MICROFILM DIVIDER

OMB/RECORDS MANAGEMENT DIVISION
SFN 2053 (2/85) 5M

ROLL NUMBER

DESCRIPTION

2399

2001 SENATE HUMAN SERVICES

SB 2399

2001 SENATE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. SB 2399

Senate Human Services Committee

❑ Conference Committee

Hearing Date February 5, 2001

Tape Number	Side A	Side B	Meter #
2	X		35.6
3	X		
February 12, 2001 1		X	6
Committee Clerk Signature	Carol Kolodejchuk		

Minutes:

The hearing was opened on SB 2399.

SENATOR FISCHER introduced the bill. The bill is recommendations that were agreed to on the interim committee on health care. We will ask Murray Sagsveen to come and speak and get the minutes of the committee meeting.

JACK DALRYMPLE, Lieutenant Governor of ND, testified in support of the bill. The Hoeven administration is feeling 2399 provides excellent framework for discussion on what to do. We are bringing in a proposal for state wide tobacco amendment. The work is in progress.

SENATOR POLOVITZ: Senator Holmberg's bill looks at youth. Are you going to be more comprehensive? LIEUTENANT GOVERNOR: Yes. We need to combine all in one comprehensive program. We do not have a preference. 2399 is probably more in sync with what we see as a true state wide program. We have no conflict with what was done in interim; we

would envision something a bit more focused and more detailed as far as money is spent. I don't know if it will all end up in statute or not. We think it needs to be structured more than what you see in this bill.

KEITH JOHNSON, RS, Administrator, Custer Health, supports bill with written testimony.

SENATOR KILZER: Mr. Sagsveen talked about a $3000 grant per county. Do you have a stance on that? MR. JOHNSON: That would be the distribution of that money on page 2.

DARLENE BARTZ, Chief, Preventive Health Section, Dept of Health, offers written comments.

LINDA L. JOHNSON, Director of School Health Programs, provided written information regarding school preventative health programs in ND.

DR. JON RICE, citizen and President of the Red River Health Promotion Coalition, commented to reemphasize points. No 1 public health problem in this state is tobacco abuse and tobacco disease. It has been shown that with significant resources and comprehensive programs you can change that. Take this opportunity to develop statewide comprehensive programs; that we not shortchange the funding and that we not send out all the money in specified categories that will not allow the comprehensive program to work.

Hearing closed on SB 2399.

The hearing was reopened.

MURRAY SAGSVEEN, State Health Officer, explained what was done. (Written testimony)

Discussion was held.

The public hearing was closed.

February 12, 2001, Tape 1, Side B, Meter 6.0.

2-12-01

SENATOR MATHERN moved a DO NOT PASS. SENATOR FISCHER seconded the motion.

Discussion was held. Roll call carried 6-0. SENATOR MATHERN will carry the bill.

Date: 2/12/01

Roll Call Vote #: 1

2001 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2399

Senate HUMAN SERVICES Committee

☐ Subcommittee on _____

or

☐ Conference Committee

Legislative Council Amendment Number _____

Action Taken Do Not Pass

Motion Made By Sen Mathern Seconded By Sen Fischer

Senators	Yes	No	Senators	Yes	No
Senator Lee, Chairperson	✓		Senator Polovitz	✓	
Senator Kilzer, Vice-Chairperson	✓		Senator Mathern	✓	
Senator Erbele	✓				
Senator Fischer	✓				

Total (Yes) 6 No 0

Absent 0

Floor Assignment Sen Mathern

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE (410)
February 12, 2001 1:31 p.m.

Module No: SR-25-3067
Carrier: T. Mathern
Insert LC: . Title: .

REPORT OF STANDING COMMITTEE

SB 2399: Human Services Committee (Sen. Lee, Chairman) recommends **DO NOT PASS** (6 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). SB 2399 was placed on the Eleventh order on the calendar.

2001 TESTIMONY

SB 2399

TESTIMONY ON SB 2399
SENATE HUMAN SERVICES COMMITTEE
February 5, 2001

by Linda L. Johnson, Director of School Health Programs
328-4138
Department of Public Instruction

Madam Chairman and members of the committee:

My name is Linda Johnson and I am the Director of School Health Programs for the Department of Public Instruction. I am here to provide information regarding school preventative health programs in North Dakota.

Only since 1998 have schools receiving Safe and Drug Free Schools funds been learning about and applying *effective* prevention programs at the school district level. The Department of Public Instruction (DPI) proposes adding the two million dollars for healthy schools grants (page 2.c.) for these same efforts and increasing the dollars available to schools through this structure that already exists. It is also necessary to retain some technical assistance dollars at the state level for training school staff. The Department of Public Instruction feels it is imperative to continue with these efforts with the additional use of these tobacco settlement dollars. A fiscal note will be submitted upon request. DPI has an existing process both for planning and accountability that could be used for these tobacco settlement school dollars.

DPI provides technical assistance to districts in effective program planning, use of a community advisory committee, research-based curriculum, and promising practices programs. This fall at regional meetings around the state for Safe and Drug Free school contacts, 22 districts with exemplary programs presented their programs to their peers. It was clearly evident by their enthusiasm and uniqueness of each program that ND is heading down the right track in implementing prevention programming.

Currently, districts get a basic grant of $9.50 per student but may apply for additional competitive Greatest Need Grant dollars. It is these extra dollars that has enabled 19 communities to move to a higher level in their prevention programming. An example of a Greatest Need Grant application is attached. Just last week one of our sites called and

enthusiastically shared anecdotal successes of a newly formed after-school program, wanting assurance there would be funding to continue. One program even featured a video of their efforts, which is available for your viewing on request. Several unique peer programs have started around the state with these dollars. Many districts are beginning to use more research-based curriculum. Others are investigating *Project Northland*, a joint community, school, and law enforcement program for prevention that evidences great effectiveness.

Realizing prevention programs do not yield evidence of behavior change, the true outcome based measure, for a minimum of five years, it makes good sense to continue programs already begun rather than create a new system. It takes time to start a new program. Presently schools are moving toward true prevention programming. Schools are in varying stages of accomplishing the following tasks that lead to effect prevention programming. These steps are also features of the Centers for Disease Control Guidelines for School Tobacco Prevention.

