2011 SENATE HUMAN SERVICES

SCR 4024

2011 SENATE STANDING COMMITTEE MINUTES

Senate Human Services Committee
Red River Room, State Capitol

SCR 4024
2-21-2011
Job Number 14775

☐ Conference Committee

Committee Clerk Signature RMolox

Explanation or reason for introduction of bill/resolution:

Directing legislative Management to study issues relating to sodium intake and legislative measures aimed at decreasing heart disease and stroke.

Minutes: Attached testimony.

Senator Judy Lee opened the hearing on SCR 4024.

June Herman, Vice President of Advocacy for the American Heart Association in ND, testified in support of SCR 4024. Attachment #1

Senator Judy Lee asked if stroke and heart disease are on the disease list for best practices as being connected to smoking.

Ms. Herman responded that some states do fund chronic disease programs and it does count towards their CDC tobacco prevention and cessation best practices.

The key criterion with the chronic disease program is if it lends itself to system changes. When you look at Go Red ND you are encouraging women to know the risks, to identify the risk, and how they can reduce heart disease and stroke. Part of that is to quit smoking so you do want to tie them in to cessation services.

A short discussion on venue based approaches took place. The American Heart Association is working with the industry at a national level. Some of the language talks about step wise reduction. Our taste buds have gotten used to salt in our food and it's not going to work to bring it all the way back down to where it should be.

Senator Spencer Berry asked if the STEMI events had anything to do with the bill in the House regarding equipping the ambulance so they could bypass hospitals that don't have available treatments.

Ms. Herman said they were looking at a bill draft as something to bring forward. They didn't' have consensus from the six large facilities on that piece of legislation which would have been the vehicle to carry the match request. Since there was not consensus on the

policy piece they opted to hold back and wait until another session so they can work with all the parties to bring a bill forward.

Senator Spencer Berry asked what the conflict was.

Ms. Herman responded that a number of the facilities agreed to a very strong draft bill and others wanted a lesser bill. There was still a facility or two that wanted to sit back and define out what the authority of the Health Department was over heart systems of care and how it all linked and worked with the leadership in authority of the hospitals.

Senator Dick Dever referred to the percentages of 36.9% in 2010 and 40 ½ % in 2030. He asked if that was because of increasing bad diets or because of an aging population and extending life expectancies.

Ms. Herman thought that was an excellent reason to pass this resolution so there could be a study group to really dig down into a lot of those issues of what is driving the increased costs. There certainly is the aging baby boomer generation. Hypertension is a key aspect.

Senator Judy Lee asked where personal responsibility fits in.

Ms. Herman replied that it is challenging for those who are trying to change their lifestyles – where the low sodium foods are and how to get easy access to them.

Joan Enderle, Director of the American Heart Association's Go Red ND Initiative, testified in support. Attachment #2

Senator Spencer Berry asked if there were any studies they have that would show a primary impact of sodium intake in its relationship to high blood pressure.

Ms. Enderle replied that the American Heart Association, in the last month, has come out with significant research background of studies showing a direct impact of sodium on lowering blood pressure and also the prevention side.

Senator Tim Mathern referred to the red dress and asked if it is a national symbol of this effort.

Ms. Enderle responded that the American Heart Association and the National Institute of Health came up with the red dress campaign seven years ago. It is co-owned as a symbol for women and heart disease prevention. She went on to elaborate on the campaign and why now there are two red dresses.

Senator Dick Dever stated that there are a lot of good things going on already and asked if she was sure they wanted to put the legislature in the middle of it.

Ms. Enderle explained that continuing the program and funding is coming to an end. The communities need the support of the legislators, both financially and with policy and system change.

Discussion continued on funding sources and the tie to tobacco use.
June Herman explained difficulties associated with funding from different programs.

Connie Hofland, ND Dietetic Association, spoke in favor of SCR 4024. Attachment #3

Senator Dick Dever wanted to know if sea salt is better.

Ms. Hofland replied that in some cases, if there is other stuff in it that you need, it can be of some benefit. Overall, sodium is sodium and it is the total sodium content.

Discussion continued on the use of sea salt.

Senator Judy Lee asked what this resolution would do. What would be accomplished if this passes?

Ms. Herman answered that it would help engage discussion of legislators into what is going to emerge as a significant fiscal challenge in the future for the legislative body on how to afford the health care costs.

There was no further testimony

The hearing was closed.

Senator Tim Mathern moved a **Do Pass**.

Seconded by **Senator Gerald Uglem**.

Roll call vote 5-0-0. **Motion carried.**

Carrier is **Senator Spencer Berry**.

Date: 2-21-2011

Roll Call Vote # _____

2011 SENATE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. 4024

Senate **HUMAN SERVICES** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☒ Do Pass ☐ Do Not Pass ☐ Amended ☐ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By **Sen.** Mathern Seconded By **Sen.** Uglem

Senators	Yes	No	Senators	Yes	No
Sen. Judy Lee, Chairman	✓		**Sen. Tim Mathern**	✓	
Sen. Dick Dever	✓				
Sen. Gerald Uglem, V. Chair	✓				
Sen. Spencer Berry	✓				

Total (Yes) 5 No 0

Absent 0

Floor Assignment Sen. Berry

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

REPORT OF STANDING COMMITTEE

SCR 4024: Human Services Committee (Sen. J. Lee, Chairman) recommends **DO PASS** (5 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). SCR 4024 was placed on the Eleventh order on the calendar.

2011 HOUSE HUMAN SERVICES

SCR 4024

2011 HOUSE STANDING COMMITTEE MINUTES

House Human Services Committee
Fort Union Room, State Capitol

SCR 4024
March 16, 2011
Job #15509

☐ Conference Committee

Committee Clerk Signature Vicky Crabtree

Explanation or reason for introduction of bill/resolution:

The Legislative Management to study issues relating to sodium intake and legislative measures aimed at decreasing heart disease and stroke.

Minutes: See attached Testimonies #1 - 3

Chairman Weisz: Opened the hearing on SCR 4024.

June Herman: Vice President of Advocacy for the American Heart Association in ND testified in support. (See Testimony #1)

Sen. Dave Nething: From Jamestown sponsored and supported the resolution. I was attending a conference on sodium and concerns and so on as a result of the information that was provided and having a history of heart problems, I thought a study would be raise the awareness of this particular problem. I hope you would see fit to approve this and then we would let the management committee determine whether or not a study should follow. It is a major problem in this country and many food processors are dealing with this already knowing of the concern.

Joan Enderle: Director of the American Heart Association's Go Red ND Initiative testified in support. (See Testimony #2)

Connie Hofland: Representing ND Dietetic Association. (See Testimony #3)

Chairman Weisz: While we are waiting for another sponsor shall we take action on this committee?

Rep. Hofstad: I move a Do Pass and placed on the consent calendar.

Rep. Devlin: I'm going to vote against that. Not because I don't understand the seriousness of it, but we have got some major study resolutions that we need to do during this next interim and I just don't feel this should be clouding that at all. I think quite honestly you would have to live under a rock not to know the dangers of too much sodium and the other things that was mentioned. I know it is easy to just pass these resolutions, but I want you to know why I am voting against it.

Rep. Pietsch: Second.

Rep. Paur: This strikes me of kind of silly. There are thousands of studies on this. The dieticians are the ones that are running most of the institutions and they are I am sure are very well aware as they testified of the affects. I agree with Rep. Devlin that we basically have better things to do.

Rep. Schmidt: I too will support Rep. Devlin in his thoughts.

Rep. Damschen: While I appreciate the intent of the people who testified in favor of this. I too am going to have to vote against it because there has been a lot of reference to nanny states. And when you talk about legislature studying and taken action about (pauses) it is good to know what is good, but you can't always force it. I can't support it.

Chairman Weisz: Sen. Lee has to get back to her committee; we will table this until after the hearing on the next resolution. I'm not closing off any discussion on it.

Chairman Weisz: We will take up where we left off and that was 4024 and we were in the middle of a discussion. I believe Rep. Damschen was the last comment. Further discussion on 4024. We do have a motion for a Do Pass. Ok, we will take a roll call on this one.

Roll Call Vote: 5 y 6 n 2 absent – Rep. Porter and Kilichowski
Motion Failed

Chairman Weisz: Well committee. I can sit on this one I guess, but we are not going to have everyone here this afternoon either.

(Rep. Porter returned to the committee and another vote was taken.)

Rep. Porter: I move a Do Pass.

Rep. Hofstad: Second.

Roll Call Vote: 5 y 7 n 1 absent – Rep. Kilichowski
Motion Failed

Rep. Paur: I move a Do Not Pass

Rep. Anderson: Second

Roll Call Vote: 7 y 5 n 1 absent – Rep. Kilichowski
Motion Carried

Bill Carrier: Rep. Devlin

Date: 3-16-11
Roll Call Vote # 1

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 4024

House HUMAN SERVICES Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☒ Do Pass ☐ Do Not Pass ☐ Amended ☐ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By Rep. Hofstad Seconded By Rep. Pietsch

Representatives	Yes	No	Representatives	Yes	No
CHAIRMAN WEISZ	✓		REP. CONKLIN	✓	
VICE-CHAIR PIETSCH	✓		REP. HOLMAN	✓	
REP. ANDERSON		✓	REP. KILICHOWSKI	A	
REP. DAMSCHEN		✓			
REP. DEVLIN		✓			
REP. HOFSTAD	✓				
REP. LOUSER		✓			
REP. PAUR		✓			
REP. PORTER	A				
REP. SCHMIDT		✓			

Total (Yes) 5 No 6

Absent 2

Floor Assignment _____

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

motion failed

Date: 3-16-11
Roll Call Vote # 2

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 4024

House HUMAN SERVICES Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☒ Do Pass ☐ Do Not Pass ☐ Amended ☐ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By Rep. Porter Seconded By Rep. Hofstad

Representatives	Yes	No	Representatives	Yes	No
CHAIRMAN WEISZ	✓		REP. CONKLIN		✓
VICE-CHAIR PIETSCH	✓		REP. HOLMAN	✓	
REP. ANDERSON		✓	REP. KILICHOWSKI	A	
REP. DAMSCHEN		✓			
REP. DEVLIN		✓			
REP. HOFSTAD	✓				
REP. LOUSER		✓			
REP. PAUR		✓			
REP. PORTER	✓				
REP. SCHMIDT		✓			

Total (Yes) 5 No 7

Absent _____

Floor Assignment _____

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

motion failed

Date: 3-16-11
Roll Call Vote # 3

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2024

House HUMAN SERVICES Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☒ Do Not Pass ☐ Amended ☐ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By Rep. Paur Seconded By Rep. ANDERSON

Representatives	Yes	No	Representatives	Yes	No
CHAIRMAN WEISZ		✓	REP. CONKLIN	✓	
VICE-CHAIR PIETSCH		✓	REP. HOLMAN		✓
REP. ANDERSON	✓		REP. KILICHOWSKI	A	
REP. DAMSCHEN	✓				
REP. DEVLIN	✓				
REP. HOFSTAD		✓			
REP. LOUSER	✓				
REP. PAUR	✓				
REP. PORTER		✓			
REP. SCHMIDT	✓				

Total (Yes) 7 No 5

Absent _____

Floor Assignment Rep. Devlin

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

motion carried

REPORT OF STANDING COMMITTEE

SCR 4024: Human Services Committee (Rep. Weisz, Chairman) recommends **DO NOT PASS** (7 YEAS, 5 NAYS, 1 ABSENT AND NOT VOTING). SCR 4024 was placed on the Fourteenth order on the calendar.

2011 TESTIMONY

SCR 4024

#1

American Heart Association. | American Stroke Association.
Learn and Live.

SCR 4024
Senate Human Services Committee

American Heart Association Testimony

Chairman Lee and members of the Senate Human Services Committee. I am June Herman, Vice President of Advocacy for the American Heart Association in North Dakota. I am here today to testify in support of SCR 4024, and ask for a "do pass" recommendation from this committee.

Consideration and recommendation on this subject is very timely, and positions North Dakota with an early start on steps that can make a difference for a significant collision course our state will experience with our baby boomers and cardiovascular disease. Today I would like to capture for you some initial steps already started in North Dakota and highlight the type of legislative considerations that could be considered moving forward. But first, let me share with you a document that arrived on my desk on Friday – **Collision Course: America's Baby Boomers and Cardiovascular Disease**

Our goal is to empower people so that they can and will make diet and lifestyle changes that add up to a healthier heart and better future. It's about making the right choices easier. What we find through American Heart Association consumer research is that even the motivated find it is very difficult to make the changes they need to do: Everyday life, food is the problem - and also the solution, the 1st thing people do after diagnosis is try to eat a bit healthier.

- Eating out of home is a problem
- Practical help is required
- **Personalisation is key**
- Diet & Food offerings need to be realistic in the context of their lives
- Credible medical advice is critical

This study will lay the ground work for action and assist North Dakota in setting recommendations and policies to reduce sodium intake for consumers and reduce the devastating effects of high sodium intake. Potential state strategies that can result from this study include:

- Continue and expand the support of core heart disease and stroke policy initiatives being considered this session:
    - Go Red ND ($453,000 Optional Request; House: $353,000 base)
    - Healthy School Program Coordinators within Regional Education Associations ($640,000 - HB 1202; House: ? $320,000)
    - Woman's Way with Heart ($983,200 Optional Request; House - $0)
    - Stroke Systems of Care ($472,700 Gov's Budget; House - $472,700)
    - Stabilizing Department of Health capacity for Heart and Stroke Program leadership (relies on federal funding, prior loss of program, trigger language)
    - *Heart Systems of Care (STEMI – foundation: $4 million <u>if</u> match of remaining third secured. House: declined $1.3 million, 12-lead devices)*
- State procurement policies for institutions and other large-scale organizations that purchase or distribute food that establish sodium specifications for the foods they purchase and the food operations they oversee
- Labeling requirements for foods available in restaurants or point of purchase
- Venue-based approaches
- Consumer awareness campaigns
- Medical home based efforts for hypertension management

Legislative study of this matter can also help further the Department of Health's outreach to key stakeholders in the state as part of North Dakota's participation in the National Salt Reduction Initiative. As I understand it, they have started to engage partners from aging services, child nutrition, and WIC to begin exploring current policies relating to sodium content in foods that are purchased and served for these populations. In addition, outreach to North Dakota local companies (supermarkets) to outreach and encourage their commitment to the NSRI targets. Other projects are sodium reduction campaign materials and toolkits.

Changing the food environment gives consumers a broader range of healthful foods which to choose. Policy and environment strategies are effective at the state and local level and help drive demand for federal action. With this resolution, North Dakota can begin the process now and identify ways to reduce sodium intake for its citizens and provide environments that support low sodium food choices. Without major change to sodium intake, hypertension and cardiovascular disease rates will continue to rise, and consumers, who have little choice, will pay the price for inaction. And so will the state.

Collision Course:

America's Baby Boomers and Cardiovascular Disease

Forecasting the Future of Cardiovascular Disease in the United States

American Heart Association. American Stroke Association.

CVD Prevalence and Costs Heading in the Wrong Direction

According to a new study by the American Heart Association, America's Baby Boomers and Cardiovascular Disease (CVD) are on a collision course of alarming proportions. By 2030, it is projected that 40.5% of Americans—116 million people—will have some form of CVD.

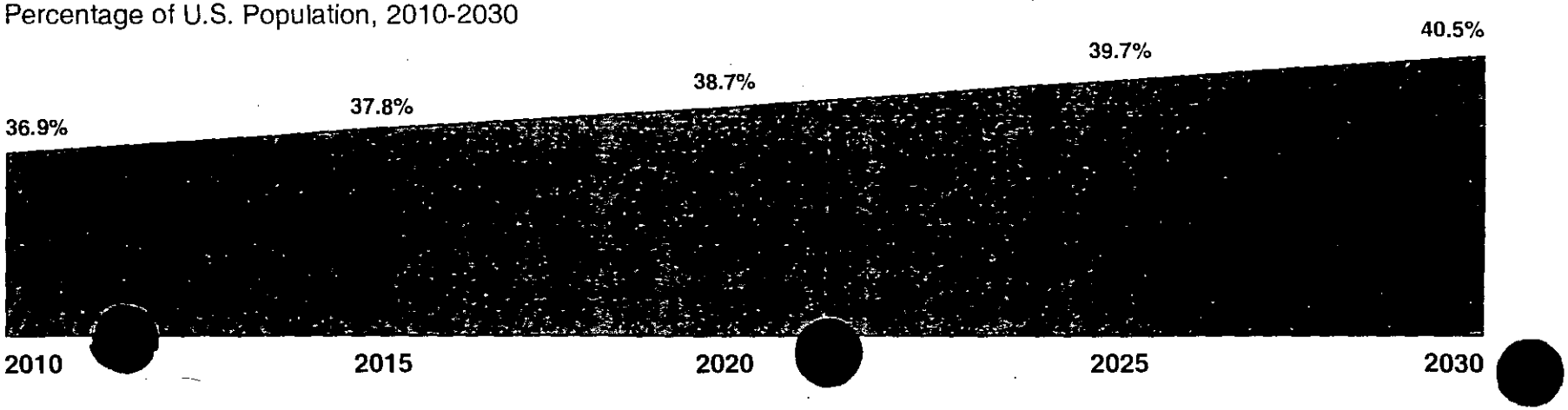
In spite of enormous advances in prevention and treatment, and a decline in mortality rates, heart disease and stroke remain respectively the number one and four killers of Americans. But can an already bad situation get even worse? The answer is a frightening "yes."

Treating cardiovascular disease is already an enormous drain on resources. In fact, CVD not only ranks as the leading killer in America, but as the most costly disease in the nation. The share of overall medical costs for CVD is seventeen percent.

The projected toll in death, human suffering and health care costs to the Nation are as staggering and crippling as the disease itself. And CVD is blind with respect to gender and ethnicity. In 2030, 39% of men and 42% of women will have some form of CVD, and blacks suffer at higher rates than whites and Hispanics.

