Prepared by the North Dakota Legislative Council staff

February 2, 1999

TOBACCO SETTLEMENT PROCEEDS - ADDITIONAL INVESTMENT INCOME

The schedule below provides an estimate of the tobacco settlement proceeds to be received by the state and projects the additional income that could be earned on the common schools trust fund if 50 percent of the proceeds is deposited in that fund. Total assets of the common schools trust fund as of November 1998 were $446,492,962.

Year	Estimated Tobacco Settlement Proceeds	50% Deposited in Common Schools Trust Fund	Cumulative Amount Deposited in Common Schools Trust Fund	Additional Investment Income Projected to Be Generated\1	Portion of Income Reinvested to Principal\2	Cumulative Increase to Fund Principal From Settlement Proceeds and Reinvested Income	Estimated Additional Income for Distribution to Schools
1999	$8,784,331	$4,392,166	$4,392,166				
2000	23,467,889	$11,733,945	$16,126,111	$483,138	$219,586	$16,345,697	$263,552
2001	25,341,550	$12,670,775	$28,796,886	$1,798,027	$817,203	$29,833,675	$980,824
2002	30,427,805	$15,213,903	$44,010,789	$3,281,704	$1,491,534	$46,539,112	$1,790,170
2003	30,715,772	$15,357,886	$59,368,675	$5,119,302	$2,326,723	$64,223,721	$2,792,579
2004	25,635,606	$12,817,803	$72,186,478	$7,064,609	$3,210,865	$80,252,389	$3,853,744
2005	25,635,606	$12,817,803	$85,004,281	$8,827,763	$4,012,218	$97,082,410	$4,815,545
2006	25,635,606	$12,817,803	$97,822,084	$10,679,065	$4,853,635	$114,753,848	$5,825,430
2007	25,635,606	$12,817,803	$110,639,887	$12,622,923	$5,737,119	$133,308,770	$6,885,804
2008	26,144,365	$13,072,183	$123,712,070	$14,663,965	$6,664,772	$153,045,725	$7,999,193
2009	26,144,365	$13,072,183	$136,784,253	$16,835,030	$7,651,521	$173,769,429	$9,183,509
2010	26,144,365	$13,072,183	$149,856,436	$19,114,637	$8,687,603	$195,529,215	$10,427,034
2011	26,144,365	$13,072,183	$162,928,619	$21,508,214	$9,775,483	$218,376,881	$11,732,731
2012	26,144,365	$13,072,183	$176,000,802	$24,021,457	$10,917,752	$242,366,816	$13,103,705
2013	26,144,365	$13,072,183	$189,072,985	$26,660,350	$12,117,129	$267,556,128	$14,543,221
2014	26,144,365	$13,072,183	$202,145,168	$29,431,174	$13,376,469	$294,004,780	$16,054,705
2015	26,144,365	$13,072,183	$215,217,351	$32,340,526	$14,698,769	$321,775,732	$17,641,757
2016	26,144,365	$13,072,183	$228,289,534	$35,395,331	$16,087,178	$350,935,093	$19,308,153
2017	26,144,365	$13,072,183	$241,361,717	$38,602,860	$17,545,000	$381,552,276	$21,057,860
2018	29,295,743	$14,647,872	$256,009,589	$41,970,750	$19,075,706	$415,275,854	$22,895,044
2019	29,295,743	$14,647,872	$270,657,461	$45,680,344	$20,761,716	$450,685,442	$24,918,628
2020	29,295,743	$14,647,872	$285,305,333	$49,575,399	$22,532,019	$487,865,333	$27,043,380
2021	29,295,743	$14,647,872	$299,953,205	$53,665,187	$24,390,827	$526,904,032	$29,274,360
2022	29,295,743	$14,647,872	$314,601,077	$57,959,444	$26,342,567	$567,894,471	$31,616,877
2023	29,295,743	$14,647,872	$329,248,949	$62,468,392	$28,391,884	$610,934,227	$34,076,508
2024	29,295,743	$14,647,872	$343,896,821	$67,202,765	$30,543,657	$656,125,756	$36,659,108
2025	29,295,743	$14,647,872	$358,544,693	$72,173,833	$32,803,007	$703,576,635	$39,370,826
Beyond 2025			$358,544,693	$77,393,430	$35,175,314	$738,751,949	$42,218,116
Total	$717,089,365						

\1 Representatives of the Board of University and School Lands estimate earnings on the common schools trust fund of 11 percent per year.