- Community advisory teams are formed to plan and coordinate appropriate local prevention efforts.
- Needs assessments from a variety of sources are analyzed by local advisory teams.
- Research-based curriculums and programs that show promising practices are investigated.
- Plans are formulated to best meet the needs.
- Materials are ordered.
- Staff is hired and trained or existing staff retrained.
- An evaluation plan is established.

Let's band together to form a system of prevention at the school and communities level to make a difference with our youth. Let our united goal be to see our youth smoking and alcohol use rates toward the bottom of the list of states and not the top. Feel free to come to me for any information about schools and prevention programs. Are there any questions?

Greatest Need Grant Application
Hazen School District 2000-2001

Extent of Need

Hazen School District has surveyed its Grades 7-12 students in 1997 and 1999 with the Search Survey. The results did show some improvement but the results are still showing a high rate of usage among our youth. It appears that usage is occurring at an earlier age. Students are scheduled to retake this survey in Spring of 2001.

There is a need in Hazen to provide resource assistance to at-risk students through after-school programs, study centers, and resource day rooms. Staff, parents and students are requesting extra tutorial help for many students in the school system. Research has shown that academic mentoring and tutoring strategies are effective in reducing and preventing AOD use (Crum, Helzer, and Anthony, 1993; Thomas and Hsiu, 1993; Wiebusch, 1994). In addition, as the self esteem of the student improves a student would most likely be academically eligible for extra-curricular activities at the upper grade levels. Students would also be more inclined toward appropriate behavior inside and outside of school, and in turn, students would make better choices toward lifelong (career) decisions.

There is a constant need to train staff, parents, and community members in drug and violence prevention efforts. Research indicates that youth having parents/adults involved in their lives is the most effective drug deterrent and that kids view parents as their most influential role models (Search Institute). There is a need for the Hazen School District to develop a comprehensive approach in dealing with safety and violence.

DISTRICT PRIORITY

First Priority need is to expand the After-School Tutorial Program, Study Center, and implement a Resource Room within the school district.

Second Priority need is to provide up-to-date materials and training for schoolwide and community drug/alcohol programs to include training/education for staff, parents, and community members in drug and violence prevention efforts. A major focus will be to develop a systemic approach by implementation of the Respect & Protect program to address violence so that there will be district-wide discipline consistency.

DATA USED IN DETERMINING PROGRAM NEEDS:

Area I: High rates of alcohol and drug use among youth
Data Source: Search Survey Results, 1999, 1997 in parenthesis
44% (52%) used alcohol once or more in the last 30 days.
28% (32%) got drunk once or more in the last two weeks.
28% (31%) smoked cigarettes once or more in the last 30 days
29% (30%) used smokeless tobacco once or more in the last 12 months
09% (15%) sniffed or inhaled substances to get high once or more in the last 12 months
19% (20%) used marijuana once or more in the last 12 months
11% (12%) used other illicit drugs once or more in the last 12 months
29% (30%) drove after drinking once or more in the last 12 months
52% (57%) rode (once or more in the last 12 months) with a driver who had been drinking

Area III: High rates of arrest and conviction of youth for violent/drug or alcohol-related crimes Data Source: Mercer County Sheriff's Department
Arrests and Convictions:
Minor in Possession/Minor in Consumption
1998 27 1999 16 2000 23 (1/1/00 - 9/30/00)
Data Source: Bureau of Criminal Investigation for Mercer County
Arrests and Convictions:
Number of juvenile arrests for Mercer County
1996 38 1997 79 1998 79
Number of juvenile arrests for DUI/MIP/MI
1996 02 1997 00 1998 02

Number of juvenile arrests for Liquor Law Violations

1996	11	1997	27	1998	20

Number of juvenile arrests for Curfew/Loitering

1996	00	1997	10	1998	00

Area VII: High rates of referral of youth to juvenile court

Data Source: South Central Judicial District Juvenile Court, Mercer County

Total Offenses

1997	195	1998	222	1999	144

Number of cases brought to Juvenile Court for Possession of Alcohol

1997	45	1998	15	1999	48

Number of cases with court sanction in Juvenile Court: driving restrictions

1999	11

Number of cases with court sanction in Juvenile Court: D/A Coun/Eval

1999	11

Number of cases with court sanction in Juvenile Court: Psych/Counseling Eval

1999	15

Number of cases brought to Juvenile Court for MIP/MIC

1997	28	1998	59	1999	48

Number of cases brought to Juvenile Court for Ungovernable Behavior

1997	13	1998	10	1999	101

Rates of reported incidents of students with police

Data Source: Search Survey Results, 1999, 1997 in parenthesis

26% (22%) got into trouble with police once or more in the last 12 months

16% (17%) committed vandalism once or more in the last 12 months

Area VIII: High rates of expulsions and suspensions of students from school

Data Source: Hazen Public School Records

1997-98	25 ATOD suspensions	1999-00	15 ATOD suspensions
1998-99	43 ATOD suspensions	2000-01	05 ATOD suspensions (as of 10-02-00)

Rates of in-school suspensions of students for violence related incidents

1997-98	02	1999-00	05
1998-99	09	2000-01	04 (as of 10-02-00)

Rates of observed violence incidents of students requiring detention

1997-98	31	1999-00	30
1998-99	07	2000-01	01 (as of 10-02-00)

Rates of reported violence incidents of students (self-reported)

Data Source: Search Survey Results, 1999, 1997 in parenthesis

36% (35%) hit someone once or more in the last 12 months

15% (10%) physically hurt someone once or more in the last 12 months

4% (1%) used a weapon to get something from a person once or more in the last 12 months

23% (20%) been in a group fight once or more in the last 12 months

8% (4%) carried a weapon for protection once or more in the last 12 months

34% (36%) threatened physical harm to someone once or more in the last 12 months

ANALYSIS OF DATA:

The above data indicates that there are high rates of alcohol and drug use, arrest and conviction, referral, and suspension among youth in our area. The data indicates that there is a need to be concerned about incidents of violence and drug use by youth in our area. According to the data, there is a need to coordinate prevention efforts into a comprehensive program which would include expanding the after-school program, purchasing study center materials, implementing a middle school resource room, updating drug/alcohol materials, and training staff, parents, and community members. A major focus will be to train staff utilizing the Respect and Protect program along with making the community/parents aware of this program. All students will benefit from these programs because all students are at-risk at some point in their lives.

