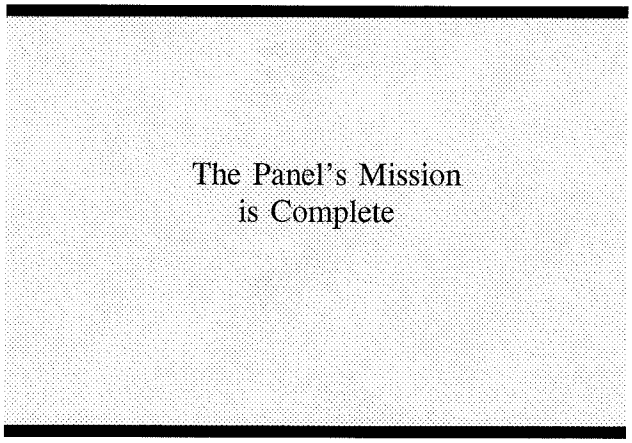
# STATE OF WEST VIRGINIA

# PRELIMINARY REVIEW OF THE RURAL HEALTH INITIATIVE ADVISORY PANEL




**OFFICE OF LEGISLATIVE AUDITOR**
**Performance Evaluation & Research Division**
**CAPITOL BUILDING**

**CHARLESTON, WEST VIRGINIA 25305**

# WEST VIRGINIA LEGISLATURE

*Performance Evaluation and Research Division*

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**Antonio E. Jones, Ph.D.**
**Director**

January 6, 1995

The Honorable A. Keith Wagner
State Senate
Box 446
Iaeger, West Virginia 24844

The Honorable Joe Martin
House of Delegates
Building 1, Room 213E
1900 Kanawha Blvd. East
Charleston, West Virginia 25305

Gentlemen:

This is to transmit a preliminary review of the Rural Health Initiative Advisory Panel on which we will report to the Joint Committee on Government Operations on Sunday, January 8, 1995. The issue covered herein is "The Panel's Mission is Complete."

Let us know if you have questions.

Sincerely,

Antonio E. Jones

AEJ/wsc

Enclosure

## MAJOR FINDING: THE RURAL HEALTH INITIATIVE ADVISORY PANEL HAS ACCOMPLISHED ITS MISSION.

The West Virginia Rural Health Initiative (RHI) Advisory Panel was created by the Legislature in 1991 to assist the Vice Chancellor of Health Sciences at the State College and University System in choosing the locations of the RHI program sites, and to provide advisory assistance in the management of the operations of the sites and the program as a whole. It should be noted that it is the advisory panel itself and not the entire RHI program that is being reviewed.

### MISSION ACCOMPLISHED

The RHI Advisory Panel was created primarily to help choose the location of the RHI project sites. This was accomplished by mid-1992. Since that time, the panel has overseen the progress and operation of the project as an advisory body.

With the 1996 expiration of the Kellogg Foundation grant, which provides funding and administration for four additional similar sites in the state, there will be a need for a plan of integration of the two programs under the jurisdiction of the RHI. Toward this end, the RHI Panel and the Kellogg Governing Board have formulated such a plan, which is to be presented to the legislature in the coming session (see Appendix C). This plan will include provisions for a new board to replace the advisory panel. The new board would be composed of a different membership than the current panel, with an emphasis on community members who are not health care related professionals. In addition, the new body would have governing powers which the current panel does not.

For this reason, the directors of the RHI programs and the panel members themselves recommend that the RHI Advisory Panel be allowed to expire under the current law, so that it may be replaced with this new entity.

### RECOMMENDATION

The Performance Evaluation and Research Division recommends that the West Virginia Rural Health Initiative Advisory Panel expire on July 1, 1995 in accordance with Chapter 18B, Article 16, Section 6 of the West Virginia Code.

## The Rural Health Initiative Advisory Panel

### Purpose and Function

The Rural Health Initiative Advisory Panel created as part of the "Rural Health Initiative Act of 1991". The panel's creation and authority are found in Chapter 18B, Article 16, Section 6 of the West Virginia Code. The panel was created to "recommend rural health care facilities to be established as primary health care education sites", including estimations of the cost allocated per site.
The panel was to adopt guidelines for application by such facilities for selection to the program, and to "provide ongoing evaluation of the Rural Health Initiative". All of its recommendations and evaluations are to be reported to the Vice Chancellor for Health Sciences, who functions as director of the Rural Health Initiative and reports to the Board of Trustees.