\2 Representatives of the Board of University and School Lands indicated that the policy of the board is to reinvest a portion of the annual earnings of the common schools trust fund to the principal of the fund. The amounts shown here assume that annual earnings equal to 5 percent will be reinvested and the other 6 percent estimated

to be earned on the fund will be distributed.

State of North Dakota

OFFICE OF THE GOVERNOR
600 E. BOULEVARD – GROUND FLOOR
BISMARCK, NORTH DAKOTA 58505-0001
(701) 328-2200
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EDWARD T. SCHAFER
GOVERNOR

March 14, 1997

Bobbie Berkowitz
Deputy Program Director
University of Washington
School of Public Health & Community Medicine
6 Nickerson, Suite 300
Seattle, WA 98109

RE: Kellogg/Robert Wood Johnson Foundations Turning Point Grant

Dear Ms. Berkowitz,

I hereby designate the North Dakota Department of Health as the official agency to coordinate the application process for the Turning Point grant in the State of North Dakota. In addition to this delegation, I would like to express my strong support of strategic planning for the future of public health and the delivery of public health as a part of the continuum of health care in the State of North Dakota.

During my 'State of the State' address, I said the following:

"In the face of sweeping changes in health care delivery and insurance, we should re-assess our public health system and make sure we are channeling appropriate resources toward prevention and maintenance of good health in our people. Our current system has served us fairly well, but it is loosely coordinated, duplicative and horribly expensive.

"Studies prove that public health initiatives are the primary reason people live longer today than in the past. Improved sanitation, immunization, contagion control, and other prevention efforts have done more to increase human life span than all of today's impressive medical advancements.

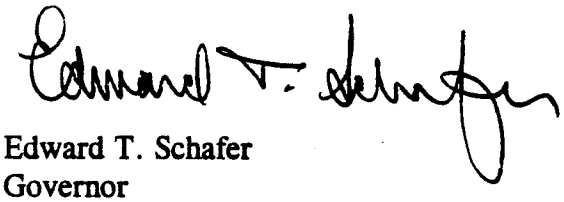
"I am asking the Health Department to develop a strategic plan for the future of public health in North Dakota. We will involve local health units, health care providers, academic institutions and the public to construct a coordinated approach for promoting long-term health and wellness in our citizens as no other state is doing.

"I will not be leading legislators on a run around the capitol as I am prone to do myself during the noon hour. But I will offer to communities around this state my help and participation in your efforts to promote fitness and well being."

I think it is imperative that in this age of consolidated services, increasing managed care, and especially looking at the rural and frontier nature of the population in the State of North Dakota, that we use our resources extremely efficiently and appropriate planning is a key to this.

I know that Dr. Rice has already been in contact with multiple potential state partners. There has been a great deal of interest on the state and local level. I hope that this grant is appropriately funded for the State of North Dakota so that we may continue our planning activities.

Sincerely,



Edward T. Schafer
Governor

Fifty-fifth
Legislative Assembly
of North Dakota

HOUSE CONCURRENT RESOLUTION NO. 3030

Introduced by

Representatives Svedjan, Stenehjem, R. Kelsch, Glassheim, Price

A concurrent resolution directing the Legislative Council to study the development of a strategic planning process for the future of public health in this state.