2. PLAN O[illegible]ERATION
2000-2001

Goals	Objectives	Activity	Responsible	Time
Goal 1: To improve K-12 student knowledge and skill toward safety, as well as prevent or decrease the incidence of violent behavior.	1. By June, 2001, 35% of K-12th grade students will participate in at least one after-school program, resource room, and/or study center.	Implement resource room in Grades 6-8, expand K-12 After-School Tutorial Program, purchase curriculum materials for study center	Cathy Brier, Counselor Mr. Langowski, Principal Mr. Opp, Principal Max Beckwith, Counselor Mr. Zimmerman, Principal	11/10/00-5/23/01
	2. By May 23, 2001, 100% of K-12th grade students will attend classroom guidance sessions on violence prevention issues.	K-12 classroom guidance instructional lessons on conflict resolution, anger management, teasing, harassment, etc.	Max Beckwith, Counselor Cathy Brier, Counselor	9/5/00-5/23/01
	3. By June, 2001, Peer Youth Workers will mentor 35 at-risk students.	Peer mentoring for at-risk students.	Max Beckwith, Counselor	11/10/00-6/30/01
	4. By May 23, 2001, the number of violence-related incidents requiring detention will be reduced from 30 to 25 and the number requiring expulsions/suspensions will be reduced from 5 to 4.	Documentation of violence-related incidents.	Mr. Langowski, Principal Mr. Opp, Principal Mr. Zimmerman, Principal	8/28/00-5/23/01
Goal 2: To improve PK-12 student knowledge and skills toward alcohol, tobacco, and other drug prevention, as well as prevent, delay, or decrease alcohol, tobacco, and other drug use.	1. By May 23, 2001, 95% of 6th, 7th, and 8th graders (Life Skills) and 95% of 7th and 10th graders (Life Skills Health) will have achieved a grade of C or better on assignments.	Life Skills instruction, Grade 6, 7, and 8 Life Skills Health instruction Grades 7 and 10	Kathy Berglund, Teacher Dennis Samuels, Teacher Ron Stanley, Instructor Randy Johnson, Health Teacher	9/1/00-5/23/01
	2. By May 23, 2001, 100% K-5th students will receive Know Your Body program.	Know Your Body instruction	Classroom Teachers	8/28/00-5/23/01

2. PLAN OF OPERATION
2000-2001

	3. By May 23, 2001, students will show an increase from pre-post attitude test showing a more positive attitude toward non-usage by 13% & increase from pre-post knowledge test by 15% & decrease the ATOD suspensions by 30%.	ATOD Prevention Programs in Grades 6-12 Principal Documentation of ATOD suspensions	Ron Stanley, Instructor Cathy Brier, Counselor Randy Johnson, Teacher Kathy Berglund, Teacher Dennis Samuels, Teacher Mr. Langowski, Mr. Opp, Mr. Zimmerman, Principals	8/28/00-5/23/01
Goal 3: To improve staff knowledge and skills toward prevention and promote practice of positive role modeling by staff for violence and ATOD prevention.	1. By June 30, 2001, 90% of staff will attend training in viol/ATOD prevention. 2. By June 30, 2001, 90% of staff will be involved in student prevention activities.	1. Attend training offered in viol/ATOD prevention which includes Respect & Protect, Roughrider Conf. 2. Staff involvement in ATOD prevention activities.	Cathy Brier, Counselor Max Beckwith, Counselor	8/28/00-6/30/01
Goal 4: To improve parent and community knowledge and attitudes toward prevention, as well as to promote involvement in violence and ATOD prevention.	1. By June, 2001, six meetings of the Hazen Community Health Task force (SDFS Advisory Council) will be held.	Meeting dates set for 3rd Wed. of each month will be held to advise, develop, disseminate information for the Hazen School District SDFS program.	Cindy Fischer & Dawn Garrett, Co-Chair, HCHTF Cathy Brier, Drug Free Coordinator	8/24/00-6/30/01
	2. By May, 2001, two Parenting for Prevention courses & two community wide presentations will be offered for parent education.	Meeting and presentation dates will be scheduled for 2000-2001 school year.	Cathy Brier, Counselor Max Beckwith, Counselor	8/24/00-6/30/01
	3. By Dec., 2000, 4 comm/student members will attend the Nat'l Healthy Comm/Healthy Youth conf. 4. By Nov. 15, 2000, a grant coordinator will be designated.	3. Attend Healthy Communities/Healthy Youth Conference in November, 2000. Report to HCHTF and SDFS Advisory Council. 4. Designate Coodinator	3. Maxine Beckwith, Counselor 4. Jerome Enget, Superintendent	11/01/00-11/30/00

Evaluation Plan

GOAL 1:

Objective1.1 By June, 2001, 35% of K-12th grade students will participate in at least one after-school program, resource room, and/or study center.

As evidenced by : Attendance records for programs will be kept.

Objective1.2 By May 23, 2001, 100% of K-12th grade students will attend classroom guidance sessions dealing with violence prevention issues.

As evidenced by: Documentation by school counselors will be kept.

Objective1.3 By June, 2001, Peer Youth Workers will mentor 35 at-risk students.

As evidenced by: Documentation by Peer Youth Worker coordinator will be kept.

Objective 1.4 By May 23, 2001, the number of violence-related incidents requiring detention will be reduced from 30 to 25 and the number of violence-related incidents requiring suspensions/expulsions will be reduced from 5 to 4.

As evidenced by: Documentation records from principal's office.