By mid-1992, the eight sites that now comprise the Rural Health Initiative program consortia were selected, thus accomplishing all of the panel's responsibilities completely except to provide "ongoing evaluation". The final eight selections were made by the Vice Chancellor on advice from the panel.

Since mid-1992 the panel has continued to meet on a regular basis to hear reports from various personnel from the sites concerning the progress of the Rural Health Initiative project. The panel made recommendations regarding the additions of new satellite members of the main site consortia, considered program policy and made recommendations on the same, and conducted visitations to the sites.

The Vice Chancellor received the recommendations and evaluations from the panel, and made the final decisions. it is important to understand that the recommendations of the panel were not binding on the Vice Chancellor. They are advisory in nature and can be overridden by the Vice Chancellor or the Board of Trustees. Since the Vice Chancellor attended and participated in the meetings of the panel, however, the possibility of major differences of opinion between the panel and the Vice Chancellor was minimal.

Evaluation of the performance of the panel is complicated by the fact that the panel only recommends courses of action rather than actually implementing them. However, it can be demonstrated by the simple presence of the eight existing Rural Health Initiative sites that the panel has successfully completed its duty of recommending these sites.

Minutes of the meetings and interviews with the Vice Chancellor, Rural Health Initiative site coordinators and others involved with the program strongly indicate that the panel did provide valuable advice, assistance and support in the ongoing operations of the program.

In short, the Rural Health Initiative Advisory Panel has successfully met its statutory requirements.

### Organizational Structure

The advisory panel consists of eighteen members. The Commissioner of the Bureau of Public Health functions as the chair,and there is one member each from the Office of Rural Health, the Health Care Planning Commission and the Office of Community Health Services. There are five members representing rural health care providers and four representing consumers and the rest are administrative personnel from state and private colleges and universities. Those members representing institutions of higher learning are non-voting members. Those individuals who are not members by virtue of their office are appointed by the Governor with the advice and consent of the Senate. Such members are to

be "geographically dispersed throughout the state".

Funding and Compensation

Funding for the panel, which has no official staff or offices of its own, is limited to reimbursement of expenses in performance of duties for panel members who are not otherwise employed by the state. There is no compensation for members. There is a special fund set aside for the incidental costs associated with the reimbursements and supplies for meetings. The moneys for this purpose come from the Rural Health Initiative operational funds, which in turn come from various educational entities' allocations.

# APPENDIX A

Meetings of the RHI Advisory Panel

| Date | Members Present |
|---|---|
| Dec 2, 1991 | 12 present |
| Jan 7, 1992 | 15 present |
| Jan 29, 1992 | 14 present |
| Mar 12, 1992 | 18 present |
| April 8, 1992 | 18 present |
| April 30, 1992 | 18 present |
| June 17, 1992 | 16 present |
| Sept 2, 1992 | 18 present |
| Jan 13, 1993 | NA |
| April 21, 1993 | 12 present |
| Aug 11, 1993 | 18 present |
| Dec 6, 1993 | 8 present |
| Mar 31, 1994 | NA |
| May 17, 1994 | NA |
| June 17, 1994 | 8 present |
| July 28, 1994 | 10 present |
| Nov 17, 1994 | 7 present |