Projections of Cardiovascular Disease Prevalence

Percentage of U.S. Population, 2010-2030



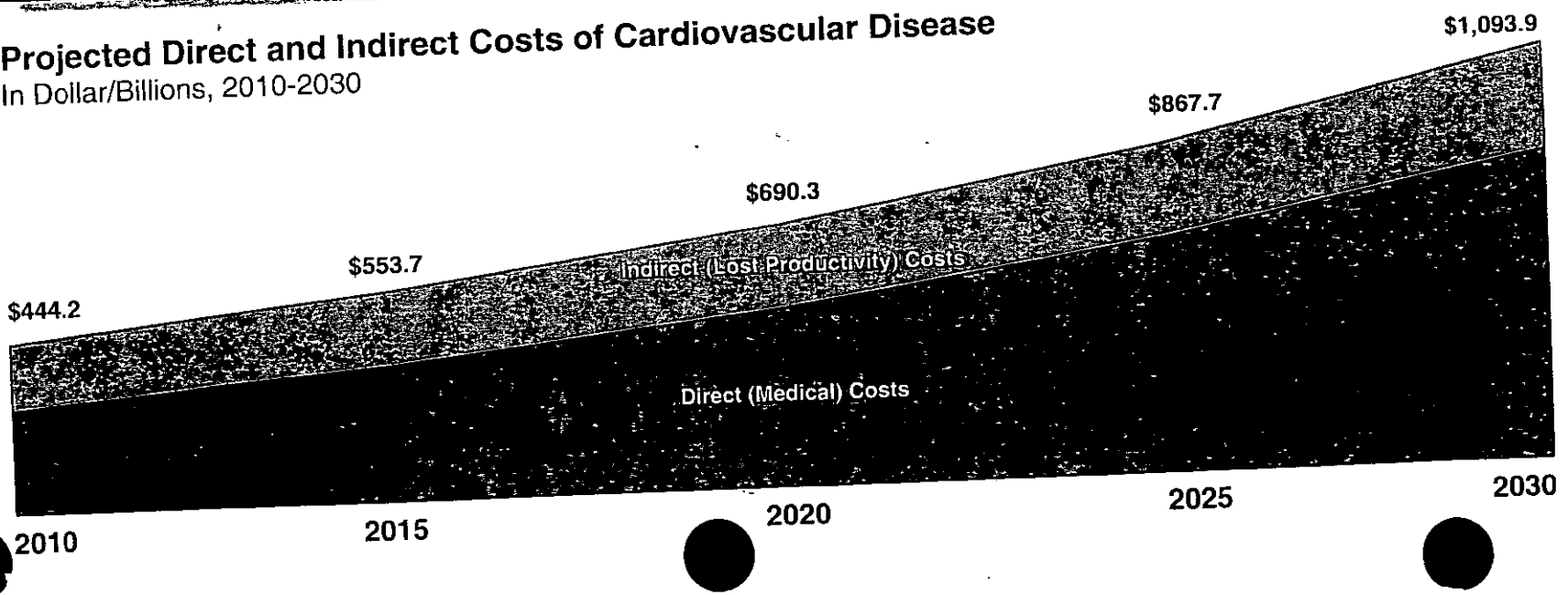
Between 2010 and 2030, total direct medical costs of CVD are projected to triple, from $273 billion to $818 billion. Real indirect costs—due to lost productivity—for all forms of CVD are estimated to increase from $172 billion in 2010 to $276 billion in 2030, an increase of more than 60 percent. The combined costs are projected to exceed $1 trillion by 2030.

What's Driving the Cost Increase?

America's 78 million Baby Boomers are babies no more. The advance guard has already reached retirement age and will be eligible for Medicare when they turn 65 in 2011. The graying of the population combined with the explosive growth in medical spending are the primary drivers of increased CVD costs, which are expected to grow the fastest for ages 65 and over. Annual CVD costs for persons age 65 to 79 are projected to increase by a whopping 238 percent, from $135 billion to $457 billion per year.

Projected Direct and Indirect Costs of Cardiovascular Disease

In Dollar/Billions, 2010-2030



Is Prevention the Silver Lining in a Very Dark Cloud?

Using a different kind of model, researchers evaluated the impact of 11 widely-recognized prevention services for reducing cardiovascular disease, such as smoking cessation, preventive aspirin therapy, cholesterol-lowering medications and weight reduction.

They found that if everyone received the 11 prevention services, myocardial infarctions (MI) and strokes would be reduced by 63 percent and 31 percent respectively in the next 30 years. At more feasible success levels—those that have been actually achieved in clinical practice—MIs and strokes would be reduced by 36 percent and 20 percent.

Researchers found that using these CVD clinical prevention measures to their fullest potential could add about 220 million life-years over the next 30 years, or an average of 1.3 years of life expectancy for each adult in the United States. About 78 percent of U.S. adults ages 20 to 80 are candidates for at least one of these clinical prevention activities.

That's the good news. The bad news is that the current use of these prevention activities is way below where it should be, contributing to the projected upsurge in CVD and stroke.

Prevention: A Chance to Change Course

Cardiovascular disease is largely preventable. We must never forget that fact because it could drive a whole new way that we as a nation look at CVD. Rather than treating the illness when it is far advanced, we should promote heart healthy habits and wellness at an early age.

Several studies show that individuals with fewer atherosclerosis (hardening and narrowing of the arteries) risk factors have a marked reduction in the onset of coronary heart disease and heart failure. Similarly, persons who follow a healthy lifestyle of regular exercise and a heart healthy diet reduce their risk of coronary heart disease and stroke. Therefore, a greater focus on prevention may help us avoid the projected CVD explosion. And history may be on our side.

Eliminating risk factors on a population-wide scale has contributed significantly to reducing CVD death rates in the U.S. For example, smoking has declined dramatically since the Surgeon General first issued his report on smoking's health risks in 1964. This was followed by nationwide awareness efforts to reduce dietary fat intake, detect and treat high blood pressure and improve cholesterol levels. All of these programs to reduce risk factors helped slash CVD death rates. They are literally life savers.

The Sooner the Better

Emerging evidence suggests that CVD prevention should begin early in life—the sooner the better. Modest improvements in risk factors earlier in life have a far greater impact than more substantial reductions later on in life. The payoffs can be huge. For example, a modest 28 percent reduction in LDL (bad) cholesterol from birth resulted in an 88 percent reduction in the risk of coronary heart disease. Contrast that to the 20-30 percent reduction in CVD seen with a 30 percent reduction in LDL with statin medications initiated in middle and older ages.

Getting a Grip on High Blood Pressure

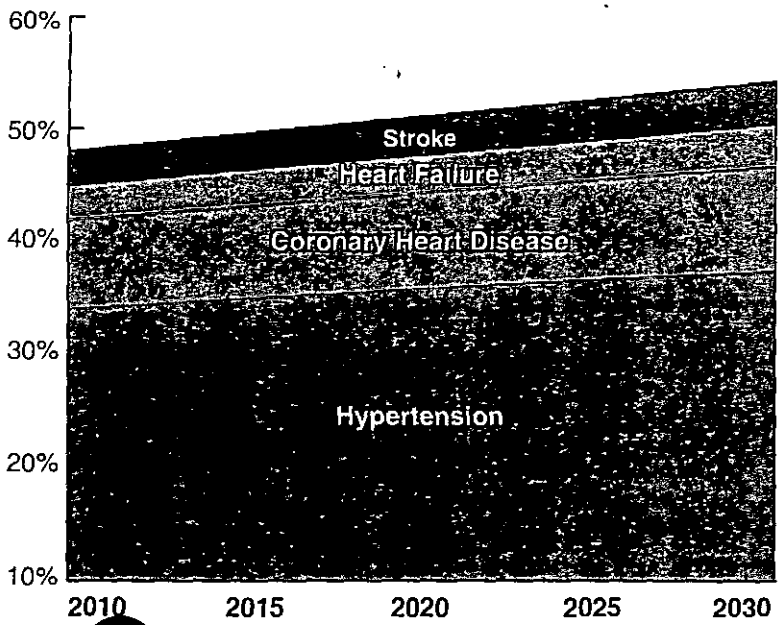
One out of three Americans currently have hypertension—a silent killer that accounts for 18 percent of CVD deaths in Western countries. It is also a major risk factor for stroke, coronary heart disease, and heart failure.

Hypertension is the most costly form of CVD. The total medical cost for hypertension makes it a particularly valuable target to reign in CVD's future costs.

Annual medical costs directly attributable to hypertension are projected to increase by $130 billion over the next 20 years for a total projected annual cost of $200 billion by 2030. And that is just scratching the surface. If the cost is expanded to include how much the presence of hypertension contributes to the treatment of related diseases, such as coronary heart disease and stroke, the increase of annual spending for 2010 to 2030 almost doubles.

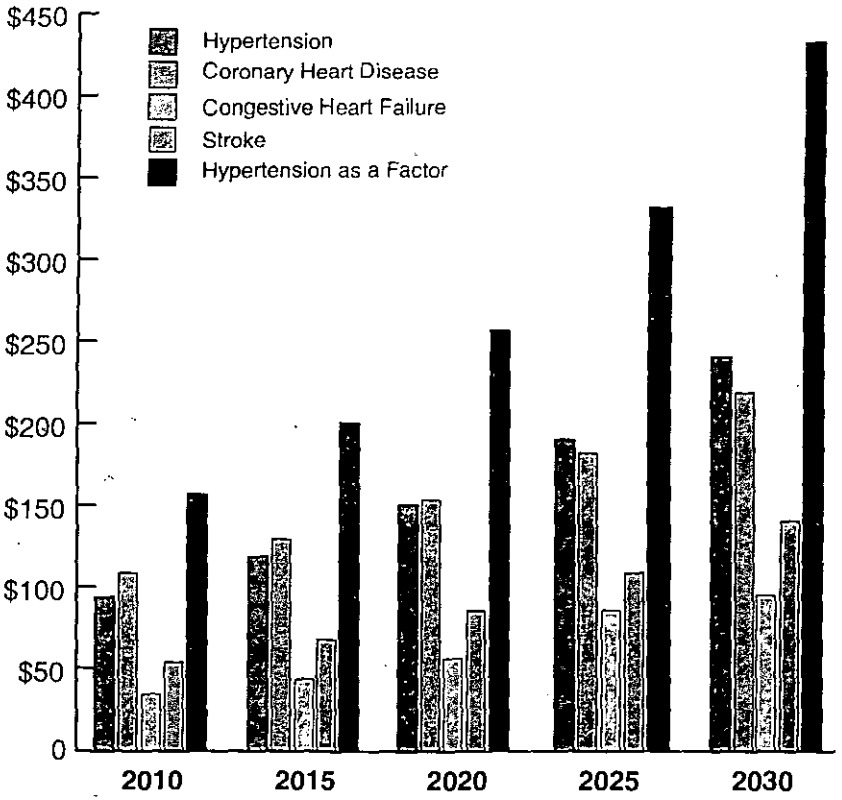
Projections of Cardiovascular Prevalence

Percentage of U.S. Population, 2010-2030



Projected Direct and Indirect Costs of CVD

In Dollar/Billions, 2010-2030



Hypertension as a risk factor includes a portion of the costs and prevalence of complications associated with hypertension, including heart failure, coronary heart disease, stroke, and other CVD.

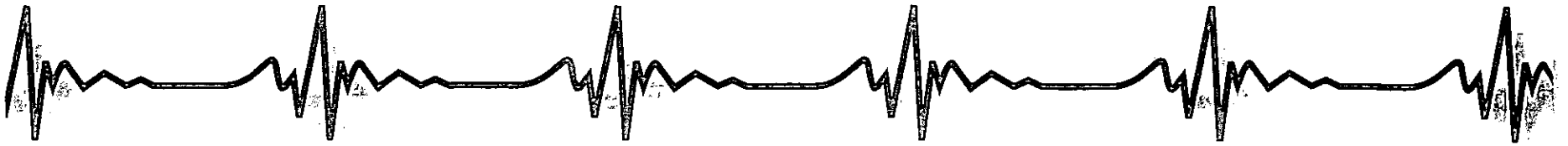
Will the Provider Workforce be Adequate?

Primary and secondary prevention of CVD requires a team approach with professionals in medicine, nursing, pharmacy, nutrition, social work, and other disciplines. But will they be there? Not if current trends continue.

The projected lack of U.S. health professionals in the fields of nursing, pharmacy, and medicine is well documented and alarming. For example, in less than 15 years, we could experience a shortage of 260,000 registered nurses. Currently, over 8,000 vacancies exist in retail pharmacies, hospitals, clinics, and other industry sectors, and these figures are expected to worsen over time. And a looming shortage of physicians most recently prompted the president of the Association of American Medical Colleges to recommend that U.S. medical schools increase the annual number of graduates by 30 percent.

While primary care physicians are already in short supply, there is a growing and significant shortage in cardiac specialty care—currently, there is a projected shortfall of 1,600 general cardiologists and 2,000 interventional cardiologists.

If the trend continues, we would need to double by 2050 the current number of cardiologists to erase the expected shortage of 16,000 cardiologists. The looming shortfall for cardiac surgeons is even worse. Only 100 new cardiothoracic residents are being certified each year. At this rate and taking into account death, retirement, and attrition, it is estimated that only 3,000 practicing cardiothoracic surgeons will be in practice by the year 2030.



Game Changer

The prevalence and costs of CVD are projected to increase substantially in the future. Fortunately, CVD is largely preventable and our health-care system should promote prevention and early intervention. In the public health arena, more evidence-based effective policy, combined with systems and environmental approaches should be applied to the prevention, early detection and management of CVD risk factors. Through a combination of improved prevention and treatment of established risk factors, the dire projected health and economic impact of CVD can be diminished.

The U.S. health system often rewards practices that treat disease and injury rather than those that prevent them and promote wellness. The result: Americans' health has remained relatively unchanged this decade despite huge and unprecedented increases in health care spending.

As our nation implements and refines new health reform policies, we must realize that a variety of policy and practice-related measures will be necessary to effect meaningful and lasting change in the health care system.

Expanding access to affordable health care coverage may provide important benefits for individuals with CVD. However, we must also reorient our health care system toward implementing effective health promotion and disease prevention. This game-changing strategy is not unrealistic, and provides an exciting opportunity and call to action.

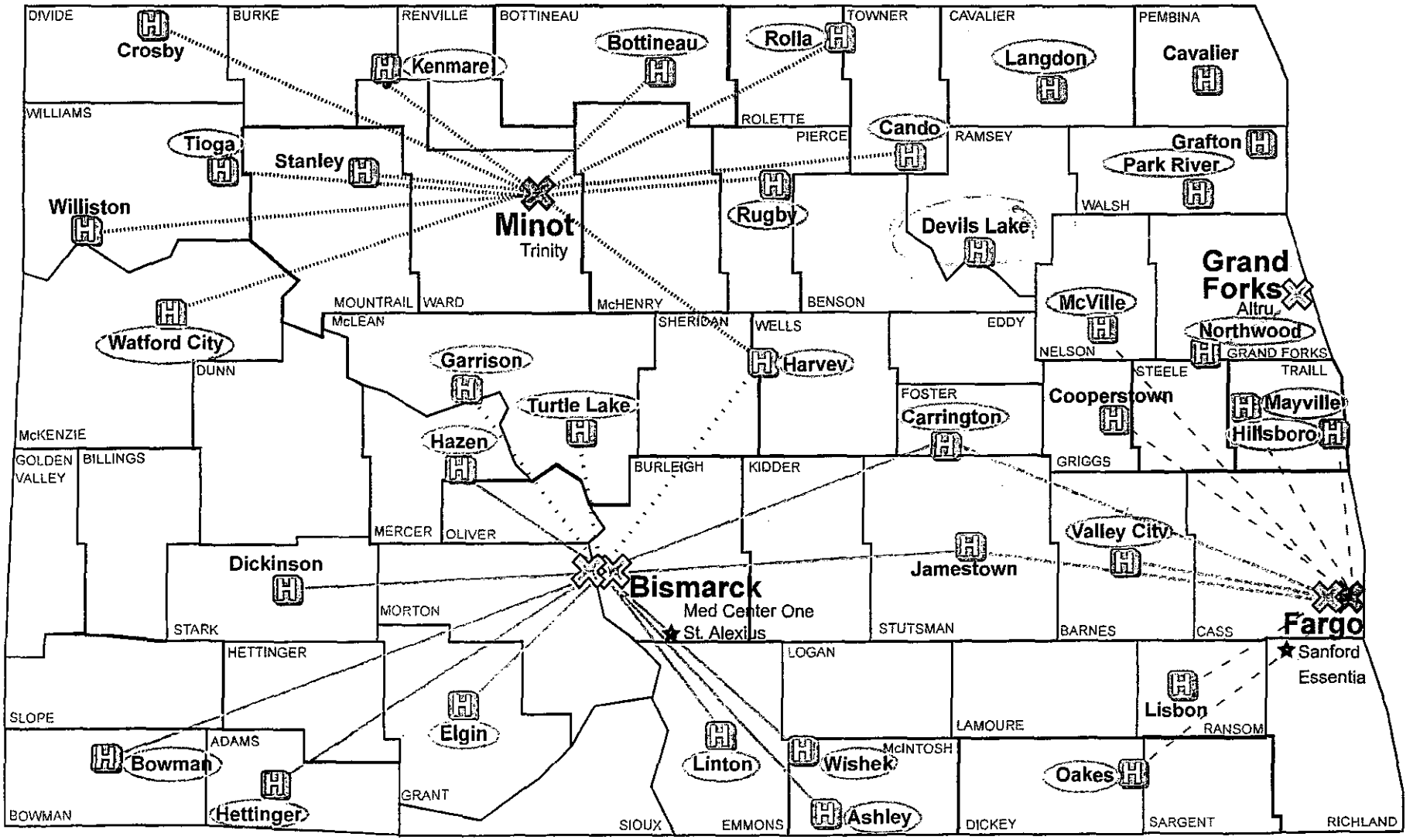
For example, prevention at the community level is one such avenue for reducing the projected burden of CVD. Community prevention efforts may include greater tobacco control, elimination of trans fat, reducing sodium intake, cutting air pollution, reducing obesity and increasing physical activity with a focus on children.

It should be recognized that while prevention will delay or even prevent the onset of CVD and the cost of treatment, patients will need medical care longer and life-time cost of care may not be reduced. Thus, prevention strategies should not be evaluated solely on their ability to reduce cost of care, but should instead be based on a combination of cost and impact on patient well-being, including length and quality of life.

All content in this paper and the research studies upon which it is based can be found in Heidenreich PA, Trogdon JG, Khavjou OA, Butler J, Dracup K, Ezekowitz MD, Finkelstein EA, Hong Y, Johnston SC, Khera A, Lloyd-Jones DM, Nelson SA, Nichol G, Orenstein D, Wilson PWF, Woo J. Forecasting the future of cardiovascular disease in the United States: A policy statement from the American Heart Association. **Circulation.** Published online ahead of print. January 24, 2011.

For More Information, Contact:
The American Heart Association Office of Federal Advocacy
1150 Connecticut Ave., NW, Suite 300, Washington, DC 20036
Ph: 202-785-7900/www.org

North Dakota Hospitals & Referral Centers



01/11

Referral Centers

Trinity Hospital

Altru Hospital

St. Alexius Medical Center

Sanford Health

MedCenter One & St. Alexius

Sanford & Essentia Health

Participating in NDDoH State Stroke Program

Designated Primary Stroke Centers ★

Critical Access Hospitals (H)

Center *for* Rural Health

The University of North Dakota School of Medicine & Health Sciences

North Dakota State Stroke Registry (SSR)

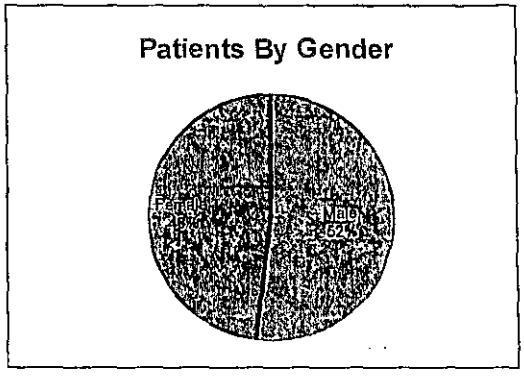
Powered by the American Heart Association's
Get With The Guidelines® – Stroke

SSR Report 1

This report includes data retrieved from the North Dakota State Stroke Registry on January 6, 2011. It reflects 1,078 records of admission that have been entered for the period January 1, 2009 through December 31, 2010. The registry data points will continue to become more robust as participating hospitals enter baseline data and new stroke cases. The following charts highlight data collected by the North Dakota State Stroke Registry:

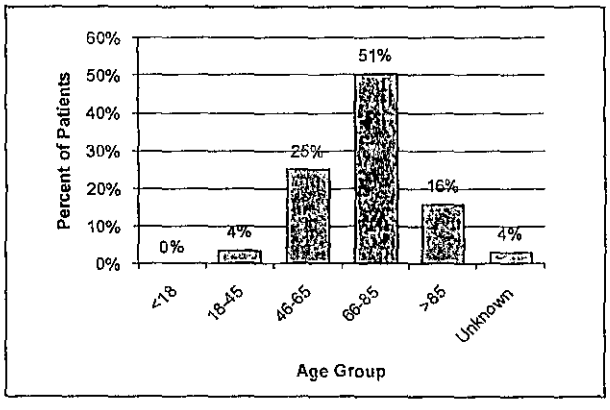
- North Dakota hospitals treated more male patients than female patients.