GOAL 2:

Objective 2.1 By May 23 , 2001, 95% of 6th, 7th, and 8th graders will have achieved a grade of C or better on assignments in the Life Skills Training curriculum and 95% of 7th and 10th graders will have achieved a grade of C or better on assignments in the Life Skills Health curriculum.

As evidenced by: All Life Skills assignments will be graded and recorded.

Objective 2.2 By May 23, 2001, 100% of K-5th grade students will receive Know Your Body instruction.

As evidenced by: Documentation by classroom teachers will be kept.

Objective 2.3 By May 23, 2001, students in ATOD prevention programs will show an increase from the pre-attitude test to the post-attitude test showing a more positive attitude towards non-usage by 13% and improve their knowledge by 15% from the pre-test to the post-test and decrease the number of ATOD suspensions by 30%.

As evidenced by: Pre-tests and Post-tests will be given to students in grades 6-12 and documentation of ATOD suspensions by principals.

GOAL 3:

Objective 3.1 By June 30, 2001, 90% of staff will attend training for researched based programs, ATOD/violence prevention workshops.

As evidenced by: Documentation of attendance for training will be kept.

Objective 3.2 By June 30, 2001, 90% of staff will participate in student prevention activities.

As evidenced by: Documentation of staff involvement in prevention activities.

GOAL 4:

Objective 4.1 By June, 2001, six meetings of the SDFS Advisory Council will be held in unison with the Hazen Community Health Task Force to advise, develop, and disseminate information for the Hazen School District SDFS program.

As evidenced by: Minutes and attendance records at meetings will be maintained by SDFS coordinator.

Objective 4.2 By May, 2001, two Parenting for Prevention six-session courses and two community wide presentations will be offered on violence and ATOD prevention.

As evidenced by: Documentation of attendance will be kept and parent/participant evaluation.

Objective 4.3 By December, 2000, 4 community/student members will attend the National Healthy Communities/Healthy Youth conference.

As evidenced by: Documentation and reports back to HCHTF/SDFS Advisory Council.

Objective 4.4 By November 15, 2000, a grant coordinator will be designated.

As evidenced by: Document of contracted time.

The various projects through this grant will be communicated to students, parents, staff, and community members through direct contact, newsletters, flyers, local newspaper, and staff meetings. Progress will be reported in the same manner.

SB 2399
Testimony in favor

Keith Johnson, R.S.
Administrator, Custer Health
Mandan, ND 58554
Ph.667-3370

For: ND Public Health Administrators
Custer District Board of Health

As you know, this bill is the Product of the Interim Committee that was charged with development of a recommendation to the Legislature for distribution of the money from the Community Health Trust Fund. We stand in support of that effort. We think they did some thoughtful work in implementation of Governor Schafer's recommendations.

We believe that this bill can accommodate the changes needed to implement the position of the Local Health Administrators, and of the local Boards of Health that have adopted position statements. I am aware of statements that have been adopted by the First District Board of Health, the Custer Board of Health, and the Fargo Cass Board of Health. These statements support the position of the ND Public Health Administrators. Those positions include:

1. **A statewide tobacco prevention program model should be facilitated by the State Health Department with local implementation.**

2. **A central resource center for "best practices" tobacco prevention programs should be established.**

3. **Funding should be made available to local Public Health Units based on a community needs assessment and the establishment of prioritized health issues.**

4. **Money should be allocated specifically for tobacco control.**

We also agree with the Committee's recommendation on line 3, Page 2, that the local public health state aid should be included in the final bill. This would continue the initiative from the last legislature that resulted in every county in the state having a local public health presence. Support, especially for these new units, should be continued.

Testimony
to the
Budget Committee on Health Care
Murray G. Sagsveen, State Health Officer
February 24, 2000

Introduction

This is a proposed concept for a *Community Health Grant Program* to be funded with the 10% of the tobacco settlement money allocated to the Community Health Trust Fund.

Summary of Testimony

Governor Schafer's concepts for the tobacco settlement money were outlined in the January 5, 1999, State of the State message: "I am proposing we devote 10 percent of any tobacco settlement dollars to public health programs, including important initiatives on diabetes, drug and alcohol abuse, and tobacco prevention and cessation. This will fund programs primarily driven at the local level..."

House Bill 1475 (1999), now codified at N.D.C.C. § 54-27-25, provides further statutory guidance: "The state department of health may use funds as appropriated for community-based public health programs and other public health programs, including programs with emphasis on preventing or reducing tobacco usage in this state."

Assuming that the 10% allocation could consistently yield $5,000,000 per biennium, a *Community Health Grant Program* could include three components:

- Healthy Schools ($2,000,000)
- Healthy Families ($2,000,000)
- Healthy Communities ($1,000,000)

The *Healthy Schools* component would be a simple grant program consisting of the following:

- Grants would be about $9 per student per year ($1,000,000 / 110,000 students = $9.09).
- The grant would be released when the local board of health and the local school board sign a memorandum of agreement (MOA) concerning the preventive health programs that would be funded. The boards may include other parties in the MOA.
- The MOA must include a plan to reduce tobacco use by students, but may include other issues that the boards consider a priority.
- The MOA must also address how the boards will evaluate the effectiveness of their program.
- A 2:1 or 4:1 "hard match" by participating schools.

The *Healthy Families* component would also be a simple grant program consisting of the following:

- Grants would be about $1.50 per capita per year ($1,000,000 / 640,000 residents = $1.56).
- The grant would be released when the local boards of health and all interested parties in a community health region (which could include a hospital, employers, local governments, etc.) develop a plan that identifies the priority needs of the region, the programs that will be funded, and the method of evaluating the programs. Although the planning and evaluation would be region-wide, the implementation would be through each public health unit in the region.
  - The community health planning regions would be similar to the existing Department of Human Services and Children's Services Coordinating Committee (CSCC) regions.
  - The existing local tobacco coordinator program, now funded by the CDC, would be augmented so that each region would have additional staff to support all communities and schools in the region.
- The plan must address tobacco-related issues (such as cessation programs for current smokers), but may include other issues that are a priority for that region.
- A 4:1 match could be required, which would leverage the $1,000,000 allocation into $1,250,000 per year.