# APPENDIX B

# RURAL HEALTH INITIATIVE ADVISORY PANEL

| | |
|---|---|
| William T. Wallace, Jr., M.D., M.P.H.<br>Commissioner<br>Bureau of Public Health<br>Building 3, Room 519<br>State Capitol Complex<br>Charleston, West Virginia 25305<br>(304) 558-2971 | Comm. - Bureau for Public Health |
| Mary Huntley, Directo r<br>Office of Community and Rural Health<br>Bureau of Public Health<br>1411 Virginia Street, East<br>Charleston, West Virginia 2530l-3013<br>(304) 558-0580 | Rep. - Office of Community and Rural Health Services |
| George Farley<br>1630 Blizzard Drive<br>Parkersburg, West Virginia 26101-6427<br>(304) 485-4307 | Rep. - Health Care Planning Commission |
| Robert V. Digman, Ph.D., President (Ad Hoc)<br>Alderson-Broaddus College<br>Philippi, West Virginia 26416<br>(304) 457-1700 | President of private college |
| Fredric W. Smith, Exec. Vice Pres. (Ad Hoc)<br>WV School of Osteopathic Medicine<br>400 N. Lee Street<br>Lewisburg, West Virginia 24901<br>(304) 645-6270 | Designee of President of WV School of Osteopathic Medicine |
| Robert D'Alessandri, M.D., Dean (Ad Hoc)<br>West Virginia University<br>Health Sciences Center, North<br>Room 1150<br>Morgantown, West Virginia 26506<br>(304) 293-4511 | Rep. - Vice President of the WV School of Medicine |
| Alvita Nathaniel<br>209 East Grandview Addition<br>Princeton, West Virginia 24740<br>(304) 425-0645 | Rep. - Advanced practice nurse practitioner with experience in rural health care delivery |
| Gerry Stover<br>Rt. 3, Box 319-Al<br>Hurricane, West Virginia 25526<br>(304) 824-5806 | Rep. - Rural Health Care Facilities |

| | |
|---|---|
| James Major<br>Post Office Box 500<br>Omar, West Virginia 25638<br>(304) 946-2813 | Rep. - Consumer |
| William Fluty<br>RD 2, Box 71<br>Stone Church Road<br>Wheeling, West Virginia 26003<br>(304) 242-1087 | Rep. - Consumer |
| Jim Welshonce<br>120 Buffalo<br>Elkins, West Virginia 26241<br>(304) 636-5431 | Rep. - Consumer |
| Janet Frye<br>Post Office Box 446<br>Petersburg, West Virginia 26847<br>(304) 257-1984 | Rep. - Consumer |
| Clyde Campbell, Ph.D., President (Ad Hoc)<br>West Liberty State College<br>West Liberty, West Virginia 26074<br>(304) 336-8000 | Rep. - President of a State College |
| Susan Higgins<br>Post Office Box 223<br>Phillipi, West Virginia 26416<br>(304) 457-1760 | Rep. - Rural Health Care Facilities |
| Greg Carico, M.D.<br>220 Forest View Drive<br>Huntington, West Virginia 25705<br>(304) 272-6227 | Rep. - Physician engaged in private practice of rural medicine |
| Robert B. Walker, M.D., Chairman (Ad Hoc)<br>Dept. of Family & Community Medicine<br>Marshall University Sch. of Medicine<br>1801 Sixth Avenue<br>Huntington, West Virginia 25703<br>(304) 696-7255 | Designee - Vice President of Marshall University School of Medicine |
| Isiah Lineberry, Director<br>Rural Health Policy<br>1411 Virginia Street, East<br>Charleston, West Virginia 25301-3013<br>(304) 558-1327 | Rep. - Office of Rural Health Policy |

# APPENDIX C

# *Recommendations on Governance Structure for Integrated/Restructured RHI/Kellogg Program*

## Introduction:

The following recommendations were made from deliberations of the RHI/Kellogg Coordinating Committee. These deliberations represent approximately 18 hours of group meetings on August 18, October 21, November 16 and 17, and numerous individual hours in reading and reviewing materials. This committee's work was based on the findings of the focus groups held to gather in put on the integration or restructuring of a joint RHI and Kellogg Community Partnerships programs, the Kellogg evaluation material, and other data sources. These recommendations also reflect the guiding principles of this planning process established jointly by both bodies on June 17, and other in put from program participants.

Approximately 24 hours were spent in 8 separate focus groups discussing issues concerning the strengths and weakness of each program and their restructuring. These focus groups identified the need for consistency of policy in all levels of this new organization to ensure that the mutual goals will be met and that the positive elements of both programs can be preserved. There was a continual theme throughout this work that the new structure had to have accountability measures built in.

## Assumptions:

There also appears to be concern that the existing consortia in RHI need to be redefined or reaffirmed and that the existing Kellogg sites need to be expanded. This restructuring will have to occur from the ground up. This means that the current sites, given some specific guidelines and requirements, will have to make decisions regarding their current structure and address changes in this structure and the expansion or reduction of the consortia. As the coordinating committee discussed at the August 18th meeting and reaffirmed at both the October 21, and November 16 and 17 meetings, it is not possible to propose the exact number for a state level governance body without knowing the total number of reconfigured consortia.