Gender	Number of Patients	Percent of Patients
Male	560	52%
Female	516	48%
Unknown	2	0%
Total	1,078	100%



- Most stroke cases occurred in patients between age 65 and 85.

Age Group	Number of Patients	Percent of Patients
<18	0	0%
18-45	43	4%
46-65	273	25%
66-85	548	51%
>85	176	16%
Unknown	38	4%
Total	1,078	100%

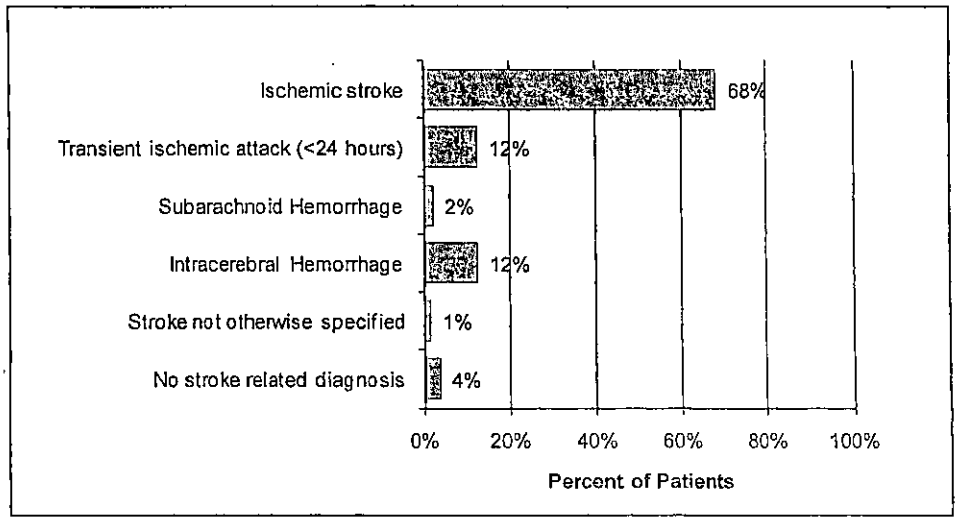


NORTH DAKOTA DEPARTMENT of HEALTH

State Stroke Program
Enhancing stroke care.
Improving outcomes.

- The most prevalent diagnosis was ischemic stroke which occurs as a result of an obstruction within a blood vessel supplying blood to the brain.

Diagnosis	Number of Patients	Percent of Patients
Ischemic stroke	736	68%
Transient ischemic attack (<24 hours)	133	12%
Subarachnoid Hemorrhage	23	2%
Intracerebral Hemorrhage	132	12%
Stroke not otherwise specified	16	1%
No stroke related diagnosis	38	4%
Total	**1,078**	**100%**



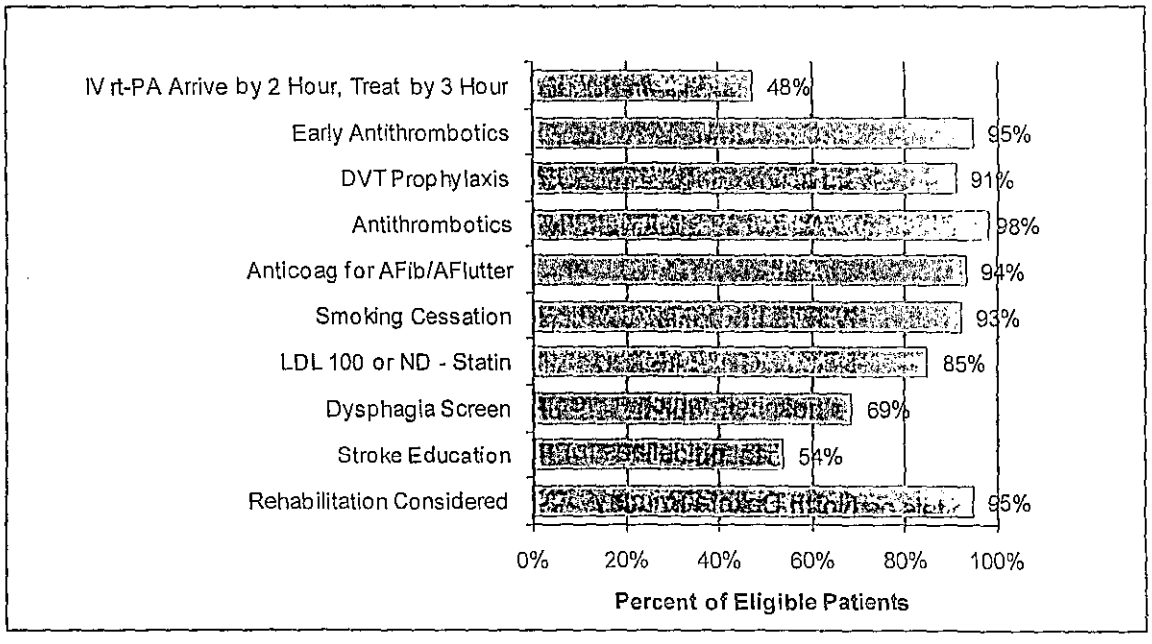
Primary stroke centers are hospitals which have been certified by the Joint Commission as centers that comply with the latest hospital guidelines for the treatment of stroke. The Department of Health designates hospitals as North Dakota Primary Stroke Centers upon verification of Joint Commission certification. To date, two of the six tertiary (general acute) hospitals have obtained Joint Commission certification.

The following data reflect the Primary Stroke Center Consensus Measures. These measures include the harmonized set of measures created by the American Stroke Association, the Joint Commission and the Centers for Disease Control and Prevention.

- Approximately half of Ischemic or hemorrhagic stroke patients or their caregivers were given education materials during the hospital stay addressing **all** of the following: activation of emergency medical system, need for follow-up after discharge, medications prescribed at discharge, risk factors for stroke and warning signs and symptoms.

Consensus Measures
North Dakota Tertiary Hospitals

Consensus Measure	Percent of Eligible Patients	Numerator	Denominator
IV rt-PA Arrive by 2 Hour, Treat by 3 Hour	48%	20	42
Early Antithrombotics	95%	541	570
DVT Prophylaxis	91%	258	283
Antithrombotics	98%	640	651
Anticoag for AFib/AFlutter	94%	101	108
Smoking Cessation	93%	111	120
LDL 100 or ND - Statin	85%	262	308
Dysphagia Screen	69%	458	667
Stroke Education	54%	208	385
Rehabilitation Considered	95%	626	660



Using these data, hospitals and the State Stroke Program are able to assess the use of best practice guidelines to measure and enhance the quality of patient care and improve stroke outcomes.

HB – 1202: Healthy School Programs within Regional Education Associations

Appropriation Recommendation - *Leadership Partn[redacted]American Heart Association, Southeast Education Coope[redacted] ND Regional Education Leadership Group, ND Rural Health Association, ND Alliance for Health, Physical Education, Recreation and Dance.*

Funding Request:

Description	FTE	General Fund	Special Fund	Total
Increase Department of Health funding for four (4) REA Health Coordinators to implement Coordinated School Health programs.	-0-	$640,000	-0-	$640,000

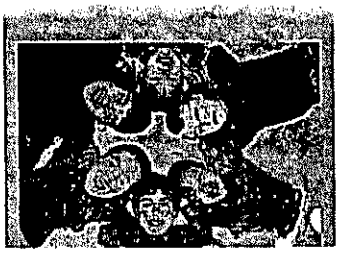
Budget Detail	2011-2012	2012-2013
4 Coordinators@ $60,000/year – salary, benefits, travel	$240,000.	$240,000.
Professional Development and training, supplies	$80,000.	$80,000.
Total Investment		**$640,000**

- This appropriation supports 4 Regional Health Coordinators who will serve all eight North Dakota Regional Education Associations to coordinate school health programs for all member school districts.
- Areas of emphasis would include: professional development, resource development and dissemination, technical assistance and on-site consultation regarding school AED maintenance, psychomotor skill based (hands on) CPR training in Health Education, quality Physical Education, and other Coordinated School Health Program Services based on school needs.
- HB 1202 identifies that the Southeast Education Cooperative will be lead administrator, with responsibility to work with all REAs in the state. By designating a REA with experience in coordinating school health resources as lead administrator for the project, we will be able to more quickly establish and implement programs for the 2011-12 school year, and be able to report back next session on initial outcomes.
- As the Southeast Education Cooperative already receives technical support through the Department of Health and Department of Public Instruction, we were able to eliminate agency administrative costs contained in the original bill ($20,000).

Project Need:

- No one likes mandates, and mandates themselves don't guarantee quality programs. This proposal comes with school and health leaders support. HB 1202 will provide coordination of workshops to improve school curriculum for PE and health, and improving activities/policies related to physical activity, nutrition and tobacco.
- This funding establishes a structure for school health outreach – external opportunities (funding and projects) and school district needs are facilitated through a Healthy School Coordinator in each part of the state.
- Through 2007 legislative action, 436 AEDs were placed in North Dakota schools. Many of the devices are not being kept current as to electrodes, battery checks, back-up batteries, and ready kits. HB 1202 will enable inventory, reminders for testing and replacement, group orders and assistance in developing ready response teams. Hands on CPR in health curriculum will be enhanced, vital for rural areas.
- SEEC pilot: Served 35 school districts individually and through workshops that drew 266 participants through 6 different trainings/workshops/multi-day sessions, leveraging $13,000 in additional grants for services. Pilot costs – coordinator/travel/office resources, speakers/trainers, school district reimbursement (teacher stipends -substitutes/travel), facility rental and food. (total trainings/workshop costs ranging from $1,900 - $8,000)

Healthy School Programs within Regional Education Associations



Appropriation Recommendation - *Leadership Partners – American Heart Association, Southeast Education Cooperative, ND Regional Education Leadership Group, ND Rural Health Association, ND Alliance for Health, Physical Education, Recreation and Dance.*

Healthier Students are Better Learners

No matter how well teachers are prepared to teach, no matter what accountability measures are put in place, no matter what governing structures are established for schools, educational progress will be profoundly limited if students are not motivated and able to learn. Health-related problems play a major role in limiting the motivation and ability to learn... Healthier students are better learners. Charles E Basch, March 2010 (Columbia University, Professor of Health Education).

When it comes to building healthy lifestyles, learning to make healthy choices early is so important. In a North Dakota classroom of 25 high school students, 5 smoke, 6 are overweight or obese, 7 binge drink, 14 don't get recommended amounts of physical activity, and 21 don't eat recommended amounts of fruits and vegetables (2009 Youth Risk Behavior Survey).

Schools by themselves cannot—and should not be expected to—solve the nation's most serious health and social problems. Families, health care workers, the media, religious organizations, community organizations that serve youth, and young people themselves also must be systematically involved. However, schools can provide a critical facility in which many agencies might work together to maintain the well-being of young people. This need can be met through a coordinated school health program (CSHP) model; consisting of eight interactive components -

- Health Education
- Counseling, Psychological and Social Services
- Physical Education
- Healthy School Environment
- Health Services
- Health promotion for staff
- Nutrition Services
- Family and Community Involvement

Regional Education Association (REA) Healthy School Program (HSP) Request

Establish a $640,000 continuing appropriation for Regional Education Association (REA) staffing grants to cover four Healthy School Program (HSP) directors per biennium, with only one recipient REA per quadrant of the state. Several REA's could apply together for a shared position to best serve their section of the state. Focus is on district implementation of research based curriculum and interventions to improve health and healthy habits within the school setting.

- Four contracted positions – estimated $60,000 a year, salary/benefits ($480,000 biennium)
- Resources per position to cover office/equipment, workshops/travel - $20,000 ($160,000 biennium)

Core Elements of a Healthy School Program Coordinator position within REAs:

- Assess/evaluates, plans, coordinates and directs the implementation of coordinated school health utilizing education, programs, policy and systems change interventions.
- Special curriculum assistance: quality PE curriculum and CPR training within high school health curriculum.
- Coordination of Automated External Defibrillator readiness in schools
- Facilitates the formation of active school level wellness committees/health advisory councils.
- Encourages and facilitates the evaluation of school environments and school wellness policies. Offers professional development and technical assistance to schools/staff with a focus on Physical Activity, Nutrition, Tobacco and Health Education.
- Provides or arranges for technical assistance for districts within the REA and partners.
- Identifies and acquires resources to support and sustain coordinated school health initiatives.

What South East Education Cooperative (SEEC) Schools are saying about the Healthy School Program

This past year, an innovative pilot was launched that placed a Healthy School Program Coordinator within a Regional Education Association (REA), using federal funds through the Coordinated School Health Program. The demonstration pilot, funded through a federal grant, resulted in benefits to REA member districts including: Physical Education curriculum development, assistance with federal grant applications for equipment and program materials, and school wellness programming for students and staff. The Program Director acts on a consultative, not regulatory, basis, and REA member schools were highly satisfied with the availability of the Program Coordinator as resource for improving school health.

Feedback from Area Schools

With the help of Amy Walters and the SEEC Coordinated School Health program our school is becoming a healthier school. We have had Amy work with us through Nutrition Education, Physical Education Curriculum, and Pep Grant writing. I have found her knowledgeable, cooperative, energetic, and professional. Our school is better equipped to help our students become and stay healthy because of the work of Amy Walters and SEEC.

Wayne Ulven, Superintendent of Schools, Richland 44

Amy worked together with 9 districts and administrators well to develop appropriate plans to implement a sound physical education, health and nutrition plans. Within her plan was the development of a sound and reliable curricula and the wellness policy which affects all staff and students in a school system. Without Amy's leadership with SEEC there are many small communities in particular who would not have the opportunity to collaborate and learn from others. Many of these smaller communities have one teacher teaching several subjects and no body to collaborate with on what is reliable and valid with the latest research in education.

Lois Mauch, Physical Education specialist Fargo Public Schools

The value of the CSH position within the SEEC goes without saying. The programs that have been brought to the table for foodservice have been far reaching and basically not doable without this position. Since having Amy in our SEEC we would not have been able to reach out to area foodservice directors and fill the need of nutrition education, consultation and challenging area schools to meet the health needs of students through the HealthierUS School Challenge. The education process has been catapulted into the future with Amy working toward bringing health and wellness to the forefront in our schools.

Sue Milender, School Food Service Director, Valley City Public Schools

As a result of the support and assistance we receive from SEEC, our school has been able to send participants to the ND Rough Rider Health Conference in Jamestown for the past several years. The contacts, information and resources have been invaluable to those of us who are working with and promoting staff wellness, health education, health services, physical education, nutritional services, healthy school environment, and family and community involvement. The fostering of shared communication has been invaluable. SEEC has impacted the entire region by providing time and space for the area participants to share ideas, establish relationships (among the schools and school districts), as well as support , encourage, and empower one another to step out of well defined "comfort zones" to try new and innovative strategies to improve the health climate in our schools and communities.

Jan Cossette, Ben Franklin Middle School Counselor, Fargo Public Schools

Heart and Stroke Funding Priorities

Governor's Budget

Stroke Registry - $472,700

- 76% participation, all 6 tertiary facilities
- Critical Access Hospital QI consultants, tools, support

Optional Appropriation Request for Stroke Funding

Recommended Elements	Base Funding	Enhanced	Fully Funded
Heart Disease and Stroke Prevention (Hypertension, community-based effort, awareness, worksite/NDPERS support: **Go Red ND**	• Contract support, 10 funded communities, $283,000 • Native American tribal community (3 communities) $20,000 • Men's Heart Health Pilot (in 2-3 communities) - $50,000	• Contract support, 15 funded communities $313,000 • Native American tribal communities, $20,000 • Men's Heart Health Pilot Initiative - $50,000	• Contact support, 20 funded communities, $333,000 • Native American Tribal communities $20,000 • Men's Heart Health Expanded Initiative (Statewide) - $100,000
Statewide coordination of integrated system of care	*Trigger language: if CDC funding lost in 2012, Dept of Health shall maintain statewide Heart Disease and Stroke Coordination through adjustments from existing stroke appropriations	Funding continued for 1 FTE for one year - $92, 200	$368,802 – 2 FTEs, biennium
Public Education of timely notification of 9-1-1 (*need shows in registry chart)*	$200,000	$275,000	$550,400
Stroke standardization and training	$100,000	?	
Primary Stroke Center certification assistance grants			($60,000)

Heart and Stroke Funding Priorities

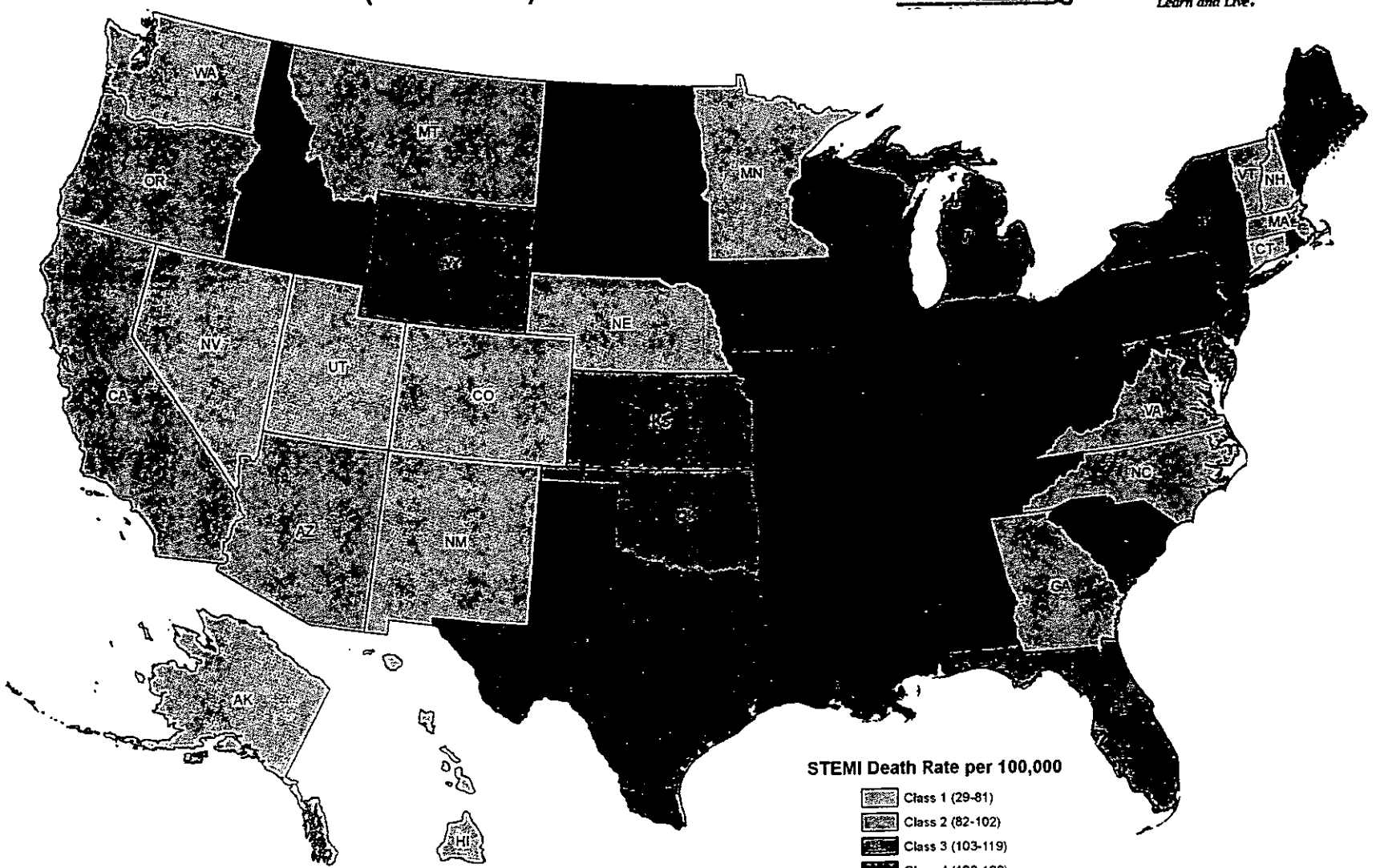
Optional Appropriation Request:

Recommended Elements	Base Funding	Enhanced	Fully Funded
Woman's Way with Heart	**Base – Pilot Project - $280,000** Pilot Project with 2 Women's Way Provider Programs • Services provided include: screening, results & Risk factor counseling, Lifestyle intervention program (including referral to ND Quit Line for tobacco cessation) $175,000 • Healthcare profession staff at the local level and program administrative costs - $95,000 • Program evaluation - $10,000	**Phased in Program – $701,200** Year 1 funds: 2 Women's Way program sites (previous heart health screening for women experience recommended) and hiring of a statewide coordinator to facilitate expansion of the Women's Way with Heart program to all Women's Way locations in year 2. • Program coordinator & program administration - $149,200 • Program marketing- $25,000 Direct Client Services year 1 at two select locations: screenings, results & risk factor counseling, lifestyle intervention program - $135,000 • Direct Client Services year 2 at statewide locations: screenings, results & risk factor counseling, lifestyle intervention program - $392,000	**Fully Funded - $983,200** Program administration (including statewide program coordinator) $149,200 • Program marketing - $50,000 Direct Client services for all Women's Way participants (statewide) Screening, results & risk factor counseling, lifestyle intervention program for those screened at risk, and physician visit based on pre-established medical criteria $784,000

Age 35+ STEMI Death Rate per 100,000 by State (2002-2006)

MISSION: Lifeline

American Heart Association. | American Stroke Association.
Learn and Live.



Source: Centers for Disease Control and Prevention, National Center for Health Statistics. Compressed Mortality File 1999-2006. CDC WONDER On-line Database. ICD 10 I21 - I22.

American Heart Association
Learn and Live.

MISSION: Lifeline

STEMI Heart Attacks

Throughout the United States each year, nearly 1,255,000 people suffer heart attacks. About 400,000 of those patients suffer the most severe type of heart attack - an ST-elevated myocardial infarction, or STEMI - caused by the total blockage of a coronary artery. To reduce risk of death or long-term disability, the STEMI must be identified quickly, the blockage cleared using balloon angioplasty or a clot-busting drug, and blood flow to the heart restored, ideally within 90-minutes of onset as recommended by American Heart Association scientific guidelines. Through Mission: Lifeline, the American Heart Association will work in collaboration with hospitals and EMS statewide to remove barriers to optimal STEMI care that will lead to lives saved and a reduction in disability. PCI procedures cost about $65,000 if provided in a timely manner. Heart surgery - $200,000.

More Lives Can Be Saved

Mission: Lifeline is the American Heart Association's initiative to improve care for STEMI patients, save lives and reduce disability. It encompasses several key activities:

- **Equip ambulances with 12-lead electrocardiograms (ECGs) in order to identify the STEMI pre-hospital, transmit ECG results to the receiving hospital, and activate the cardiac catheterization laboratory**
- **Train emergency medical providers in using the 12-lead ECG**
- **Establish protocols standardizing recommendations for treatments**
- **Train all levels of system personnel in STEMI care**
- **Document patient care to identify opportunities for improvement by adopting a standardized patient data registry**

Two Patients, Two Experiences

Ken R, 75, called 9-1-1 when severe chest pain began. Paramedics arrived within 6 minutes, used a 12-lead ECG to identify the STEMI and transmitted the ECG to the receiving hospital where the cardiac cath lab staff was prepared to perform angioplasty. Within 50 minutes of onset the blockage was cleared and Ken's life saved.

Roy F, 81, wasn't nearly as fortunate. Roy called 9-1-1 and the responding ambulance was not equipped with a 12-lead ECG. He was taken to the closest hospital where his STEMI was identified, but the hospital did not have a cath lab so Roy had to be transferred to another hospital. He finally received angioplasty but it took 3 hours and 6 minutes! Thankfully, Roy's life was saved. However, the delays resulted in serious heart muscle death and permanent disability.

EMS Response

- It's like having a cardiologist in the field with me
- SD – our 12-lead is worth more than our ambulance to us

Project Status

A national foundation, with an interest in rural health, has expressed willingness to fund approximately two-thirds of the total $6.5 million project for a STEMI response program in North Dakota, on the condition that an additional $2 million is secured. This is extraordinarily generous and has enormous implications for improving heart attack care throughout the state.

#2

American Heart Association. | American Stroke Association.
Learn and Live.

SCR 4024
Senate Human Service Committee

American Heart Association Go Red ND Testimony

Chairman Lee and members of the Senate Human Services committee. I am Joan Enderle, Director of the American Heart Association's Go Red ND Initiative. I am here today to testify in support of SCR 4024, and ask for a "do pass" recommendation from this committee.

Heart disease is the leading cause of death in North Dakota and the United States. Cardiovascular diseases, including heart disease and stroke now kill more than 800,000 adults in the US each year. Of these, 150,000 are younger than age 65 according to a report released earlier this month by the National Center for Chronic Disease Prevention and Health Promotion. Every 39 seconds an adult dies of heart attack, stroke, or other cardiovascular disease.

The 2006 cost of cardiovascular diseases in the US was estimated to be $403.1 billion. Based on this figure, the estimated cost of CVD in North Dakota was $920 million. This figure includes both direct and indirect costs.

Hypertension (High Blood Pressure) is a significant risk factor for heart disease and stroke.
High Blood Pressure – By the Numbers:

- ✓ About 69 percent of people who have a first heart attack, 77 percent who have a first stroke, and 74 percent who have congestive heart failure have blood pressure higher than 140/90
- ✓ High Blood Pressure (hypertension) affects 1 in 3 adults.
- ✓ 1 in 3 adults with high blood pressure does not get treatment.
- ✓ Less than half of those with high blood pressure (hypertension) have it under control. People who lack health insurance have even lower rates of control.

Reducing blood pressure saves lives and money.

- ✓ Reducing systolic blood pressure just 12 – 13 mm HG over 4 years can reduce:
  - o Coronary heart disease by 21%
  - o Stroke by 37%
  - o Cardiovascular disease deaths by 25%
- ✓ Reducing the average intake to 1,500 milligrams of sodium per day in the United States population would result in an estimated 25.6 percent overall decrease in high blood pressure and $26.2 billion in health care savings

A comprehensive approach that involves policy, systems changes to improve health care access, quality of preventive care, patient adherence to treatment in addition to individual adoption of healthy behaviors is critical to save lives and reduce healthcare costs.

Go Red North Dakota is a highly successful multi-faceted statewide health initiative launched in 2006 as a partnership between the American Heart Association and Dakota Medical Foundation to improve the cardiovascular health of women and their families in North Dakota. Engagement of individuals, communities, health care providers, and worksites in a heart disease prevention campaign, targeted at a population group, results in risk awareness and drives lifestyle change.

- ✓ Increase in awareness of heart disease and stroke as leading cause of death to 87% (compared to 64% national survey results)
- ✓ Over 15,000 women joined the Go Red For Women movement in North Dakota
- ✓ 92% of women responding to a Go Red survey made at least one lifestyle change to reduce their heart disease risk
  - o 64% increased their exercise
  - o 60% made heart healthy dietary changes
  - o 40% lost weight

Go Red ND Initiative, over the past four years, has progressed along the behavior change continuum, from a focus on awareness, to education of heart disease risk factors, to determine your personal risk, to lifestyle change to reduce your risk. This year, an environment and systems change component was added. The momentum continues to build with increasing engagement of individuals, healthcare providers, communities, worksites and partner organizations.

Blood pressure is the focus of the Go Red ND action grants this year creating healthier communities with engagement of key community partners. Each community committee designs and implements a plan unique to their community including a media campaign, partnering with key community groups and health care providers to provide free blood pressure screenings, worksite blood pressure initiative, education and an outcome measurement component. The activities engage both women and men. Communities are building on past successes to reach additional audiences.

My Heart. My Health. is a pilot project in Stark County that reached out to 50 Women's Way clients to provide women with the opportunity to "know their numbers" for heart health, and provide knowledge, skills, and opportunities to improve diet, physical activity and other lifestyle behaviors to prevent, delay and/or control cardiovascular diseases. The collaboration of Pathways to Healthy Lives with the American Heart Association Go Red North Dakota Initiative with funding and approval of HRSA was modeled after the CDC WiseWoman program. CDC funds WiseWoman in only 21 states including Minnesota and South Dakota. This group of low income, underinsured or uninsured women ages 40 – 64 received heart disease risk factor screening, lifestyle assessment, education, lifestyle intervention and referral services based on pre-established medical criteria.

<u>My Heart. My Health. Program Results</u>

Health Risk Factors

- 26% had high blood pressure (35% had pre-hypertension)
- 51% had high cholesterol
- 38% smoked
- 65% were overweight or obese (49% obese)

Intervention and Results

- 28% were referred to a physician
  - 25% had no history of previous heart health screening
  - 50% were prescribed prescription medication (half for high blood pressure and half for high cholesterol)
  - 83% indicated that they had made lifestyle changes as a result of the program
    - 60% increased physical activity
    - 25% lost weight
    - 83% made dietary changes
- 16% participated in the lifestyle intervention program
  - 57% had cholesterol levels drop to the normal range at the follow-up screenings (an average of 14% reduction in 6 months)

The mission of the American Heart Association is: Building Healthier Lives, free of cardiovascular diseases and stroke. 2020 Impact Goal: By 2020, improve the cardiovascular health of all Americans by 20 percent while reducing deaths from cardiovascular disease and stroke by 20 percent.

The mission and 2020 impact goal is achievable in North Dakota support and expansion of core heart disease and stroke policy initiatives.

In addition to legislative study and funding heart disease and stroke policy initiatives, I encourage you to find out how healthy you are with **My Life Check**. The American Heart Association's online assessment tool you can get your overall health score and create an action plan with small simple steps to start living a longer, better life.
www.heart.org/MyLifeCheck

Make It Your Mission to fight heart disease.

Blood pressure classification for adults age 18 and older

Blood Pressure Category	Systolic (mm Hg)		Diastolic (mm Hg)
Normal*	less than 120	and	less than 80
Prehypertension	120–139	or	80–89
Hypertension, Stage 1	140–159	or	90–99
Hypertension, Stage 2	160 or higher	or	100 or higher

*Unusually low readings should be evalnated for clinical significance.

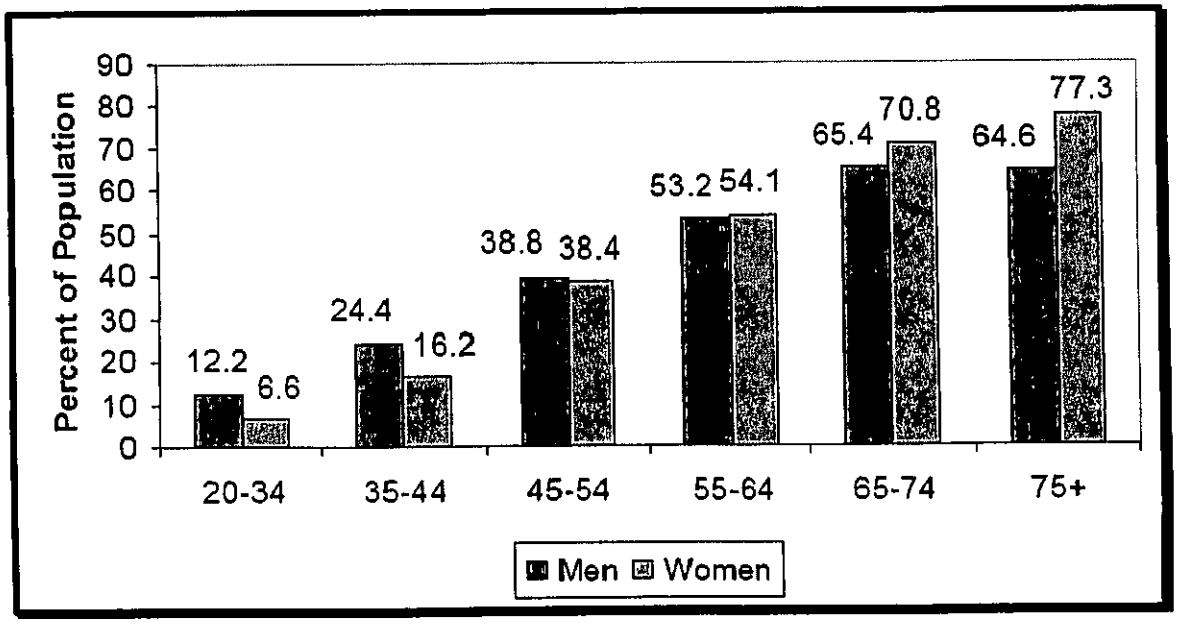
Source: Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC 7 Express) NIH Publication No. 03-5233, May 2003

High Blood Pressure — Statistics

(ICD/10 codes I10-I15) (ICD/9 codes 401-404)

Prevalence of High Blood Pressure in Adults Age 20 and Older by Age and Sex

NHANES: 2003–06



Source: NCHS and NHLBI.

Hypertension Facts
North Dakota

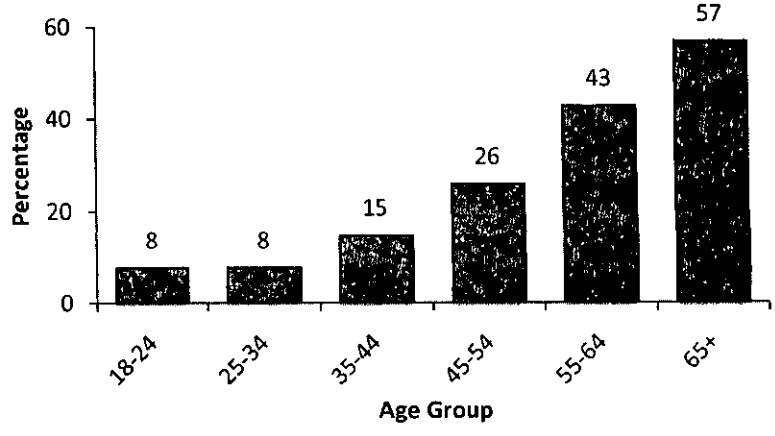
November 2010

High blood pressure: the silent killer

Elevated blood pressure often is ignored and under treated because it causes few symptoms. Over one in four North Dakotans (27%) have been diagnosed with high blood pressure, also called hypertension. Hypertension damages blood vessels throughout the body, increasing the risk for many common chronic diseases including heart attack, strokes, heart failure, kidney failure, and even blindness.

Lowering the blood pressure to normal levels greatly reduces the risk. Medications are often necessary to control blood pressure, but reducing body weight to normal, increasing physical activity and reducing salt intake are the first steps in blood pressure control. A blood pressure of 140/90 or higher is abnormal; an optimum blood pressure is less than 120/80.

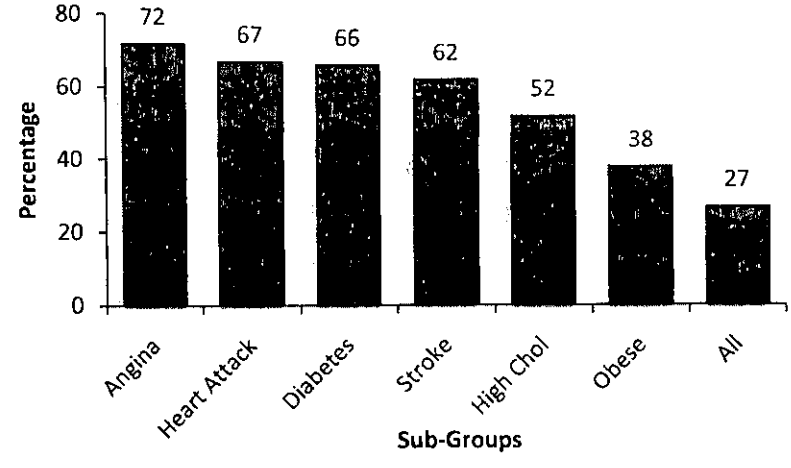
Figure 1: Percentage of Respondents Ever Told by a Doctor That They Had Hypertension, by Age North Dakota, 2009



Hypertension rises with age

- Fifty-seven percent of respondents age 65 and older reported being diagnosed with hypertension. (Figure 1) (North Dakota, 2009)
- Hypertension afflicts men (28%) and women (26%) equally. (North Dakota, 2009)
- Hypertension was common among respondents who reported ever having heart disease or angina (72%), a heart attack (67%), or a stroke (62%). (Figure 2) (North Dakota, 2009)
- Respondents who reported other risk factors for cardiovascular disease (obesity, diabetes, high cholesterol) also frequently reported hypertension. (Figure 2) (North Dakota, 2009)

Figure 2: Prevalence of Hypertension Among Sub-Groups, North Dakota, 2009



Source: North Dakota Behavioral Risk Factor Surveillance System

Take steps each day to keep blood pressure levels normal.

Lifestyle changes can help you control and prevent high blood pressure – even if you are taking blood pressure medication. Here's what you can do:

Eat in a healthy way. Follow a low-fat diet high in fruits, vegetables and whole grains. Get plenty of potassium which can help prevent and control high blood pressure. Eat foods that are low in saturated fat and cholesterol.

Avoid sodium by limiting the amount of salt in your diet. Although less than 2,400 milligrams (mg) of sodium a day is the current limit for otherwise healthy adults, limiting sodium intake to 1,500 mg a day will have a more dramatic effect on your blood pressure. Pay close attention to the amount of salt that is in the processed foods you eat, such as canned soups or frozen dinners. Read the food labels carefully and compare products since sodium varies by manufacturer.