The *Healthy Communities* component, $500,000 per year, could be dedicated to several essential community-based objectives:

- Increase state aid from $3,000 per county per year (plus about $0.53 per capita) to $7,000 per county per year (plus the same per capita amount) (53 x $4000 = $212,000).
- A $25,000 grant to each region to augment the CDC funding for local tobacco program specialists and to plan, implement, and evaluate regional programs (8 x $25,000 = $200,000).
- $88,000 for statewide training, improvement of data management programs, and evaluation of the *Community Health Grant Program*.

The Emphasis on Communities

Governor Schafer and the Legislative Assembly emphasized that the *Community Health Grant Program* should be a community-based program. The recent USDHHS report titled "Healthy People 2010 ~ Understanding and Improving Health" also emphasized this point:

> Over the years, it has become clear that individual health is closely linked to community health – the health of the community and environment in which individuals live, work, and play. Likewise, community health is profoundly affected by the collective

behaviors, attitudes, and beliefs of everyone who lives in the community.

Indeed, the underlying premise of Health People 2010 is that the health of the individual is almost inseparable from the health of the larger community and that the health of every community in every State and territory determines the overall health status of the Nation. That is why the vision for Healthy People 2010 is "Healthy People in Health Communities."

The Emphasis on Tobacco

The proposed *Community Health Grant Program* would be an effort to decrease tobacco use throughout North Dakota.

A landmark study titled "Actual Causes of Death in the United States" was published in the November 10, 1993, *Journal of the American Medical Association* (JAMA) at 2207-2212. The authors concluded that tobacco use is the largest "actual cause" of death in the United States (graphs illustrating the findings of the authors are attached at pages 12 - 13):

> Tobacco accounts for approximately 400 000 deaths each year among Americans. It contributes substantially to deaths from cancer (expecially cancers of the lung, esophagus, oral cavity, pancreas, kidney, and bladder, and perhaps of other organs), cardiovascular disease (coronary artery disease, stroke, and high blood pressure), lung disease (chronic obstructive pulmonary disease and pneumonia), low birth weight and other problems of infancy, and burns. In a major effort that drew on analyses that had been commissioned to assess the mortality, morbidity, and financial burden imposed by each of 15 priority health problems, the Carter Center's *Closing the Gap* project attributed 17% (338 000) of all deaths in 1980 and 13% of all potential years of life lost from death before 65 years of age to tobacco. Other estimates have placed tobacco's contribution in the range of 11% to 30% of cancer deaths, 17% to 30% of cardiovascular deaths, 30% of lung disease deaths, 24% of pneumonia and influenza deaths, 10% of infant deaths, and 20% to 30% of low-birth-weight infants. Approximately 3000 lung cancer deaths annually among nonsmokers have been attributed to environmental tobacco smoke. The sum of the lower and upper boundaries, respectively, for these estimates would yield an approximate range of 257 000 to 468 000 tobacco-attributable deaths in 1990. Using a specially developed software package, the Centers for Disease Control and Prevention (CDC) estimated that 418 690 deaths were caused by tobacco in 1990, including approximately 30% of all cancer deaths and 21% of cardiovascular disease deaths. The CDC estimates have been widely accepted and provide the basis for the 400 000 figure... [Footnotes omitted]

Many recent scientific studies have focused on the relationship between tobacco use and decreased quality of life, increased healthcare costs, and premature death. For example, a November 5, 1999, article titled "Tobacco Use – United States, 1900-1999" in the CDC's Morbidity and Mortality Weekly Report (MMWR) stated:

> Smoking – once a socially accepted behavior – is the leading preventable cause of death and disability in the United States. During the first decades of the 20th century, lung cancer was rare; however, as cigarette smoking became increasingly popular, first among men and later among women, the incidence of lung cancer became epidemic. In 1930, the lung cancer death rate for men was 4.9 per 100,000; in 1990, the rate had increased to 75.6 per 100,000. Other diseases and conditions now known to be caused by tobacco use include heart disease, atherosclerotic peripheral vascular disease, laryngeal cancer, oral cancer, esophageal cancer, chronic obstructive pulmonary disease, intrauterine growth retardation, and low birthweight. During the latter part of the 20th century, the adverse health effects from exposure to environmental tobacco smoke also were documented. These include lung cancer, asthma, respiratory infections, and decreased pulmonary function.

An article titled "Medical costs of smoking in the United States: estimates, their validity, and their implications," in the most recent edition of *Tobacco Control* (8:290-300) concludes:

> The peer-reviewed literature on the medical costs of smoking in the United States indicates that at least 6-8% of annual personal health expenditures in the United States, and quite possibly considerably more, is devoted to treating diseases caused by smoking. The 6-8% figure represents a solid estimate of expenditures directly related to smoking's three most important disease causes of death, lung cancer, heart disease, and chronic obstructive pulmonary disease. * * *
>
> In closing this review of the findings and costs of smoking, we wish to emphasise that whatever measure is used, the financial healthcare costs of smoking constitute only one indication of the burden of smoking on a society, in some ways a rather minor one. The most important outcome of tobacco use remains the one that underlies the estimates of monetary cost: the devastation it wreaks on human health.

When the Centers for Disease Control and Prevention (CDC) recently published its *Best Practices for Comprehensive Tobacco Control Programs, August 1999)*, the introductory comments explained:

> Tobacco use is the single most preventable cause of death and disease in our society. Most people begin using tobacco in early adolescence, typically by age 16; almost all first use occurs before high school graduation. Annually, tobacco use causes more than 430,000 deaths and costs the Nation approximately $50-$73 billion in medical expenses alone.

Accordingly, it is my recommendation that the primary focus of the *Community Health Grant Program* should be a statewide effort to decrease the use of tobacco by youth and adults.