It is possible however to describe levels of governance and even representation without knowing the final number of the consortia within the state. From the focus group discussions, it also appears that the stronger and more successful components of the program are best applied at the most local level as possible. These components include such things as community representation in governance, multi/interdisciplinary sessions, community research and service projects, definition of staff roles including site coordinators, and field professors.

## *Summary of Recommendations*

The coordinating committee, in addition to the guiding principles, established a rationale for their deliberations and the final choice of governance structure that was to be recommended. This rationale includes:

(1) that the new structure should truly reflect a partnership of educational institutions and community involvement and that all these players are to be at the table;

(2) that the consortia representation reflect a 51% community representation;

(3) that the Bureau of Public Health be strongly represented for resource knowledge and coordination and because the Bureau brings together health promotion and population based issues; and

There must be consortia level governance structures made up of representation from each of the training sites and community members from each of these training sites. This consortium level body must mirror the state level body in function and principle. The rationale for this consortia level governing structure are: the need to protect and maintain local autonomy and the integrity and allocation of local budgets to reflect the effective use of funds to meet local needs. This rationale also includes that these consortia level governing bodies should reflect and support the overall program philosophy, ensure community in put, be representative of the entire consortia and model a democratic process.

The state level governing body is to be made up of representation from each of the consortia, representatives from the participating health sciences schools, and the Bureau of Public Health

The current configuration of RHI Consortia and Kellogg Community Partnership sites are to propose new consortia or reaffirm existing consortia using specific guidelines.

## *Guidelines and Requirements for the Restructuring of Consortia*

1. Each consortium must reflect the primary and/or secondary contiguous patient service area of the majority of its members

2. Consortium membership:

   (a) Membership needs to be defined in terms of the role each members plays in the training, education, or enhancement of student experiences.

   (b) Each consortium should consist of a varied group of members selected to provide a comprehensive educational and community experience. This membership can then be categorized by their level of participation in direct student training. These members should include but not be limited to primary care/community health clinics, hospitals, private provider offices, public health department, behavioral health services, social service agencies, nursing care facility, public education systems and facilities, home health and other community and home based care programs, cooperative extension services, and institutions of higher education, and local service councils or networks. These members can be categorized as follows:

   Community members: at large members of the community who may or may not be board members of agency consortium members, and those who are volunteers. Community members are recommended to represent a variety of facets of the community, i.e. business and economic leaders, community leaders in general, clergy, school officials, etc.

   primary sites: those that have the heaviest concentration of students depending on patient volumes, availability of field professors or preceptors, and where students may rotate on a more daily basis.

   secondary sites: those that have students on a weekly basis and may have fewer preceptors than primary sites.

   Supporting agencies or sites: those to which students may rotate on a basis of one day per month or be participants in community service projects on a limited basis.

3. Consortium has to have at least one LRC within approximately a one hour commute of all consortium member agency locations; those locations which have or will have students.

4. Consortium must have a consortium level governing body that meets at least 10 times per year, maintains records, has a defined decision making process, and is staffed with the site coordinator. This consortium level body must have at least 51% community member representation. These members are to be voluntary and selected by a community wide process. The responsibilities of this consortium level governing body should include but not be limited to:

(a) provides oversight on policy development and implementation consistent with state level policy and the needs of the consortium in areas of fiscal matters and management including budget review and approval, operations, and administration and governance.

(b) oversees the delegation of duties, hiring, and performance evaluation of the site coordinator.

(c) Selects one community representative from the consortium to serve on the state governing body.

(d) participation in and approval of affiliation agreements.

(c) oversees the evaluation of the consortium's work and the evaluation data provided to the state governing body.

5. The consortium must designate a lead agency to serve as the fiscal agent for the consortium .

6. The consortium must have a full time site coordinator whose duties are approved by the consortium governing body and whose work load is not divided between the consortium responsibilities and those of the lead agency.

7. The consortium must develop a system to designate field professors and preceptors for all disciplines. The consortium must also develop a payment system for the services of these professionals. The consortium must endorse the policies of both these systems.

8. The consortium must designate a primary field professor for each discipline who will take the responsibility of administrative coordination with their respective schools; faculty development for the consortium ; overseeing that multi/interdisciplinary are planned and conducted; and coordination with the site coordinator on all student activities.