Maintain a healthy weight. Being overweight can raise your blood pressure. Losing even five (5) pounds can lower your blood pressure.

Be physically active. Regular physical activity can help your blood pressure and keep your weight under control. Strive for at least 30-miutes of physical activity on most days of the week.

Don't smoke. Tobacco injures blood vessels and speeds up the hardening of the arteries. If you don't smoke, don't start. If you do smoke, quitting will lower your risk for heart disease and stroke. Need help quitting? Call the North Dakota Tobacco Quitline at **1.800.QUIT.NOW** or go online to the North Dakota QuitNet at www.nd.quitnet.com.

Limit alcohol use. Drinking too much alcohol is associated with high blood pressure. If you drink alcohol, you should do so in moderation – no more than one drink per day for women and two drinks per day for men.

Check your blood pressure. Getting your blood pressure checked on regular basis is important because high blood pressure often has no symptoms.

High blood pressure isn't a problem that you can treat and then ignore. It's a condition you need to manage for the rest of your life. To keep your blood pressure under control:

Take your medications properly. If you already have high blood pressure, your doctor may prescribe medication in addition to lifestyle changes. If side effects or costs pose problems, don't stop taking your medications. Ask your doctor about other options.

Adopt healthy habits. Eat healthy foods, lose excess weight and get regular physical activity. Limit alcohol. If you smoke, quit. Schedule regular doctor visits.

My Heart. My Health.
Heart Screenings for Woman's Way Clients

Background Information

The Pathways to Healthy Lives program is part of the Southwestern District Health Unit serving the Southwest region of North Dakota - Stark, Dunn, Billings, Golden Valley, Bowman, Hettinger, Adams, and Slope County.

The initial components of the Pathways to Healthy Lives program included lung, prostate, skin, colorectal, female breast cancer, and promotion of healthy lifestyles. In 2009, Pathways to Healthy Lives was awarded an unprecedented third HRSA (Health Resources and Services Administration) grant which expanded the program focus to include cardiovascular disease prevention including screenings. The need to provide low cost or free cardiovascular screenings to those without insurance coverage, underinsured and/or low income was identified as a result of the Dickinson community participation in the Go Red ND Community grant funding. Since the addition of the cardiovascular disease screenings, awareness and education activities to our program, the response has been overwhelming. At the midpoint of the grant cycle, we are experiencing a 70% increase in participation in the community screenings.

My Heart My Health Pilot Program Overview

My Heart My Health is a pilot project of Pathways in collaboration with the American Heart Association Go Red North Dakota Initiative with approval of HRSA to assist Women's Way clients in Stark County in accessing heart health screenings and lifestyle intervention services. Knowing ones heart health numbers is an important step in identifying and treating heart disease risk factors.

My Heart My Health, is modeled after the CDC WiseWoman program. WiseWoman is the sister program to what is known as Women's Way in North Dakota. CDC funds WiseWoman in only 21 states including Minnesota and South Dakota. Both programs shared their materials which we used as resources for our program.

The vision is to provide women with the opportunity to "know their numbers" for heart health, and provide knowledge, skills, and opportunities to improve diet, physical activity and other lifestyle behaviors to prevent, delay and/or control cardiovascular diseases.

Key components:

- Eligibility- Women's Way clients ages 40-64
- Heart Health Screenings to include: Body Mass Index (BMI), blood pressure, cholesterol (total, HDL, LDL, Triglycerides), tobacco use, personal medical history and family history for cardiovascular disease and diabetes, and current lifestyle.
- Individual risk reduction counseling by healthcare professional.
- Physician referral for follow-up and medical treatment when indicated based on pre-established medical guidelines.
- Lifestyle intervention counseling, education, tools and strategies to help the women develop healthy lifestyle behaviors.
- Follow-up screenings to assess changes in risk factors and lifestyle.
- The Pilot Project enrollment was limited to 50 women. Enrollment was opened on January 21st, 2010.

My Heart My Health Pilot Program Results

Health Risk Factors

- 26% had high blood pressure (35% had pre-hypertension)
- 51% had high cholesterol
- 38% smoked
- 65% were overweight or obese (49% obese)

Intervention and Results

- 28% were referred to a physician
  - 25% had no history of previous heart health screening
  - 50% were prescribed prescription medication (half for high blood pressure and half for high cholesterol)
  - 83% indicated that they had made lifestyle changes as a result of the program
    - 60% increased physical activity
    - 25% lost weight
    - 83% made dietary changes
- 16% participated in the lifestyle intervention program
  - 57% had cholesterol levels drop to the normal range at the follow-up screenings (an average of 14% reduction in 6 months)

Summary

My Heart My Health pilot project in Stark County built on the success of the Women's Way program in North Dakota; reaching out to a group of low income, underinsured or uninsured women ages 40 – 64 with heart disease risk factor screening, lifestyle assessment, education, lifestyle intervention and referral services in an effort to prevent cardiovascular disease. We are excited about the results of this program to save the lives of women in our service area and to serve as a model for the state of North Dakota.

Cardiovascular disease, including heart disease and stroke, are the leading cause of death of women and costly health problems facing our state today, yet among the most preventable. Early detection and treatment of risk factors can lead to prevention of cardiovascular disease. Many uninsured and underinsured women cannot afford these preventative screenings. Increasing the access to quality care is essential if we are to impact the rate of cardiovascular disease among North Dakota women, ages 40 to 64 that are Women's Way clients.

I encourage your consideration of funding Women's Way with Heart.

Together we can save lives – one heart at a time.

CDC WISEWOMAN

Program Results

Between January 2000 and June 2008, WISEWOMAN participants were found to have the following health risk factors:

- 28% had high blood pressure.
- 40% had high blood cholesterol.
- 23% had diabetes.
- 29% smoked.
- 74% were overweight or obese.

Reduction In Cardiovascular Risk

WISEWOMAN participants after 1 year saw a reduction in Cardiovascular Disease Risk (January 2000-June 2007)

- Reduction in 5-Year Cardiovascular Disease Risk among WISEWOMAN Participants
  - White 8.1%
  - Black 8.6%
  - Hispanic 10.7%
  - American Indian/Alaska Native 7.4%
- Reduction in Smoking Rates (Self reported)
  - White 6.5%
  - Black 10.0%
  - Hispanic 13.8%
  - American Indian/Alaska Native 6.1%

By having access to screening services, many women learn for the first time that they have high blood pressure, high blood cholesterol, and/or diabetes. The lifestyle intervention services result in the reduction in risk factors such as cardiovascular disease and tobacco use.

WISEWOMAN: Program That is Low Cost and High Yield

Health economists generally agree that if an intervention can save 1 year of life for less than $50,000, it is cost-effective. Studies of the WISEWOMAN program found that its programs have extended women's lives at a cost of $4,400 per estimated year-or-life saved. The cost to provide cardiovascular disease risk reduction services to a WISEWOMAN participant is approximately $400.

Success Story: Nebraska

Since the Nebraska WISEWOMAN program begin in 2000, more than 19,000 women with low incomes have been screened. When risk factors are found, participants are offered medical referrals as needed and ongoing health y lifestyle counseling and intervention support.

Half of Nebraska residents live in rural areas of the state, the other half live in three counties. To meet the challenges of a large state with few large communities, the program has set up a network of lifestyle interventionists, who contact participants by phone. These lifestyle interventionists provide tailored counseling and tools to clients, based on their identified health risks and support women as they increase their physical activity, improve their dies and quit using tobacco products.

The Nebraska WISEWOMAN program has been a 5.4% reduction in 10-year estimated chronic heart disease risk and a 7.5% reduction in 5-year estimated cardiovascular disease risk. Smoking incidence has also declined 7.1% since the start of the program.

For heart- or risk-related information, call the American Heart Association at 1-800-AHA-USA1 (1-800-242-8721) or visit us online at heart.org.

For stroke information, call our American Stroke Association at 1-888-4-STROKE (1-888-478-7653) or visit strokeassociation.org. For information on life after stroke, call and ask for the Stroke Family Support Network.

The statistics in this brochure were up to date at publication. For the latest statistics, see the Heart Disease and Stroke Statistics Update at heart.org/statistics.

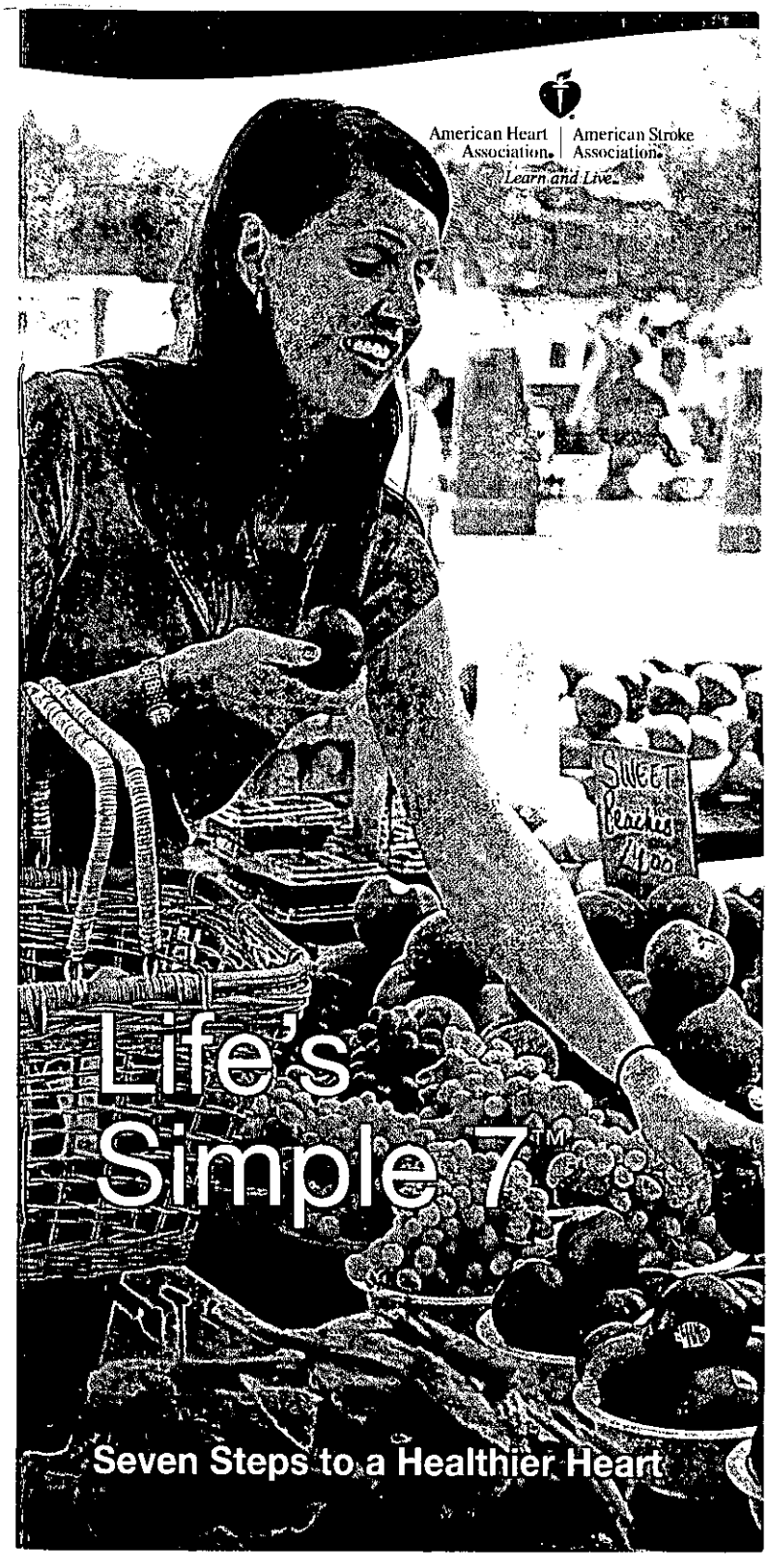
American Heart Association. | American Stroke Association.
Learn and Live.
National Center
7272 Greenville Avenue
Dallas, Texas 75231-4596

KRAMES.
PATIENT EDUCATION
A MediMedia Company

Published and distributed by Krames.

To order, call: 800-333-3032
www.krames.com/aha

50-1644 1004



Introducing *Life's Simple 7*™

No matter where you are in life, it's never too late to make better health choices. All you need is a goal, a plan and the desire to live better.

You can achieve excellent cardiovascular health by keeping seven factors in check. They're known as ***Life's Simple 7:***

- Don't smoke cigarettes or use other tobacco products.
- Keep a healthy body weight (body mass index less than 25 kg/m).
- Get at least 150 minutes of moderate-intensity physical activity or 75 minutes of vigorous-intensity activity (or a combination) each week.
- Eat a healthy diet consistent with current recommendations from the American Heart Association.
- Keep total cholesterol less than 200 mg/dL.
- Keep blood pressure below 120/80 mm Hg.
- Keep fasting blood glucose less than 100 mg/dL.

Make a **New Life Resolution**

1 Stop Smoking

Avoiding tobacco smoke is the best thing you can do to maintain your health. In fact, tobacco smoke is the single most preventable cause of death in the United States. Both smoking and constant exposure to other people's smoke increases your risk of heart disease and stroke. If you smoke, get help to quit. As soon as you stop smoking, your risk of heart disease and stroke starts to drop. In time, your risk will be about the same as if you'd never smoked.

2 Maintain a Healthy Weight

It's important to reach and maintain a healthy weight. If you have too much body fat, especially at the waist, you have a higher risk for health problems. These include heart disease, stroke, high blood pressure, high blood cholesterol and diabetes. A high-risk waistline is 35 inches or more for women and 40 inches or more for men. Obesity is defined as a body mass index (BMI) of 30.0 kg/m^2 or greater, or about 30 pounds or more overweight. To find your body mass index, multiply your weight in pounds by 703 and divide by your height in inches. Then divide again by your height in inches. Or, visit **heart.org/bmi.**

Follow American Heart Association guidelines for a balanced, nutritious diet as you reduce and maintain your weight. Watch your calories and the amount of saturated and *trans* fats and cholesterol you eat.

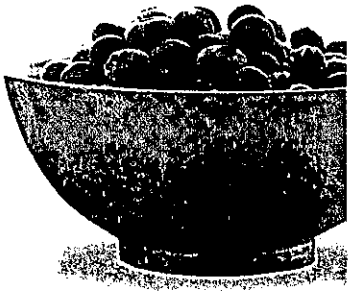
3 Get Active

Regular physical activity is important. Getting at least 150 minutes (2 hours and 30 minutes) of moderate-intensity aerobic physical activity each week provides health benefits for your heart. You can achieve this by getting at least 30 minutes of moderate physical activity on most or all days of the week. Moderate to vigorous activities include brisk walking, jogging, running, basketball, rowing, swimming, soccer and tennis. If you haven't been active, start with 10 minutes a day and then work up to more.

Generally, you don't need to consult your healthcare provider before becoming physically active unless you have a chronic condition. However, healthcare providers can provide advice on appropriate types of activities and ways to progress at a safe and steady pace.

4 Eat Better

A heart-healthy diet takes into account proper energy balance. This means balancing what you eat with the energy that you burn. If you can meet four to five of the following goals and keep your calorie levels in check, your diet is on a good path for excellent heart health. (Based on a 2,000-calorie-per-day diet.)



- Eat at least 4.5 cups of fruits and vegetables per day.
- Eat at least 2 (3.5-oz) servings of fish per week.
- Eat at least 3 1-oz servings of fiber-rich whole grains per day.
- Keep sodium to less than 1,500 mg per day.
- Limit sugar-sweetened beverages to no more than 450 calories (36 oz) per week.

Also include nuts, legumes and seeds in your diet. Limit processed meats and choose fat-free or low-fat dairy products.

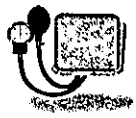
Control Cholesterol

You should keep your total cholesterol under 200 mg/dL. Aim to eat less than 300 mg of dietary cholesterol each day. To do so, here's how:

Read food labels to make sure you choose foods low in saturated fats, *trans* fats and cholesterol. Limit your saturated fat intake to less than 7 percent of total calories. Also, keep your *trans* fat intake to less than 1 percent of total calories. If you eat a diet high in saturated fat, *trans* fat and cholesterol or inherit a tendency toward high cholesterol, your arteries are more likely to become clogged with cholesterol and other substances.

Get your blood cholesterol level checked by a healthcare professional at least once every five years. Start at age 20. If your total blood cholesterol level is 240 milligrams per deciliter or higher, it's too high. Levels of 200–239 are borderline-high risk. If your level is high, you'll need it checked more often. You can lower it with diet changes, regular physical activity, weight loss and/or drug therapy.

6 Manage Blood Pressure



Have your blood pressure checked regularly. High blood pressure makes your heart work harder. That puts more strain on the heart and arteries. You have high blood pressure if two or more of your readings are 140/90 mm Hg or higher. A single high reading of blood pressure is not an immediate cause for alarm. But if you get a high reading, have your blood pressure checked several more times. Also, consult your healthcare professional to make sure you don't have a problem.

If your blood pressure is normal (below 120/80 mm Hg), have it checked at least every two years. If not, follow your healthcare provider's advice to control it. You may need to eat more fruits and vegetables along with non-fat dairy products. You may also need to lose weight, be more physically active and reduce salt (sodium) intake. Your healthcare provider may put you on medication.

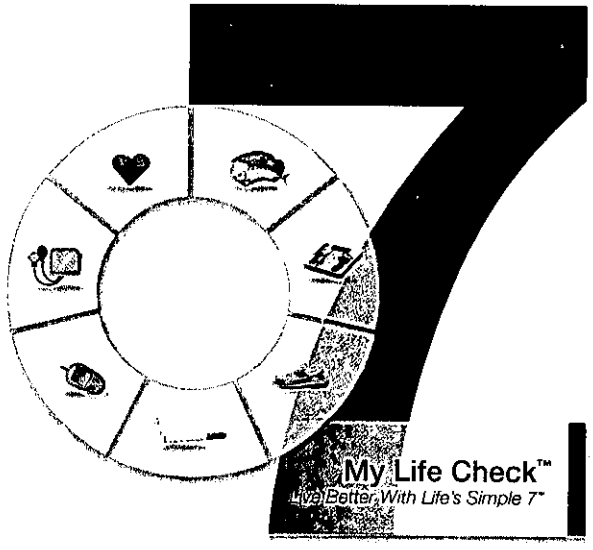
7 Control Blood Sugar

It's important to know your fasting blood glucose number. A healthy non-diabetic adult should have a reading of less than 100 mg/dL. If your fasting blood sugar level is between 100 mg/dL and 125 mg/dL, you are said to have "pre-diabetes." If you have pre-diabetes, then your risk of developing heart disease (including heart attack) or diabetes is higher. Diabetes seriously increases your risk of developing cardiovascular disease. If you have diabetes, it's extremely important to work with your healthcare provider to manage it and control any other cardiovascular disease risk factors you have.

What's Your **Heart Score?**

The American Heart Association's **My Life Check™** empowers Americans to take a big step toward a better life. In just a few minutes, you can learn where you stand with ***Life's Simple 7,™*** get your personal heart score and a custom plan with the seven steps you need to start living your best life. Visit **heart.org/mylifecheck** to start your new life resolution.