However, it is also my recommendation that communities within a region should have the flexibility to address other public health issues, such as obesity. The graph at page 13 clearly indicates that diet and activity patterns are the second leading cause of death in the United States. The 1993 *JAMA* article, "Actual Causes of Death in the United States," also addressed this significant public health issue:

> Dietary factors and activity patterns that are too sedentary are together accountable for at least 300 000 deaths each year. Dietary factors have been associated with cardiovascular diseases (coronary artery disease, stroke, and high blood pressure), cancers (colon, breast, and prostate), and diabetes mellitus. Physical inactivity has been associated with an increased risk of death for heart disease and colon cancer. The interdependence of dietary factors and activity patterns as risk factors for certain diseases is illustrated by the case of obesity, which is associated with increased risk for cardiovascular disease, certain cancers, and diabetes, and is clearly related to the balance between calories consumed and calories expended through metabolic and physical activity. Similarly, high blood pressure, a major risk for stroke, can be affected by dietary sodium, obesity, and sedentary lifestyle. [Footnotes omitted]

The chart at page 14, prepared from 1994-1998 data in the department's Division of Vital Records, confirms that heart disease and cancer is the leading killer of North Dakotans after age 30.

Communities may decide other public health issues also deserve attention. For example, the chart at page 14 also reveals that accidents and suicide cause three out of four deaths in the 20-24 age range.

CDC's *Best Practice's for Comprehensive Tobacco Control Programs (August 1999)*

The CDC has developed a comprehensive tobacco control recommendation for all states. A summary of the nine-point program is at page 16.

The comprehensive program recommended by the CDC would cost $8,161,000 - $16,547,000 annually to implement. Since the 10% allocation to public health programs may yield about $2,500,000 annually, a comprehensive program, as defined by the CDC, is not possible.

It was my decision that the 10% allocation would partially fund two components of a comprehensive tobacco control program: (1) community programs to reduce tobacco use and (2) school programs.

Because of limited funds, local authorities must finance enforcement programs, we must rely on national counter-marketing programs (such as the American Legacy Foundation, which is funded by tobacco settlement dollars), smokers (or their insurance programs) must finance cessation programs, and we must continue existing surveillance and evaluation programs.

Healthy Schools

The Association of State and Territorial Health Officials (ASTHO) and the Council of Chief State School Officials (CCSSO), with the support of the Centers for Disease Control and Prevention (CDC) have developed a "coordinated approach to school health." This effort was prompted by alarming nationwide statistics concerning school-age children:[1]

- Alcohol Abuse ~ In 1997, almost 1 in 3 12th graders, 1 in 4 10th graders and 1 in 10 8th graders reported heavy drinking (at least 5 drinks in a row).
- Tobacco Use ~ From 1991-1997, cigarette smoking increased 80% among black high school students, 34% among Hispanic high school students, and 28% among white high school students.
- Poor Nutrition ~ At least 11% and possibly as many as 25% of US children and adolescents are overweight.
- Mental Well-Being ~ Nationwide, 1 in 5 students grades 9-12 has seriously considered attempting suicide.
- Substance Abuse ~ 26% of all 12th graders, 23% of 10th graders, and 13% of 8th graders report using illicit drugs.

[1] The statistics are quoted from a joint ASTHO-CCSSO publication titled "Why Support a Coordinated Approach to School Health?"

- Violent Crimes ~ Youth aged 12-17 are nearly 3 times more likely than adults to be victims of serious violent crimes.
- Suicide ~ Suicide is the #3 cause of death among 15-24 year olds.
- Sexually Transmitted Diseases ~ Every year, 3 million adolescents become infected with an STD.
- Accidental Deaths ~ Motor vehicle accidents are the number one cause of death among teens. Almost 50% of these are alcohol-related.

The two organizations have developed an eight-point program for a coordinated public-school health program. The executive summary of the program is quoted below because it concisely explains a coordinated program:

> Most people agree that for kids to succeed in school, they cannot be tired, hungry, using illegal drugs, or concerned that violence may occur at any time around them. Perhaps less apparent, however, is the fact that problems such as poor nutrition, domestic violence, alcoholism, substance abuse, depression and more – can adversely affect not only a child's health, but also his or her *ability to learn!*
>
> And that is precisely why a coordinated approach to school health can make a difference!
>
> A coordinated approach to school health improves kids' health and their capacity to learn through the support of families, schools, and communities working together. At its very core, Coordinated School Health (CSH) is about keeping students healthy over time, reinforcing positive healthy behaviors throughout the school day, and making it clear that *good health and learning go hand in hand.* CSH offers students the information and skills they will need to make good choices in life.
>
> More specifically, a coordinated approach to school health can address up to eight different aspects of health and education. These include:
>
> *1. School Environment...*
>
> To learn effectively, children must be in a school environment where they feel comfortable and supported. It is also important that parents and other adults working with kids have high expectations about learning and provide students with the support they need.
>
> *2. Health Education...*
>
> School staff – teachers, nurses, administrators, or counselors – can work together to develop an ongoing approach to help students build health-related knowledge and skills from kindergarten through 12th grade.
>
> *3. School Meals and Nutrition...*
>
> Many students eat one or two meals a day at school. Thus, schools have a unique opportunity to offer more nutritious food, as

well as develop coordinated educational activities to encourage students to make healthful eating and good nutrition a priority for life.

4. Physical Education...

Schools can and should encourage students to lead a physically active lifestyle both in and out of school. One way to start is to emphasize the importance of regular exercise as a lifelong activity.

5. Health Services...

Growing kids require a regularly scheduled health "maintenance" program – including immunizations, dental checkups, physicals, eye exams, other types of screenings, and in certain instances, daily medication. With the help of health professionals, schools can encourage preventive services to enable students to take proactive measures to stay healthy and get more out of school.

6. Counseling, Psychological, and Mental Health Services...

Today, many students have the added stress of coping with emotional challenges stemming from problems such as parental divorce, alcoholism, abuse, and drug addiction. By offering counseling and instruction to students, as well as referrals to mental health professionals, schools can help parents take a big step toward making an even greater difference in a student's total performance.

7. Staff Wellness...

Students aren't the only ones who need to stay in good health. Educators and school staff are important role models for students. Successful schools have healthy, highly motivated staff with low rates of employee absenteeism.