9. Lead agency has to be located in a HPSA.

10. Consortia are to develop proposals to include areas of counties or portions of counties currently not served by the RHI or Kellogg programs as indicated.

11. Existing consortia membership are to decide if they are in or out of the consortium they are currently in.

12. Patient volume at primary training sites has to be adequate to support training.

13. Consortium has to have at least one LRC or be in an area designated by the Bureau of Public Health to be served by their proposed telecommunications system.

14. Student housing must be available at all primary training sites which is adequate and meets fire and life safety codes and public health standards.

The RHI Act should be amended to designate a governing body to the Vice Chancellor in the development and implementation of the restructured program. The program should be renamed to something such as "The West Virginia Partnerships for Rural Health Education."

1. The purpose of this state level governing body is to report directly to the Vice Chancellor. Based upon the experiences in the Rural Health Initiative and the Kellogg programs, this body shall articulate the mission and goals of the restructured and integrated program.

2. The functions and duties of the state level governing body are to be as follows:

Establish and oversee development and implementation of policy in, but not limited to, the following areas:

(a) Governance and administration including personnel policies.

(b) Operations and management

(c) Finance including approval of budgets and disbursements, monitoring of budgets including line item adjustments, advocating for revenue sources, and review of annual audits and establishing a mechanism for reconciliation of discrepancies.

(d) Recommendations to the Vice Chancellor on the duties, hiring, and performance evaluation of an executive director.

(e) Oversight responsibility for the evaluation of all aspects of system.

3. The membership of this body will be approved by the Vice Chancellor and will consist of the following:

- One community representative from each of the designated consortia (minimum of 11, estimated to average 15)
- Dean or designee from each of the participating health sciences schools..
- One representative from the private colleges.
- One representative from the state college system.
- One site coordinator
- Two representatives from the Bureau of Public, one to be the Commissioner of Public Health and one to be the Director of the Office of Community and Rural Health Services.
- The Chair of this body will be elected by and from the membership of the body.

D. There will be term limitations of three years for the community representatives and terms will be staggered to achieve a 1/3 annual turnover of the body. The private and state colleges, and the site coordinators are to select their representative and set the term limits to be not greater than three years.

The governing body should meet not less than 10 times per year and in addition to the above cited duties and functions, review the following standard reports:

All committee reports

All network level and centralized budgets

All matters of policy

All site coordinators reports

Annual review of affiliation agreements

Annual review of evaluation information and data

Annual review of number of student rotations

The committee recommends that the Vice Chancellor hire an executive director to operate from his office to address the issues of this developing organization. This individual would serve as the communications contact point for the organization and would staff the state level governing body.

## *Timeline and Activities*

| | Activity | Completion Date |
|---|---|---|
| 1. | Revision current RHI Act to reflect new structure | January, 1995 |
| 2. | Current RHI Advisory Panel Sunsets | July 1, 1995 |
| 3. | Current Kellogg funding terminates | August 31, 1996 |
| 4. | New Structure of State level body in place | July 1, 1996 |
| 5. | Transitional Steering Board with representatives from both programs | Begins July 1, 1995<br>Ends September 1, 1996 |
| 6. | RHI and Kellogg Community Partnership Board recommends transitional membership to Dr. Weston | January 1, 1995 |
| 7. | Meets at least quarterly and as needed | Quarterly beginning in January, 1995 |
| 8. | Consortia restructuring process to be completed in stages:<br>Geographic definitions by<br>Fully operational by | <br>July 1, 1995<br>December 31, 1995 |
| 9. | Anticipated overlap of current funds from both sources | December 31, 1995 to August 31, 1996 |
| 10. | Request for new appropriations<br>New funding to begin | January, 1996<br>July 1, 1996 |

document:
initial draft 9/10/94 h r heady
revised 10/12/94 h r heady
revised 10/21/94 coordinating committee
revised 11/17/94 coordinating committee
approved as revised 11/17/94 rhi advisory panel
revised 11/30/94 kellogg joint governing board
approved as revised 11/30/94 kellogg governing board
revised per decisions of the Vice Chancellor 12/20/94

# APPENDIX D

P.E.R.D. comments and recommendations on the integration plan

After analysis of the Coordinating Committee's recommendations, including interviews with site coordinators and others involved in the program, the P.E.R.D. would like to make the following observations and recommendations concerning the plan.