Remember, you can stop heart disease before it even starts. Start small. And keep it simple. Make one change today and then you're ready to make another. Before you know it, you've stopped making poor choices and started making life choices.



For **More Information**

We have many educational booklets to help you make healthier choices to reduce your risk, manage disease or care for a loved one. Topics include nutrition and weight management, smoking, cholesterol, high blood pressure, physical activity, controlling risk factors, cardiovascular conditions, treatments, procedures, stroke and more.

To learn more about healthy weight loss and the American Heart Association's No-Fad Diet, visit our Web site at **americanheart.org/no-faddiet.**

To learn more, call us toll-free at **1-800-AHA-USA1 (1-800-242-8721)** or contact your nearest American Heart Association office. You can also visit our Web site, **heart.org.**

For information on stroke, call **1-888-4-STROKE (1-888-478-7653)** or visit us online at **strokeassociation.org.**

Knowledge
is power, so
Learn and Live!

Heart Attack Warning Signs

Some heart attacks are sudden and intense, but most of them start slowly, with mild pain or discomfort. Here are some of the signs that can mean a heart attack is happening:

- **Chest discomfort.** Most heart attacks involve discomfort in the center of the chest that lasts more than a few minutes, or that goes away and comes back. It can feel like uncomfortable pressure, squeezing, fullness or pain.
- **Discomfort in other areas of the upper body.** Symptoms can include pain or discomfort in one or both arms, the back, neck, jaw or stomach.
- **Shortness of breath.** This may occur with or without chest discomfort.
- **Other signs.** These may include breaking out in a cold sweat, nausea or lightheadedness.

As with men, women's most common heart attack symptom is chest pain or discomfort. But women are somewhat more likely than men to experience some of the other common symptoms, particularly shortness of breath, nausea/vomiting and back or jaw pain.

If you or someone you're with has any of these symptoms, immediately call 9-1-1 or your emergency response number. Don't wait longer than five minutes before calling for help. You need to get to a hospital right away. (Calling 9-1-1 is almost always the fastest way to get lifesaving treatment.)

Stroke Warning Signs

- Sudden numbness or weakness of the face, arm or leg, especially on one side of the body
- Sudden confusion, or trouble speaking or understanding
- Sudden trouble seeing in one or both eyes
- Sudden trouble walking, dizziness or loss of balance or coordination
- Sudden, severe headache with no known cause

If you or someone with you has one or more of these signs, don't delay! Immediately call 9-1-1 or your emergency response number so an ambulance (ideally with advanced life support) can be sent for you. Also, check the time so you'll know when the first symptoms appeared. ***It's very important to take immediate action.*** If given within three hours of the start of symptoms, a clot-busting drug can reduce long-term disability for the most common type of stroke.

Cut along dotted line and keep

#3

Testimony in Support of Senate Concurrent Resolution 4024
Senate Human Services Committee
February 21, 2011

Good morning Chair Lee and committee members. My name is Connie Hofland. I represent the North Dakota Dietetic Association. I am an attorney here in Bismarck and am also a registered dietitian. I am here today to speak in support of Senate concurrent resolution 4024.

The North Dakota Dietetic Association represents about 300 registered dietitians in North Dakota; we are the state affiliate of the American Dietetic Association, the largest organization of food and nutrition experts with 70,000 members. Registered dietitians have the unique combination of health and food knowledge that enables us to translate health recommendations into what we should eat.

Sodium is an essential nutrient and is needed by the body in relatively small quantities. But pretty much all of us in this state, and this country, consume more sodium than we need. The estimated average intake of sodium for Americans is approximately 3,400 mg per day. The current recommendation, included in the newest Dietary Guidelines for Americans that were just released last month, is we should reduce our sodium intake to less than 2,300 mg or 1,500 mg per day depending on age and other individual characteristics.

Usually, the higher your sodium intake is, the higher your blood pressure is. A strong body of evidence in adults documents that as sodium intake decreases, so does blood

pressure. Keeping blood pressure in the normal range reduces the risk of cardiovascular disease, congestive heart failure, and kidney disease. Heart disease is the number one cause of death in North Dakota; stroke is number six.

Here are some suggestions on how to reduce sodium:

- Read the Nutrition Facts label for information on the sodium content of foods and purchase foods that are low in sodium.
- Consume more fresh foods and fewer processed foods that are high in sodium.
- Eat more home-prepared foods, where you have more control over sodium, and use little or no salt or salt-containing seasonings when cooking or eating foods.
- When eating at restaurants, ask that salt not be added to your food or order lower sodium options, if available.

Of course, another way to reduce sodium intake, is to eat less food – because sodium is found in a wide variety of foods. In fact, that is the first tip in the new dietary guidelines to help us translate the Dietary Guidelines into our lives:

1. Enjoy your food, but eat less.
2. Avoid oversized portions.
3. Make half your plate fruits and vegetables.
4. Switch to fat-free or low-fat (1%) milk.
5. Compare sodium in foods like soup, bread, and frozen meals – and choose the foods with lower numbers.
6. Drink water instead of sugary drinks.

Given the current U.S. marketplace, it is challenging to meet even the less than 2,300 mg recommendation; fewer than 15 percent of Americans do so currently. But, we have to keep trying because of the health impact. This study is one way to help the ongoing effort to keep an eye on sodium content of food purchased and come closer to making the sodium intake recommendations, and the resulting health benefits, a reality.

We urge a do pass. Thank you.

American Heart Association. | American Stroke Association.
Learn and Live.

SCR 4024
House Human Services Committee

American Heart Association Testimony

Chairman Weisz and members of the House Human Services Committee. I am June Herman, Vice President of Advocacy for the American Heart Association in North Dakota. I am here today to testify in support of SCR 4024, and ask for a "do pass" recommendation from this committee.

Consideration and recommendation on this subject is very timely, and positions North Dakota with an early start on steps that can make a difference for a significant collision course our state will experience with our baby boomers and cardiovascular disease. Recently, all legislative members received a status report of Chronic Disease in North Dakota. Cardiovascular disease is the number one cause of death in North Dakota. Progress is being made, but we must continue to work harder. Attached to my testimony is another document that may be of interest to you as to cardiovascular trends and the impact our state and nation will soon be facing -

Collision Course: America's Baby Boomers and Cardiovascular Disease

Our goal is to empower people so that they can and will make diet and lifestyle changes that add up to a healthier heart and better future. It's about making the right choices easier. What we find through American Heart Association consumer research is that even the motivated find it is very difficult to make the changes they need to do: Everyday life, food is the problem - and also the solution, it's the 1st thing people do after diagnosis is try to eat a bit healthier. We know

- Eating out of home is a problem
- Practical help is required
- **Personalisation is key**
- Diet & Food offerings need to be realistic in the context of their lives
- Credible medical advice is critical

SCR 4024 will lay the ground work for action and assist North Dakota in setting recommendations and policies to reduce sodium intake for consumers and reduce the devastating effects of high sodium intake. Potential state strategies that can result from this study include:

- Continue and expand the support of core heart disease and stroke policy initiatives underway in our state – Go Red ND, school health, heart screening for Woman's Way clients, stroke systems of care, and status of the state's Heart Disease and Stroke Program within the Department of Health.
- State procurement policies for institutions and other large-scale organizations that purchase or distribute food that establish sodium specifications for the foods they purchase and the food operations they oversee
- Labeling requirements for foods available in restaurants or point of purchase
- Venue-based approaches – increasing low sodium options
- Consumer awareness campaigns
- Medical home based efforts for hypertension management

Legislative study of this matter can also help further the Department of Health's outreach to key stakeholders in the state as part of North Dakota's participation in the National Salt Reduction Initiative. The Heart Disease and Stroke Program has started to engage partners from aging services, child nutrition, and WIC to begin exploring current policies relating to sodium content in foods that are purchased and served for these populations. In addition, outreach to North Dakota local companies (supermarkets) to encourage their commitment to the NSRI targets. Other projects are sodium reduction campaign materials and toolkits.

Changing the food environment gives consumers a broader range of healthful foods which to choose. Policy and environment strategies are effective at the state and local level and help drive industry changes. With this resolution, North Dakota can begin the process now and identify ways to reduce sodium intake for its citizens and provide environments that support low sodium food choices. Without major change to sodium intake, hypertension and cardiovascular disease rates will continue to rise, and consumers, who have little choice, will pay the price for inaction. And so will the state.

Collision Course:

America's Baby Boomers and Cardiovascular Disease

Forecasting the Future of Cardiovascular Disease in the United States

American Heart Association | American Stroke Association.

CVD Prevalence and Costs Heading in the Wrong Direction

According to a new study by the American Heart Association, America's Baby Boomers and Cardiovascular Disease (CVD) are on a collision course of alarming proportions. By 2030, it is projected that 40.5% of Americans—116 million people—will have some form of CVD.

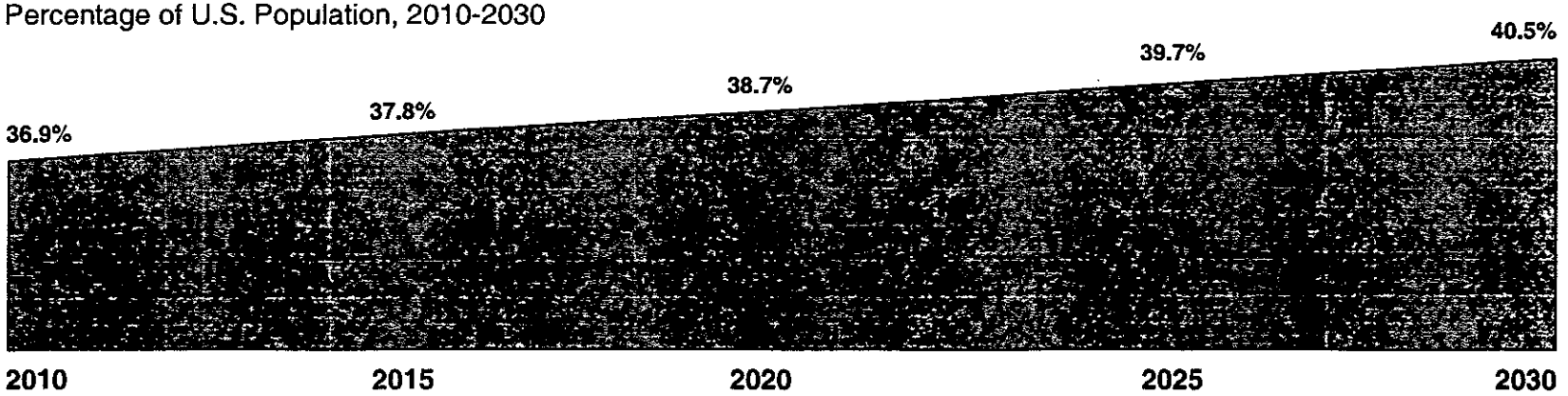
In spite of enormous advances in prevention and treatment, and a decline in mortality rates, heart disease and stroke remain respectively the number one and four killers of Americans. But can an already bad situation get even worse? The answer is a frightening "yes."

Treating cardiovascular disease is already an enormous drain on resources. In fact, CVD not only ranks as the leading killer in America, but as the most costly disease in the nation. The share of overall medical costs for CVD is seventeen percent.

The projected toll in death, human suffering and health care costs to the Nation are as staggering and crippling as the disease itself. And CVD is blind with respect to gender and ethnicity. In 2030, 39% of men and 42% of women will have some form of CVD, and blacks suffer at higher rates than whites and Hispanics.

Projections of Cardiovascular Disease Prevalence

Percentage of U.S. Population, 2010-2030



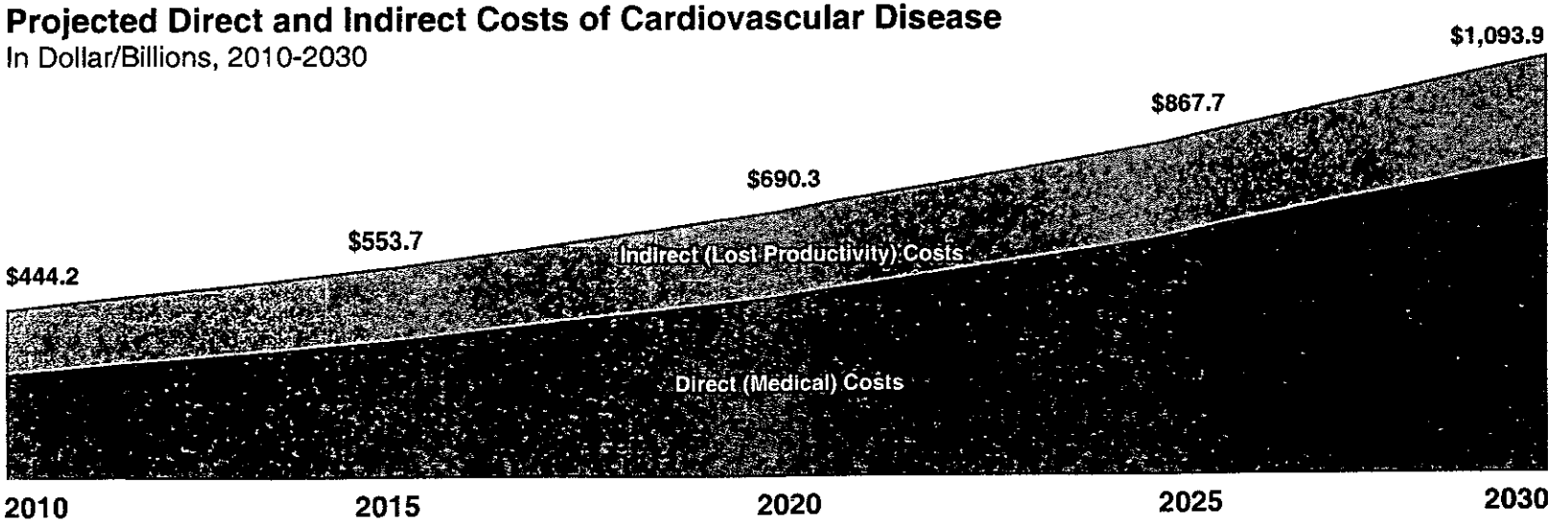
Between 2010 and 2030, total direct medical costs of CVD are projected to triple, from $273 billion to $818 billion. Real indirect costs—due to lost productivity—for all forms of CVD are estimated to increase from $172 billion in 2010 to $276 billion in 2030, an increase of more than 60 percent. The combined costs are projected to exceed $1 trillion by 2030.

What's Driving the Cost Increase?

America's 78 million Baby Boomers are babies no more. The advance guard has already reached retirement age and will be eligible for Medicare when they turn 65 in 2011. The graying of the population combined with the explosive growth in medical spending are the primary drivers of increased CVD costs, which are expected to grow the fastest for ages 65 and over. Annual CVD costs for persons age 65 to 79 are projected to increase by a whopping 238 percent, from $135 billion to $457 billion per year.

Projected Direct and Indirect Costs of Cardiovascular Disease

In Dollar/Billions, 2010-2030

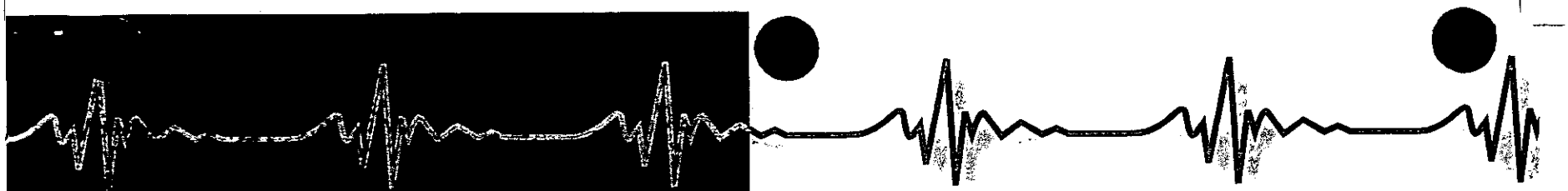


The Status Quo is a Killer

Under current prevention and treatment trends, CVD will grow by nearly 10 percent over the next 20 years, while direct costs will increase almost threefold. Direct costs of CVD will continue to account for a relatively stable and large share of the nation's overall medical expenditures.

However, if some risk factors, such as diabetes and obesity continue to increase rapidly, we may see a greater increase in CVD prevalence and its associated costs.

Recent studies project that current overweight adolescents will bump up future adult obesity rates by 5 percent to 15 percent by 2035, resulting in more than 100,000 cases of coronary heart disease, while associated costs will increase by $254 billion.



Is Prevention the Silver Lining in a Very Dark Cloud?

Using a different kind of model, researchers evaluated the impact of 11 widely-recognized prevention services for reducing cardiovascular disease, such as smoking cessation, preventive aspirin therapy, cholesterol-lowering medications and weight reduction.

They found that if everyone received the 11 prevention services, myocardial infarctions (MI) and strokes would be reduced by 63 percent and 31 percent respectively in the next 30 years. At more feasible success levels—those that have been actually achieved in clinical practice—MIs and strokes would be reduced by 36 percent and 20 percent.

Researchers found that using these CVD clinical prevention measures to their fullest potential could add about 220 million life-years over the next 30 years, or an average of 1.3 years of life expectancy for each adult in the United States. About 78 percent of U.S. adults ages 20 to 80 are candidates for at least one of these clinical prevention activities.

That's the good news. The bad news is that the current use of these prevention activities is way below where it should be, contributing to the projected upsurge in CVD and stroke.

Prevention: A Chance to Change Course

Cardiovascular disease is largely preventable. We must never forget that fact because it could drive a whole new way that we as a nation look at CVD. Rather than treating the illness when it is far advanced, we should promote heart healthy habits and wellness at an early age.

Several studies show that individuals with fewer atherosclerosis (hardening and narrowing of the arteries) risk factors have a marked reduction in the onset of coronary heart disease and heart failure. Similarly, persons who follow a healthy lifestyle of regular exercise and a heart healthy diet reduce their risk of coronary heart disease and stroke. Therefore, a greater focus on prevention may help us avoid the projected CVD explosion. And history may be on our side.

Eliminating risk factors on a population-wide scale has contributed significantly to reducing CVD death rates in the U.S. For example, smoking has declined dramatically since the Surgeon General first issued his report on smoking's health risks in 1964. This was followed by nationwide awareness efforts to reduce dietary fat intake, detect and treat high blood pressure and improve cholesterol levels. All of these programs to reduce risk factors helped slash CVD death rates. They are literally life savers.

The Sooner the Better

Emerging evidence suggests that CVD prevention should begin early in life—the sooner the better. Modest improvements in risk factors earlier in life have a far greater impact than more substantial reductions later on in life. The payoffs can be huge. For example, a modest 28 percent reduction in LDL (bad) cholesterol from birth resulted in an 88 percent reduction in the risk of coronary heart disease. Contrast that to the 20-30 percent reduction in CVD seen with a 30 percent reduction in LDL with statin medications initiated in middle and older ages.