8. Parent/Community Partnerships...

One of the biggest benefits of CSH can be a closer working relationship between parents and schools. Working with parents, businesses, local health officials, and other community groups, schools can form powerful coalitions to address the health needs of students.

Beyond these eight elements, for CSH to truly succeed, one critical component is essential: *The public must believe that educators, policy makers, and opinion leaders are committed to addressing their concerns about children's health and education.*[2]

The 1997 Youth Risk Behavior Survey (which will be distributed with this testimony) shows that the state statistics about youth generally mirror the national statistics.[3]

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[2] *Id.*

[3] The 1999 data should be available in several months.

My *Healthy Schools* proposal includes several issues that merit further comment.

I am recommending that public health units should be the fiscal agents for the program and that the funds should be available when the local board of health, the local school board, and appropriate others sign a memorandum of agreement concerning the elements of *their* coordinated school health program. Other than requiring that the coordinated school health program must address efforts to reduce tobacco use by students and must include a mechanism for evaluating the overall effectiveness of the program, the parties to the agreement may develop their own priorities.

I am also recommending a 2:1 or 4:1 "hard match" by the participating schools for several reasons:

- *Healthy Schools* is not just a "public health" issue (i.e., the responsibility of the local board of health). School boards should be an active participant, and an active financial contributor, in a *Healthy Schools* program.
- The allocation of tobacco settlement payments included 45% to schools and 10% to public health. A small fraction of the 45% should be dedicated to a *Healthy Schools* program.
- A 2:1 hard match would increase the funds for *Health Schools* each biennium from $2,000,000 to $3,000,000 and a 4:1 hard match would increase the funds from $2,000,000 to $2,500,000.

Healthy Families

The *Community Health Grant Program* should not only focus on school-age youth. There are many tobacco-related and other public health issues that involve pre-school children and adults of all ages.

If $2,000,000 per biennium is allocated to a *Healthy Families* component, about $1.50 per capita would be available each year for tobacco and other public health programs.

The charts at pages 12 - 13 illustrate the national public health challenges. The state data available to me, such as at page 14, suggests that the national and state public health challenges are quite similar.

It is my recommendation that a *Healthy Families* component should be developed on a regional basis (see the map at page 15) for several reasons:

- Each region would include at least one regional medical center.
- Each region would generally mirror the Children's Services Coordinating Council (CSCC) regions.
- Each region would generally mirror the existing Department of Human Services regions.

- Each region would have the professional support from the local tobacco control and prevention program (now located in eight cities and one reservation).
- Three of the eight regions are existing multi-county public health units (Upper Missouri District Health Unit, First District Health Unit, and Southwestern District Health Unit).
- Planning and evaluation of a *Health Families* component should be on a regional basis (to avoid duplication, gaps, and unnecessary expenses).

It is also my recommendation that the appropriate public health unit would be the fiscal agent for the region and that the funds should be available when the local boards of health, the participating cities, and other appropriate parties develop a plan that identifies the priority needs of the region. The plan must address efforts to reduce the prevalence of smoking in the region and other tobacco-related issues, but may include other priorities for that region.

It is also my recommendation that at least a 1:4 "hard match" be required, for at least the following reasons:

- A community that is sincerely interested in the *Healthy Families* program will have the necessary funds for a 1:4 match.
- *Healthy Families* is not just a "public health" issue (i.e., an challenge only for the local board of health).
- A 1:4 match would increase the available funds each biennium from $2,000,000 to $2,500,000.

Healthy Communities

The *Healthy Communities* component of the grant program addresses the essential public health infrastructure for North Dakota.

The *Healthy Schools* and *Healthy Families* components of the grant program primarily benefit the high population areas. Accordingly, the less populated areas may not have the necessary funding to deliver the essential public health programs.

It is my recommendation that the existing per county state aid be increased from $3,000 to $7,000 annually (53 x $4,000 = $212,000). This amount would supplement, not supplant, the local effort. My meetings with county commissions and local boards of health across the state have usually focused on one issue: the limited resources available to accomplish essential public health programs.

It is also my recommendation that $25,000 should be available to each region to augment the CDC funding for local tobacco program specialists and to fund a region-wide planning, implementation, and evaluation program with all appropriate partners (8 x $25,000 = $200,000).

It is also my recommendation that the remaining amount ($88,000) be available for statewide training, the necessary improvement of the state's public health data management programs, and the statewide evaluation of the *Community Health Grant Program* (i.e., accountability to the governor, the legislature, and the public).

Conclusion

This is a concept, with some details, for a *Community Health Grant Program* with three major components: *Healthy Schools, Healthy Families,* and *Healthy Communities.*

The concept in this testimony has evolved for more than one year, beginning with the governor's State of the State Message in January 1999 and the legislature's additional statutory guidance in House Bill 1475. I've also solicited input from the general public, from interest groups, the Health Council, and from Department of Health Staff in the intervening months. However, more work is required on many details, such as addressing the public health needs of higher education students, ensuring that these funds supplement rather than supplant local funding, and transitioning to a regional (rather than county- or city-wide) planning.

My testimony today may generate additional comments, which I will carefully consider as I prepare my budget recommendations to OMB and Governor Schafer in the months ahead.

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Attachments

Testimony
to the
Budget Committee on Health Care
Murray G. Sagsveen, State Health Officer
June 27, 2000

Introduction

This is my recommendation for the 10% of the tobacco settlement money allocated to the Community Health Trust Fund during the current biennium.

Governor Schafer's concepts for the tobacco settlement money were outlined in the January 5, 1999, State of the State message: "I am proposing we devote 10 percent of any tobacco settlement dollars to public health programs, including important initiatives on diabetes, drug and alcohol abuse, and tobacco prevention and cessation. This will fund programs primarily driven at the local level..."

House Bill 1475 (1999), now codified at N.D.C.C. § 54-27-25, provides further statutory guidance: "The state department of health may use funds as appropriated for community-based public health programs and other public health programs, including programs with emphasis on preventing or reducing tobacco usage in this state."