It seems to be universally agreed within the RHI program that the panel should be recreated into a body which has greater input and decision making authority. The idea of a governing body is seen as a positive change by all those who were interviewed. Although the final decisions will be made by the Vice Chancellor under the authority of the Board of Trustees, the proposed new governing board would have a stronger voice in the operations of the program because the board's decisions would be policy instead of merely advisory opinions.

The recommendation is made to create an executive director to work from the Vice Chancellor's office and to function as staff for the governing body. This would create a position that would deal with the operations and management of the program on a day to day basis. It would also relieve individuals who are now serving as "unofficial staff" for the project while performing other duties at the same time. This change is also seen as a positive one. It would create the cost factor of salaries for the director and possibly a secretary, which cost would presumedly come from the RHI fund. The P.E.R.D. office agrees with these recommendations.

The P.E.R.D. does, however, have some concerns regarding the proposed membership of the governing body.

Recommendations to the Coordinating Committee

1. The idea of having a majority of the board to be community representatives is a sound one. They would represent the consumers and the interests of the populations of the areas served by the sites. The selection process is left quite vague, and the Legislature should make certain that a uniform process of appointing these members is devised. Although these members should certainly be leaders of their communities, either elected officials, business leaders or in some other way spokespersons for the local area, it is important that they be representative of the entire population of the community. The person who represents the host community should have an understanding of the point of view of the local indigenous consumer.

2. The fact that under the proposed system no practicing health care providers are included should be examined. Since this program is designed to provide greater health care accessibility to the rural regions, the insight of those who are engaged in rural health care as a profession should not be ignored. It is the opinion of the P.E.R.D. that rural health providers should be

represented in some capacity on the governing body, even if in a non-voting role.

3. Under this new board the representatives of the institutions of higher learning would be voting members of the board. This changes their status from non-voting members on the current panel and is also a sound idea.

4. It might be advisable to include more than one site coordinator as a member. While there are many areas in which the various sites have common problems and issues, the diverse regions in which they operate are certain to create problems that are unique to one particular consortium. With sites spread from the southern coal counties to both panhandles, it would follow that these differing regions would have a differing set of prevailing economic and social factors that would bear upon the performance of the RHI project at each locale. The problems that confront one coordinator may not confront any of the others. In order to fairly distribute accessibility and influence on the proposed new board, the idea of including more than one site coordinator as a member should be seriously considered.

# APPENDIX E

Appendix E

RHI Site Consortia Locations

1. Boone Memorial Hospital Consortium

Main Site: Boone Memorial Hospital, Madison, WV

Additional Locations of Members: Chapmanville, Man, Whitesville, Delberton, Logan, Williamson, Pineville, Chattaroy, Gilbert, Wharton, Wilcoe, Danville.

2. Cabin Creek Community Health Center Consortium

Main Site: Cabin Creek Community Health Center, Dawes, WV

Additional Locations of Members: None

3. Country Roads Consortium

Main Site: Monroe Health Center, Union, WV

Additional Locations of Members: Hinton, Williamsburg, Lewisburg.

4. Eastern Panhandle Health Education Consortium

Main Site: Grant Memorial Hospital, Petersburg, WV

Additional Locations of Members: Martinsburg, Moorefield, Frannklin, Hancock, Baker, Ranson, Riverton, St. George, Berkely Springs.

5. Fayette-Raliegh-Nicholas Consortium

Main Site: New River Health Association, Scarbro, WV

Additional Locations of Members: Sophia, Oak Hill, Beckley, Summersville.

6. Little Kanawha Area Consortium

Main Site: Calhoun General Hospital, Grantsville, WV

Additional Locations of Members: Harrisville, Pennsboro.

7. Maternal and Childcare Consortium of Southern West Virginia

Main Site: Fort Gay Family Health Center, Fort Gay, WV

Additional Locations of Members: Hamlin, Huntington, Wayne, Hurricane, Harts, Milton, Kenova, Point Pleasant.

8. St. Joseph's Hospital Consortium

Main Site: St. Joseph's Hospital, Buckhannon, WV

Additioonal Locations of Members: Philippi, Sutton, Clay, Elkins, Grafton, Gassaway, Weston, Helvetia, Kingwood, Lumberport, Nutter Fort, Fairmont, Rowlesburg, Clarksburg, Reedsville, Webster Springs.