Getting a Grip on High Blood Pressure

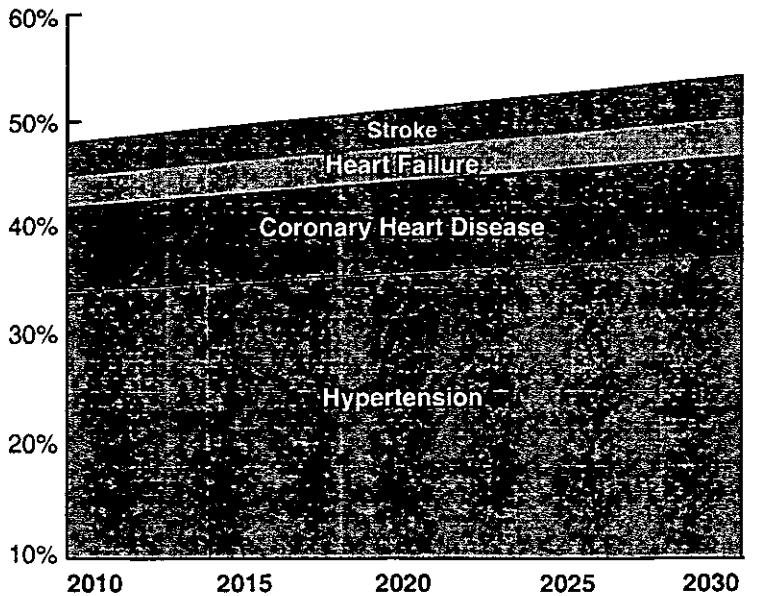
One out of three Americans currently have hypertension—a silent killer that accounts for 18 percent of CVD deaths in Western countries. It is also a major risk factor for stroke, coronary heart disease, and heart failure.

Hypertension is the most costly form of CVD. The total medical cost for hypertension makes it a particularly valuable target to reign in CVD's future costs.

Annual medical costs directly attributable to hypertension are projected to increase by $130 billion over the next 20 years for a total projected annual cost of $200 billion by 2030. And that is just scratching the surface. If the cost is expanded to include how much the presence of hypertension contributes to the treatment of related diseases, such as coronary heart disease and stroke, the increase of annual spending for 2010 to 2030 almost doubles.

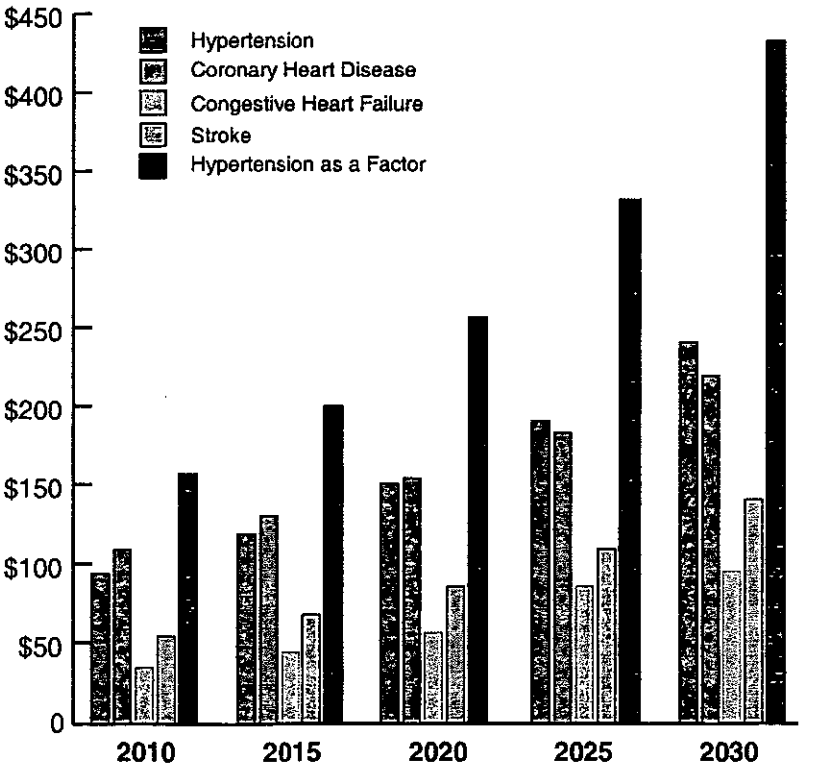
Projections of Cardiovascular Prevalence

Percentage of U.S. Population, 2010-2030



Projected Direct and Indirect Costs of CVD

In Dollar/Billions, 2010-2030



Hypertension as a risk factor includes a portion of the costs and prevalence of complications associated with hypertension, including heart failure, coronary heart disease, stroke, and other CVD.

Will the Provider Workforce be Adequate?

Primary and secondary prevention of CVD requires a team approach with professionals in medicine, nursing, pharmacy, nutrition, social work, and other disciplines. But will they be there? Not if current trends continue.

The projected lack of U.S. health professionals in the fields of nursing, pharmacy, and medicine is well documented and alarming. For example, in less than 15 years, we could experience a shortage of 260,000 registered nurses. Currently, over 8,000 vacancies exist in retail pharmacies, hospitals, clinics, and other industry sectors, and these figures are expected to worsen over time. And a looming shortage of physicians most recently prompted the president of the Association of American Medical Colleges to recommend that U.S. medical schools increase the annual number of graduates by 30 percent.

While primary care physicians are already in short supply, there is a growing and significant shortage in cardiac specialty care—currently, there is a projected shortfall of 1,600 general cardiologists and 2,000 interventional cardiologists.

If the trend continues, we would need to double by 2050 the current number of cardiologists to erase the expected shortage of 16,000 cardiologists. The looming shortfall for cardiac surgeons is even worse. Only 100 new cardiothoracic residents are being certified each year. At this rate and taking into account death, retirement, and attrition, it is estimated that only 3,000 practicing cardiothoracic surgeons will be in practice by the year 2030.

Game Changer

The prevalence and costs of CVD are projected to increase substantially in the future. Fortunately, CVD is largely preventable and our health-care system should promote prevention and early intervention. In the public health arena, more evidence-based effective policy, combined with systems and environmental approaches should be applied to the prevention, early detection and management of CVD risk factors. Through a combination of improved prevention and treatment of established risk factors, the dire projected health and economic impact of CVD can be diminished.

The U.S. health system often rewards practices that treat disease and injury rather than those that prevent them and promote wellness. The result: Americans' health has remained relatively unchanged this decade despite huge and unprecedented increases in health care spending.

As our nation implements and refines new health reform policies, we must realize that a variety of policy and practice-related measures will be necessary to effect meaningful and lasting change in the health care system.

Expanding access to affordable health care coverage may provide important benefits for individuals with CVD. However, we must also reorient our health care system toward implementing effective health promotion and disease prevention. This game-changing strategy is not unrealistic, and provides an exciting opportunity and call to action.

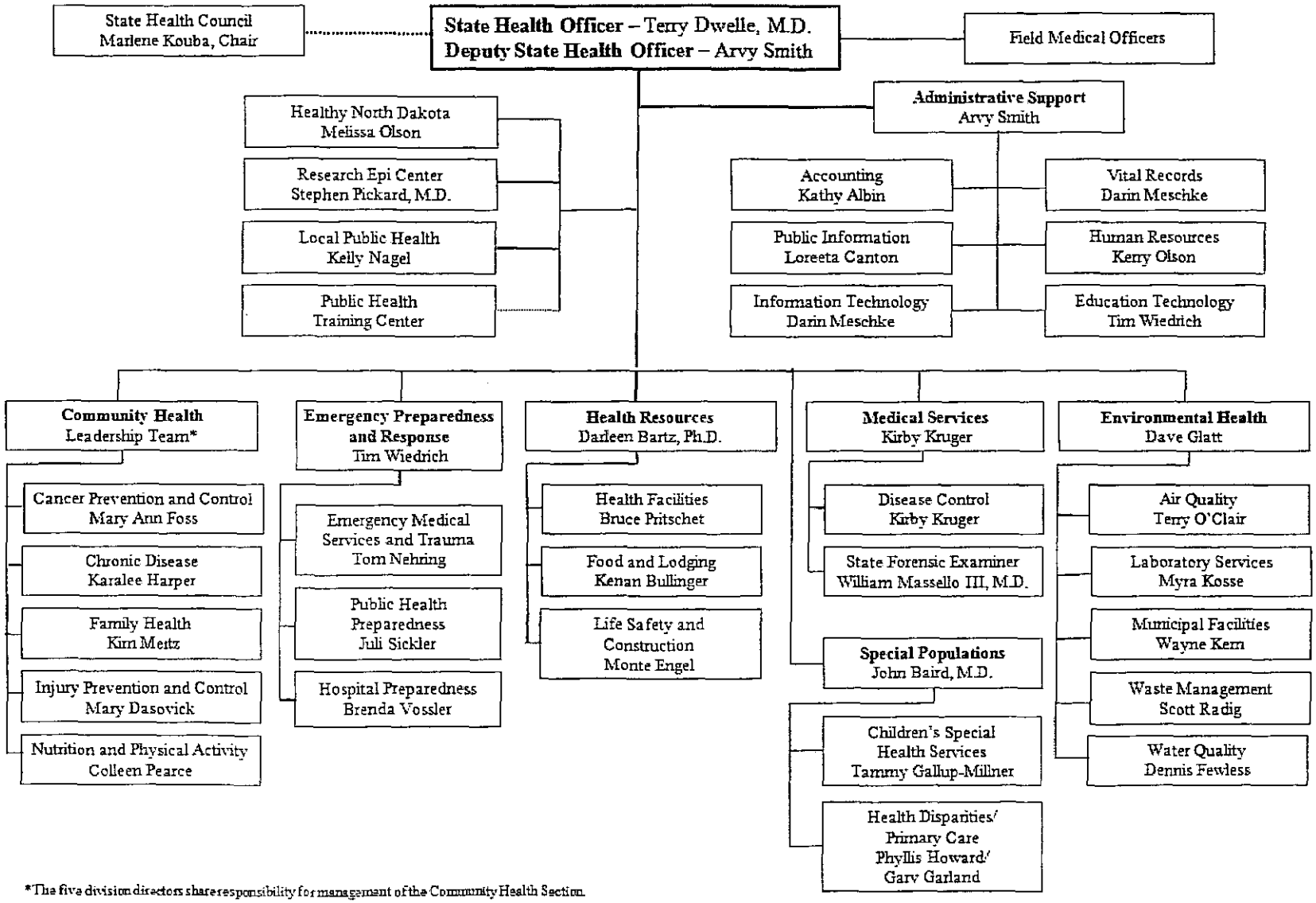
For example, prevention at the community level is one such avenue for reducing the projected burden of CVD. Community prevention efforts may include greater tobacco control, elimination of trans fat, reducing sodium intake, cutting air pollution, reducing obesity and increasing physical activity with a focus on children.

It should be recognized that while prevention will delay or even prevent the onset of CVD and the cost of treatment, patients will need medical care longer and life-time cost of care may not be reduced. Thus, prevention strategies should not be evaluated solely on their ability to reduce cost of care, but should instead be based on a combination of cost and impact on patient well-being, including length and quality of life.

All content in this paper and the research studies upon which it is based can be found in Heidenreich, PA, Trogdon JG, Khavjou OA, Butler J, Dracup K, Ezekowitz MD, Finkelstein EA, Hong Y, Johnston SC, Khera A, Lloyd-Jones DM, Nelson SA, Nichol G, Orenstein D, Wilson PWF, Woo J. Forecasting the future of cardiovascular disease in the United States: A policy statement from the American Heart Association. **Circulation.** Published online ahead of print January 24, 2011.

For More Information, Contact:
The American Heart Association Office of Federal Advocacy
1150 Connecticut Ave., NW, Suite 300, Washington, DC 20036
Ph: 202-785-7900/www.heart.org

North Dakota Department of Health
Organizational Chart
March 2010



*The five division directors share responsibility for management of the Community Health Section.

COMMUNITY HEAL[redacted] SECTION (CHS)

Novem[redacted]10

HEALTHY NORTH DAKOTA
★ Melissa Olson ★

SSDI (State Systems Development Initiative)
★ Devaiah Muccatira ★

★ Not CHS Staff, but work closely with section. ★

CHS LEADERSHIP TEAM
Mary Dasovick
Mary Ann Foss
Karalee Harper
Kim Mertz
Colleen Pearce

ADMINISTRATIVE SUPPORT
Ros Norstedt
Carleen Scherr

GRANTS MANAGEMENT
Lonny Mertz

INFORMATION TECHNOLOGY COORDINATOR
Corey Bergrud

CANCER PREVENTION & CONTROL (4521)

DIRECTOR
Mary Ann Foss

Breast & Cervical Cancer (Women's Way)
Mary Ann Foss
Ann Lunde
Barbara Steiner
* Bobbie Will *

Cancer Registry
Marlys Knell
Donna O'Shaughnessy
Alice Musumba
* Joell Letzring *
* Nancy Cossette *

Comprehensive Cancer
Joyce Sayler
Dubi Schwanz

Administrative Support
Sandra Bush
Candace Getz

Contact Us

CHRONIC DISEASE (4531) and (4571)

DIRECTOR
Karalee Harper

Grants Management
Lonny Mertz

Heart Disease & Stroke Prevention (HDSP)
Susan Mormann
Kathy Moum
Clint Boots

Tobacco Cessation
Michelle Walker
* Micki Savelkoul *

Tobacco Disparities
Neil Charvat

Tobacco Prevention & Control
Karalee Harper
Neil Charvat
Kara Dodd

Tobacco Surveillance / Evaluation
Clint Boots

Administrative Support
Carleen Scherr
Jenifer Brubakken

Contact Us

FAMILY HEALTH (4541)

DIRECTOR
Kim Mertz

Abstinence Education
Sandra Fetzer

Behavioral Risk Factor Surveillance System (BRFSS)
Melissa Parsons

Coordinated School Health / School Nursing
Becky Bailey
Judy Thomson

Early Childhood Comprehensive Systems
Cheryle Masset-Martz

Family Planning / Women's Health
Char Reiswig
Sandra Fetzer

Information Technology
Corey Bergrud

Maternal & Child Health (MCH) Nurse Consultant / Cribs for Kids / Sudden Infant Death Syndrome (SIDS)
Kjersti Hintz

MCH / Oral Health Epidemiologist
Gregg Reed

Newborn Screening
Barb Schweitzer

Optimal Pregnancy Outcome Program (OPOP)
Sandra Fetzer

Oral Health
Kimberlie Yineman
Robyn Stearns
* Michael Goebel, DDS *
* Hollie Harrington *
* Tracy Haugenoe *
* Marcia Olson *

Title V / MCH
Kim Mertz

Administrative Support
Ros Norstedt
Colleen Ebach
Peggy Stanton
Joni Steinke

Contact Us

INJURY PREVENTION & CONTROL (4551)

DIRECTOR
Mary Dasovick

Child Passenger Safety
Dawn Mayer

Domestic Violence / Rape Crisis
Mary Dasovick
* Bonnie Palecek *

Injury / Violence Prevention
Diana Read

Suicide / Family Violence Prevention
Gail Erickson

Administrative Support
Mallory Sattler

Contact Us

NUTRITION & PHYSICAL ACTIVITY (4561)

DIRECTOR
Colleen Pearce

Diabetes Prevention & Control
Tera Miller
Kathy Moum

Healthy Communities
Deanna Askew

Healthy People 2010
Kathy Moum

MCH Nutrition
Kate Black

WIC
Colleen Pearce
Kristi Miller
Kim Hinnenkamp

Administrative Support
Lynne Wise
Joni Steinke

Contact Us

* "Tem[redacted]itions *

Organizational Chart 11-2010

American Heart Association. | American Stroke Association.
Learn and Live.

SCR 4024
House Human Service Committee

American Heart Association Go Red ND Testimony

Chairman Weisz and members of the House Human Services committee. I am Joan Enderle, Director of the American Heart Association's Go Red ND Initiative. I am here today to testify in support of SCR 4024, and ask for a "do pass" recommendation from this committee.

Heart disease is the leading cause of death in North Dakota and the United States. Cardiovascular diseases, including heart disease and stroke now kill more than 800,000 adults in the US each year. Of these, 150,000 are younger than age 65 according to a report released earlier this month by the National Center for Chronic Disease Prevention and Health Promotion. Every 39 seconds an adult dies of heart attack, stroke, or other cardiovascular disease.

The 2006 cost of cardiovascular diseases in the US was estimated to be $403.1 billion. Based on this figure, the estimated cost of CVD in North Dakota was $920 million. This figure includes both direct and indirect costs.

Hypertension (High Blood Pressure) is a significant risk factor for heart disease and stroke. High Blood Pressure:

- ✓ About 69 percent of people who have a first heart attack, 77 percent who have a first stroke, and 74 percent who have congestive heart failure have blood pressure higher than 140/90
- ✓ High Blood Pressure (hypertension) affects 1 in 3 adults.
- ✓ 1 in 3 adults with high blood pressure does not get treatment.
- ✓ Less than half of those with high blood pressure (hypertension) have it under control. People who lack health insurance have even lower rates of control.

Reducing blood pressure saves lives and money.

- ✓ Reducing systolic blood pressure just 12 – 13 mm HG over 4 years can reduce:
  - Coronary heart disease by 21%
  - Stroke by 37%
  - Cardiovascular disease deaths by 25%
- ✓ Reducing the average intake to 1,500 milligrams of sodium per day in the United States population would result in an estimated 25.6 percent overall decrease in high blood pressure and $26.2 billion in health care savings

A comprehensive approach that involves policy, systems changes to improve health care access, quality of preventive care, patient adherence to treatment in addition to individual adoption of healthy behaviors is critical to save lives and reduce healthcare costs.

Go Red North Dakota engages individuals, communities, health care providers, and worksites in a heart disease prevention campaign, targeted at a population group, resulting in risk awareness that drives lifestyle change.

- ✓ Increase in awareness of heart disease and stroke as leading cause of death to 87% (compared to 64% national survey results)
- ✓ Over 15,000 women joined the Go Red For Women movement in North Dakota
- ✓ 92% of women responding to a Go Red survey made at least one lifestyle change to reduce their heart disease risk
  - 64% increased their exercise
  - 60% made heart healthy dietary changes
  - 40% lost weight

Go Red ND Initiative, over the past four years, has progressed along the behavior change continuum, from a focus on awareness, to education of heart disease risk factors, to determine your personal risk, to lifestyle change to reduce your risk. This year, an environment and systems change component was added. The momentum continues to build with increasing engagement of individuals, healthcare providers, communities, worksites and partner organizations.

Blood pressure is the focus of the Go Red ND action grants this year creating healthier communities with engagement of key community partners. Each community committee designs and implements a plan unique to their community including a media campaign,

partnering with key community groups and health care providers to provide free blood pressure screenings, worksite blood pressure initiative, education and an outcome measurement component. The activities engage both women and men.

My Heart. My Health. was a pilot project in Stark County. A group of low income, underinsured or uninsured women ages 40 – 64 received heart disease risk factor screening, lifestyle assessment, education, lifestyle intervention and referral services based on pre-established medical criteria.