The Office of Management and Budget (OMB) now estimates that $5,667,020 will be allocated to the Community Health Trust Fund during this biennium.

Recommendation

It is my recommendation that the interest from the trust fund be appropriated next biennium to the Department of Health for community-based public health programs and other public health programs, including programs with emphasis on preventing or reducing tobacco usage in this state.

It is also my recommendation that the legislature reserve the accumulated principal in the Community Health Trust Fund for only two purposes:

1. to provide an appropriate cash flow to the department to fund a Community Health Grant Program (the primary payments will be made each year in April); and
2. to provide an appropriation (e.g., $1,000,000) to the department for public health contingencies if the governor declares an emergency in accordance with North Dakota Century Code Chapter 37-17.1.

Testimony on SB 2399
Regarding the Community Health Trust Fund
Before the
Senate Human Services Committee

Darleen Bartz, Chief
Preventive Health Section
North Dakota Department of Health Promotion

February 5, 2001

Madame chairman, and members of the Committee. I am Darleen Bartz, Chief of the Preventive Health Section, North Dakota Department of Health. The Department does not support or oppose Senate Bill 2399, but offers the following comments.

The Department's goal is to work towards establishing a comprehensive, statewide tobacco control program as summarized on the attached fact sheet. The Department will receive approximately $2.4 million in federal funds for tobacco control this next biennium. We propose using $5 million from the community health trust fund to supplement this existing program, combining resources to equal approximately $7.4 million per biennium. These combined resources will move North Dakota forward in implementation of a statewide tobacco control program based on the U.S. Centers for Disease Control and Prevention's (CDC) *Best Practices for Comprehensive Tobacco Control Programs* (August 1999). Funding from the community health trust fund specifically for reducing tobacco use will help the state move toward a comprehensive, statewide tobacco control program.

We are pleased with portions of Senate Bill 2399 such as countermarketing and community resources for tobacco control, which are part of the CDC *Best Practices* standards. However, we do have some concerns with SB 2399 as currently written.

SB 2399, as currently written, may not move the state closer to a more comprehensive, statewide tobacco control program. In 1999, the N.D. Legislature created a community health trust fund to receive tobacco settlement dollars. This trust fund was to be used for programs including programs with an emphasis on tobacco control. The Department of Health believes the $5 million from the community health trust fund can establish a sustainable statewide tobacco control program. A $7 million program may not be sustainable, based on current settlement payments.

Therefore, we recommend the committee consider amending Senate Bill 2399 to provide for a comprehensive, statewide tobacco control program based on CDC *Best Practices*, with $5 million from the community health trust fund per biennium .

I and others from the Department would be happy to respond to any questions you may have. Thank you.

Comprehensive Programs Fact Sheet

RATIONALE FOR COMPREHENSIVE INTERVENTIONS

- Statewide programs have emerged as the new laboratory for developing and evaluating comprehensive plans to reduce tobacco use.

- Initial results from statewide tobacco control programs are encouraging, particularly in per capita declines of tobacco consumption.

- State findings also suggest that youth behaviors regarding tobacco use are more difficult to change than adult ones.

- People do not make behavior choices in isolation, but rather in a larger, complex context that includes the family, community, and culture; the economy and physical environment; formal and informal government policy; and the prevailing legal atmosphere. Programs to reduce tobacco use will be most effective if they address all the components that may influence the individual's behavior choices.

- There are several advantages to shifting from an approach that targets the individual to a population approach that uses social, policy, and environmental strategies.

- First, by recognizing that many environmental determinants of health behavior are not under the direct control of the individual, the population approach avoids blaming persons who fail to change their behavior.

- Second, many individual efforts may fail to reach those in greatest need. Because many of these strategies are most effective with better-educated, wealthier persons, the disparities in health between population groups may widen.

- Third, making regulatory and policy changes can be more cost-effective than conducting numerous interventions to modify individual behavior.

CDC'S NATIONAL TOBACCO CONTROL PROGRAM

- In May 1999 CDC launched the National Tobacco Control Program (NTCP), bringing the various federal initiative activities into one national program. In fiscal year 2000, the NTCP distributed $59 million for comprehensive tobacco control efforts in all states, the District of Columbia, seven U.S. territories, and Native American tribal organizations.

- CDC recommends four program goals in its comprehensive framework for statewide programs:*
  1. Prevent initiation of tobacco use among young people.
  2. Promote quitting among adults and young people.
  3. Eliminate exposure to environmental tobacco smoke (ETS).
  4. Identify and eliminate health disparities among population groups.

- Each program goal would be fully addressed by implementing four program components:
  1. community interventions, which include diverse entities such as schools, health agencies, city and county governments, and civic, social, and recreational organizations;
  2. countermarketing, which includes using media advocacy, paid media, pro-health promotions, and other media strategies to change social norms related to tobacco use;
  3. program policy and regulation, which addresses such issues as minors' access, tobacco pricing, advertising and promotion, clean indoor air, product regulation, and tobacco use treatment; and
  4. surveillance and evaluation, which includes monitoring the tobacco industry's promotional campaigns, evaluating the economic impact of ETS laws and policies, conducting surveys of public opinion on program interventions, and making ongoing refinements that lead to more effective prevention strategies.

- The elimination of health disparities among population groups remains a challenge due to the lack of culturally appropriate programs of proven efficacy. However, in recent years, a number of people and organizations with more diverse backgrounds have assumed a greater role in efforts to reduce tobacco use. Particularly in view of the tobacco industry's targeted marketing to women, young people, and racial/ethnic populations, such heightened activity is critically important for ensuring that nonsmoking becomes the norm within diverse communities.

- To be effective, comprehensive programs should include campaigns that:
  1. target young people and adults with complementary messages;
  2. highlight nonsmoking as the majority behavior;
  3. communicate the dangers of tobacco while providing constructive alternatives;
  4. use multiple non-preachy voices in a complementary, reinforcing mix of media and outdoor advertising;
  5. include grassroots promotions, local media advocacy, event sponsorships, and other community tie-ins, and
  6. encourage youth empowerment and involvement.