Kellogg Foundation Sites

1. Cameron Community Health Center, Cameron, WV

2. Camden-on-Gauley Medical Center, Inc., Camden-on-Gauley, WV

3. Rainelle Medical Center, Rainelle, WV

4. Roane Family Health Care, Spencer, WV

# Chapter 23

## Workers Compensation

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23-1-1

"In the administration of this chapter the commissioner shall exercise all the powers and duties described in this chapter and in article two [21A-2-1] of said chapter. The commissioner is authorized to promulgate rules and regulations to implement the provisions of articles one through five....The commissioner shall have an official seal for authentication of orders and proceedings.."

"..the commissioner of the bureau of employment programs shall continue to administer this chapter until July, 1 1996, to allow the joint committee on government operations to monitor compliance with recommendations set forth in the full performance audit of the office of the workers' comp. commissioner completed in the 1990."

The attorney general shall perform all legal services required by the commissioner under the provisions of this chapter: Provided, that in any case in which an application for review is prosecuted from any final decision of the workers' comp. appeal board to the supreme court of appeals, as provided in section 4, article 5, or in any court proceeding before the wcab, or in any proceedings before the office of judges, the commish may designate a regular employee of his/her office (if qualified) to represent the commish.

23-1-2

All expenses peculiar to the administration of this chapter....shall be paid out of the workers' compensation fund.

23-1-3

Salaries and expenses..."All payments of salaries and expenses ...shall be made by the state treasurer upon requisition signed by the commish....such payment shall be charged to the workers' comp. fund.....total charges for any one fiscal year shall not exceed the amount appropriated."

23-1-4

(a) The offices of the commissioner shall be open for business from 8:30 a.m. to 5:00 p.m. each and every day, except Saturdays, Sundays and legal holidays..."

(b)"....information obtained from employers and claimants pursuant to this chapter for the purpose of its administration shall not be subject to provisions of [29B-1-1] (public

records) unless provisions are specifically made.....such info. may be released in formal orders or opinions of any tribunal or court which is presented with an issue arising under this chapter. ....Nothing in this subsection shall prevent the release of information to another state or federal agency for legitimate purposes....Nothing in this subsection shall prevent the commish from complying with any subpoena. "

The Commissioner may release the following information:

1. The base premium rate for an employer
2. Whether or not a specific employer has obtained coverage
3. Whether a specific employer is in good standing, delinquent or in default
4. For delinquent of de fault employers, the payments due the commissioner and what

the components of that payment are including the time periods affected.

23-1-6

The commish may employ a secretary, actuary, accountants, inspectors, examiners, experts, clerks, etc.

23-1-10

Each officer who serves subpoenas shall receive the same fee as a sheriff, each witness who appears in obedience to the subpoena before the commish shall receive expenses.

23-1-11

(a) In an investigation into any matter arising under this chapter, the commish may cause depositions of witnesses residing within or without of the state to be taken in the manner prescribed by law for depositions in the circuit court....

(b) The commissioner shall have the discretion to accept and consider depositions taken within or without the state by either the claimant or employer.....the commissioner shall have authority to refuse or permit the taking of such depositions or reject such deposition after the taking thereof.....

23-1-13

(a) The commissioner shall adopt reasonable and proper rules of procedure, regulate and provide for the kind and character of notices, and the services thereof, in cases of accident and injury to employees, the nature and extent of the proofs and evidence, the method of taking and furnishing the same to establish the rights and benefits or compensation from the fund hereinafter provided for, or directly from employers as hereinafter provided, as the case may require, and the method of making investigations, physical examinations and inspections and prescribe the within which adjudications and awards shall be made.

23-1-14

The commissioner shall prepare and furnish free of cost blank forms (and provide in his rules for their distribution so that the same may be readily available) of applications for benefits for compensation from the worker's' compensation fund, or directly from employers....

23-1-17

Annually, the commissioner and occupational pneumoconiosis board shall make a report to the governor, which shall include a statement of the causes of the injuries for which awards were made, an explanation of the diagnostic techniques used by the occupational pneumoconiosis board and all examining physicians to determine the presence of the disease.....The report shall include a detailed statement of all disbursements and the condition of the fund, together with any recommendations for improvements in the workers' comp. law and for more efficient and responsive administration thereof....