<u>My Heart. My Health. Program Results</u>

Health Risk Factors

- 26% had high blood pressure (35% had pre-hypertension)
- 51% had high cholesterol
- 38% smoked
- 65% were overweight or obese (49% obese)

Intervention and Results

- 28% were referred to a physician
  - 25% had no history of previous heart health screening
  - 50% were prescribed prescription medication (half for high blood pressure and half for high cholesterol)
  - 83% indicated that they had made lifestyle changes as a result of the program
    - 60% increased physical activity
    - 25% lost weight
    - 83% made dietary changes
- 16% participated in the lifestyle intervention program
  - 57% had cholesterol levels drop to the normal range at the follow-up screenings (an average of 14% reduction in 6 months)

The mission of the American Heart Association is: Building Healthier Lives, free of cardiovascular diseases and stroke. 2020 Impact Goal: By 2020, improve the cardiovascular health of all Americans by 20 percent while reducing deaths from cardiovascular disease and stroke by 20 percent.

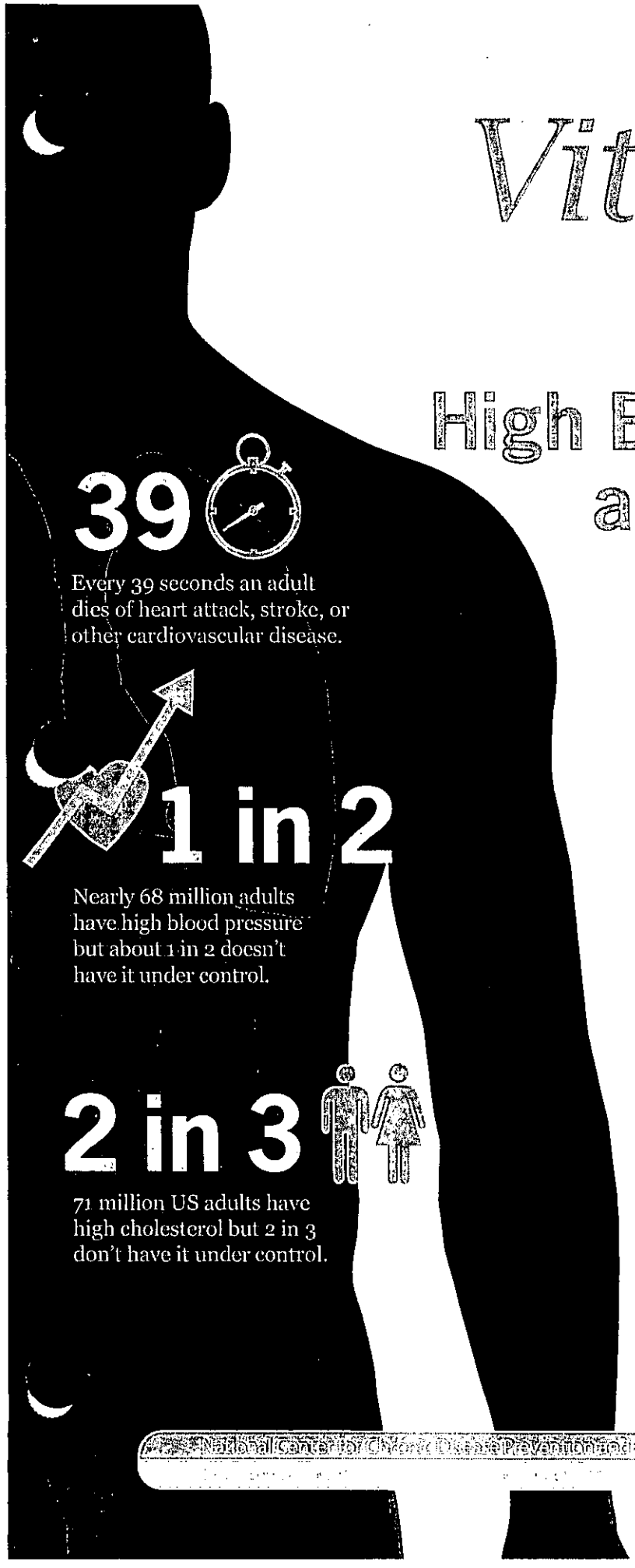
The mission and 2020 impact goal is achievable in North Dakota with support and expansion of core heart disease and stroke policy initiatives.

Thank you for your support of SCR 4024.

CDC Vital Signs™
February 2011

High Blood Pressure and Cholesterol

Out of Control



Heart disease, stroke, and other cardiovascular (blood vessel) diseases are among the leading causes of death and now kill more than 800,000 adults in the US each year. Of these, 150,000 are younger than age 65. These diseases are also two of the leading causes of health disparities in the US. Treatment of these diseases accounts for 1 in every 6 US health dollars spent. Two main reasons people have heart disease or stroke are high blood pressure* and cholesterol, which are common, deadly, and preventable. Nearly 2 out of 3 adults with high cholesterol and about half of adults with high blood pressure don't have their condition yet under control. Clearly, other steps are needed to gain control of these health risks.

*High blood pressure means at least 140/90 mmHg. High cholesterol in this report means high LDL ("bad") cholesterol.

Learn what you can do to reduce heart disease and stroke.

→ **See page 4**

Want to learn more? Visit

http://www.cdc.gov/vitalsigns

National Center for Chronic Disease Prevention and Health Promotion

High Blood Pressure and Cholesterol

Improved care could save more than 100,000 lives a year.

By the Numbers

High Blood Pressure

1 in 3 Adults has high blood pressure.

1 in 3 Adults with high blood pressure does not get treatment.

1 in 2 Adults with high blood pressure does not have it under control.

High Cholesterol

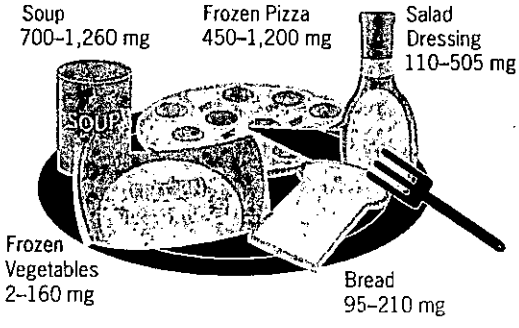
1 in 3 Adults has high cholesterol.

1 in 2 Adults with high cholesterol does not get treatment.

2 in 3 Adults who have high cholesterol do not have it under control.

Salt Level Can Vary in Common Food Items

Range (mg sodium per serving)



Current guidelines for sodium intake for adults are less than 2,300 mg of sodium per day at most and 1,500 mg for adults at high risk.

Why is control difficult to achieve?

◇ More than 80% of people who don't have their blood pressure or cholesterol under control actually have health insurance. Not only do individuals need to be continually checked for these conditions, they also need good, affordable treatment along with regular follow-up care.

◇ Many people don't have regular access to medical care, prescription medications, or lifestyle counseling. Some people don't go back to the doctor when they should. This makes it difficult to control their blood pressure and cholesterol. About 1 in 2 adults stops taking cholesterol medicine within 1 year.

◇ Improvements in the way health care is delivered are needed. Clinical services that detect and control high blood pressure or cholesterol are not being delivered to all those in need. Changes in how we reimburse for and provide health care services can improve health by giving more people access to treatment.

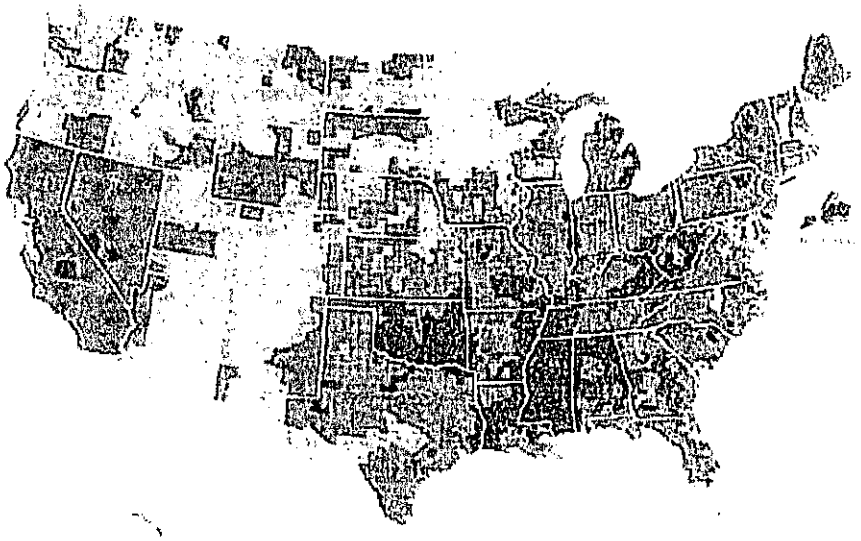
◇ People get 77% of their sodium (mostly salt) from eating processed or restaurant foods, which can raise blood pressure. Even people who want to eat low-salt foods may have trouble finding them in grocery stores or on restaurant menus.

◇ Trans fat found in fried and processed foods such as cookies and donuts can raise cholesterol, contributing to heart disease and stroke. Only 1 in 5 Americans lives where there are policies that eliminate artificial trans fat from restaurant foods.

◇ Everyday decisions can help keep a heart healthy. These include not smoking, eating right, exercising, and taking prescription medicines. Policies that make it easier for people to eat a healthy diet, walk or bicycle for transportation or fun, and have smoke-free areas can help lower blood pressure and cholesterol.

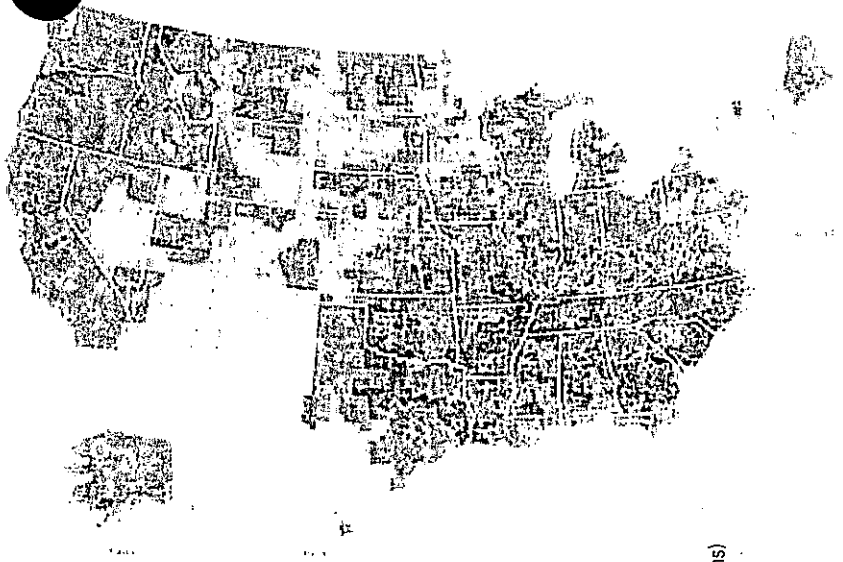
US State Info

Heart Disease Death Rates 2002-2007, Adults Ages 35+, by County



SOURCES: National Vital Statistics System and US Census Bureau.

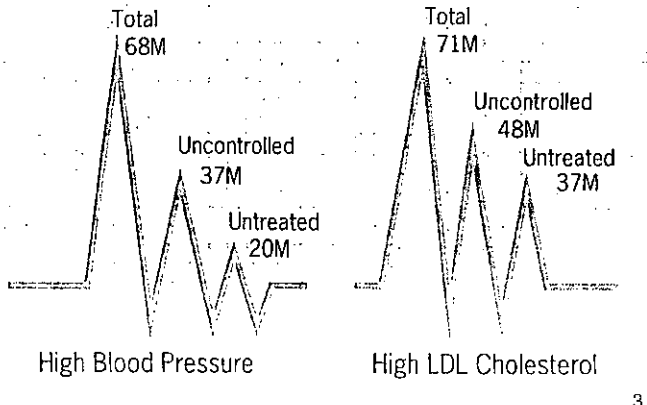
Stroke Death Rates 2002-2007, Adults Ages 35+, by County



http://apps.nccd.cdc.gov/GISCVH2/

High Blood Pressure and High Cholesterol Among US Adults

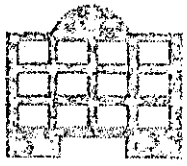
SOURCES: National Health and Nutrition Examination Survey 2005–2008.



What Can Be Done

The Affordable Care Act

- ◇ Will expand health insurance coverage to up to 94% of people under age 65 by 2019.
- ◇ Will require new health plans to cover preventive services for certain populations including
  - Testing for high blood pressure and cholesterol.
  - Counseling on the use of daily aspirin to reduce the risk of a heart attack or a stroke.
  - Using counseling and medication to help people quit smoking.
  - Managing obesity and providing counseling on diet and weight loss.
- ◇ Will provide more trained health professionals to treat people with high blood pressure and cholesterol.
- ◇ Will improve the delivery of services.



Policymakers can

- ◇ Develop policies that reward effective disease prevention and chronic disease management.
- ◇ Develop policies that allow other health care professionals (pharmacists, dietitians, community health workers, nurses and nurse practitioners) to have a more active role in managing high blood pressure and cholesterol.
- ◇ Develop policies for medical care that increase the use of electronic health records and doctor reminder systems.
- ◇ Champion policies to reduce salt and eliminate artificial trans fat in the nation's food supply.

Doctors, nurses, and other health providers can

- ◇ Follow current guidelines for prevention, treatment, and control of heart disease and stroke. (http://www.cdc.gov/dhdsp/materials_for_professionals.htm).
- ◇ Use electronic health records and registries of their patients with high blood pressure and cholesterol, or who smoke so patients get the follow-up care they need, and providers get feedback on their performance.
- ◇ Manage these conditions at every patient visit at every provider to help them control their blood pressure and cholesterol.
- ◇ Remind patients about follow-up care (e.g., automatic phone calls, Internet reminders) and self-monitoring of high blood pressure at home.
- ◇ Urge patients at every opportunity to quit smoking.

Individuals can

- ◇ Follow your doctor's instructions and stay on your medications to control your blood pressure and cholesterol.
- ◇ Eat a healthy diet that is low in salt; low in total fat, saturated fat, and cholesterol; and rich in fresh fruits and vegetables.
- ◇ Take at least 1 brisk 10-minute walk, 3 times a day, 5 days a week.
- ◇ Don't smoke. If you smoke, quit as soon as possible (http://www.cdc.gov/tobacco and http://www.smokefree.gov).

CS219354D

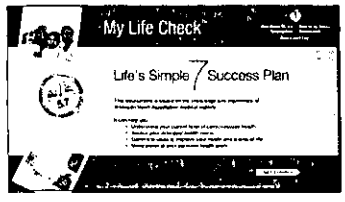
For more information, please contact
Telephone: 1-800-CDC-INFO (232-4636)
TTY: 1-888-232-6348
E-mail: cdcinfo@cdc.gov
Web: www.cdc.gov
Centers for Disease Control and Prevention
1600 Clifton Road NE, Atlanta, GA 30333
Publication date: 02/01/2011

American Heart Association

Learn and Live

small steps to BIG changes

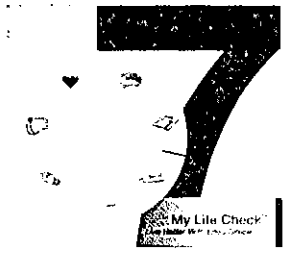
Find out how healthy you are



with My Life Check™
our new online health assessment tool.
Assess the state of your heart-health
and get your overall health score
at heart.org/MyLifeCheck.

Create your Simple Seven Action Plan

to move
closer to
your
health goals.
Learn
the seven
simple
steps you
can take
to start living a longer, better life.



(over)

American Heart Association. | American Stroke Association.
Learn and Live.

My Life Check™
Live Better With Life's Simple 7™

heart.org/MyLifeCheck

Life's Simple 7

SEVEN SIMPLE STEPS TO LIVE BETTER.

	Your Goal
Smoking Status	**No Smoking**
Healthy Weight	**BMI of 18.5 to 24.9**
Physical Activity	**150 min. moderate or 75 min. vigorous** (or equivalent combination)
Healthy Diet	**4-5 components** 4.5 cups fruit/vegetables/day 3 oz. or more whole grain/day At least 2 servings fish/wk Under 450 cal. from beverages w/added sugar/wk Under 1,500 mg sodium/day
Blood Pressure	**Systolic** Less than 120 mm HG **Diastolic** Less than 80 mm HG
Blood Cholesterol	**Less than 200 mg/dL**
Blood Sugar	**Less than 100 mg/dL**

The My Life Check™ health assessment is based on the knowledge and experience of American Heart Association medical experts.

Important Notice: Health assessments are based on averages from studies of large groups of people. Your situation may be different. It is important to discuss your personal situation with your healthcare provider. It is not intended to replace medical advice from your healthcare provider, but rather help you set health goals and make healthy lifestyle choices.

#3

Testimony in Support of Senate Concurrent Resolution 4024
House Human Services Committee
March 16, 2011

Good morning Chairman Weisz and committee members. My name is Connie Hofland. I represent the North Dakota Dietetic Association. I am an attorney here in Bismarck and am also a registered dietitian. I am here today to speak in support of Senate concurrent resolution 4024.

The North Dakota Dietetic Association represents about 300 registered dietitians in North Dakota; we are the state affiliate of the American Dietetic Association, the largest organization of food and nutrition experts with 70,000 members. Registered dietitians have the unique combination of health and food knowledge that enables us to translate health recommendations into what we should eat.

Sodium is an essential nutrient and is needed by the body in relatively small quantities. But pretty much all of us in this state, and this country, consume more sodium than we need. The estimated average intake of sodium for Americans is approximately 3,400 mg per day. The current recommendation, included in the newest Dietary Guidelines for Americans that were just released last month, is we should reduce our sodium intake to less than 2,300 mg or 1,500 mg per day depending on age and other individual characteristics.

Usually, the higher your sodium intake is, the higher your blood pressure is. A strong body of evidence in adults documents that as sodium intake decreases, so does blood

pressure. Keeping blood pressure in the normal range reduces the risk of cardiovascular disease, congestive heart failure, and kidney disease. Heart disease is the number one cause of death in North Dakota; stroke is number six.

Here are some suggestions on how to reduce sodium:

- Read the Nutrition Facts label for information on the sodium content of foods and purchase foods that are low in sodium.
- Consume more fresh foods and fewer processed foods that are high in sodium.
- Eat more home-prepared foods, where you have more control over sodium, and use little or no salt or salt-containing seasonings when cooking or eating foods.
- When eating at restaurants, ask that salt not be added to your food or order lower sodium options, if available.

Of course, another way to reduce sodium intake, is to eat less food – because sodium is found in a wide variety of foods. In fact, that is the first tip in the new dietary guidelines to help us translate the Dietary Guidelines into our lives:

1. Enjoy your food, but eat less.
2. Avoid oversized portions.
3. Make half your plate fruits and vegetables.
4. Switch to fat-free or low-fat (1%) milk.
5. Compare sodium in foods like soup, bread, and frozen meals – and choose the foods with lower numbers.
6. Drink water instead of sugary drinks.

Given the current U.S. marketplace, it is challenging to meet even the less than 2,300 mg recommendation; fewer than 15 percent of Americans do so currently. But, we have to keep trying because of the health impact. This study is one way to help the ongoing effort to keep an eye on sodium content of food purchased and come closer to making the sodium intake recommendations, and the resulting health benefits, a reality.

We urge a do pass. Thank you.