WHEREAS, the well-being of the residents of this state relies on a strong, effective, and efficient health care system; and

WHEREAS, health care costs are a concern of the Legislative Assembly and the residents of this state; and

WHEREAS, public health has played a significant role in the improvement of the health status of North Dakotans; and

WHEREAS, it is necessary to transform and strengthen public health in order to respond to the challenges of the 21st century; and

WHEREAS, the Governor of this state has encouraged strategic planning for the future of public health in this state; and

WHEREAS, this strategic plan should include local public health departments, health care providers, academic institutions, and the public in order to construct a coordinated approach for promoting long-term health and wellness in the residents of this state;

NOW, THEREFORE, BE IT RESOLVED BY THE HOUSE OF REPRESENTATIVES OF NORTH DAKOTA, THE SENATE CONCURRING THEREIN:

That the Legislative Council study the development of a strategic planning process for the future of public health in this state, and

BE IT FURTHER RESOLVED, that the Legislative Council report its findings and recommendations, together with any legislation required to implement the recommendations, to the Fifty-sixth Legislative Assembly.

TURNING POINT:

Collaborating for a New Century in Public Health

Letter of Intent

submitted by

The North Dakota Department of Health

March 1997

Table of Contents

Application Contact

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North Dakota Department of Health
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Building on Local Partnerships

Bismarck-Burleigh Nursing Service
Serves: Burleigh County
Headquarters: Bismarck, North Dakota

Central Valley Health Unit
Serves: Logan and Stutsman Counties
Headquarters: Jamestown, North Dakota

City-County Health Department
Serves: Barnes County
Headquarters: Valley City, North Dakota

Custer District Health Unit
Serves: Grant, Mercer, Morton, Oliver and Sioux Counties
Headquarters: Mandan, North Dakota

Fargo Cass Public Health
Serves: Cass County
Headquarters: Fargo, North Dakota

First District Health Unit
Serves: Bottineau, Burke, McHenry, McLean, Renville, Sheridan and Ward Counties
Headquarters: Minot, North Dakota

Grand Forks Public Health Department
Serves: Grand Forks County
Headquarters: Grand Forks, North Dakota

McIntosh District Health Unit
Serves: McIntosh County
Headquarters: Ashley, North Dakota

Southwestern District Health Unit
Serves: Adams, Billings, Bowman, Dunn, Golden Valley, Hettinger, Slope and Stark Counties
Headquarters: Dickinson, North Dakota

Spirit Lake Sioux Nation
Serves: Spirit Lake Sioux Tribe
Tribal Headquarters: Fort Totten, North Dakota

Turtle Mountain Band of Chippewa
Serves: Turtle Mountain Chippewa Tribe
Tribal Headquarters: Belcourt, North Dakota

Upper Missouri District Health Unit
Serves: Divide, McKenzie, Mountrail and Williams Counties
Headquarters: Williston, North Dakota

Wells County District Health Unit
Serves: Wells County
Headquarters: Fessenden, North Dakota

North Dakota at a Crossroads: An Executive Summary

North Dakota stands at a crossroads in the delivery of public health to our citizens. While those closest to the process see the need for change, the magnitude of this task can be overwhelming. A simple tweaking of the way we provide services won't solve the problem; instead, a complete examination of what we do and why we do it is in order.

The North Dakota Department of Health is up to this challenge. Known as an agent of change in our state, the department recently led efforts for incremental health care reform which resulted in small group reform, better data collection and expansion of Medicaid coverage. By partnering with the Insurance Commissioner, the department helped to develop the state changes necessary for implementation of the Health Insurance Portability and Accountability Act. Strategies for improvement in the state's handling of long-term care activities are being developed in cooperation with the Department of Human Services.

Participation in the *Turning Point: Collaborating for a New Century in Public Health* grant program would make possible the most comprehensive strategic development and implementation process ever undertaken by our state's public health system. This grant opportunity comes at the same time Governor Edward T. Schafer has called upon the North Dakota Department of Health to develop a strategic plan for the future of public health in our state.

The process already has begun. The dialogue and planning that have gone into preparation of this Letter of Intent have been an important first step toward affecting change. The state health department, local public health departments, tribal program leaders, and key public and private sector partners have begun development of a "blueprint" for change.

The strategic planning process proposed in this document has generated a great deal of excitement among state and local partners. The consensus opinion is that this is a project whose time has come. All partners are committed to the development of a common vision of public health in our state, but we also realize our goals are ambitious. The financial support and guidance of the W.K. Kellogg and Robert Wood Johnson Foundations will help us assess our state's most important public health needs as we prepare to move into the 21st century.

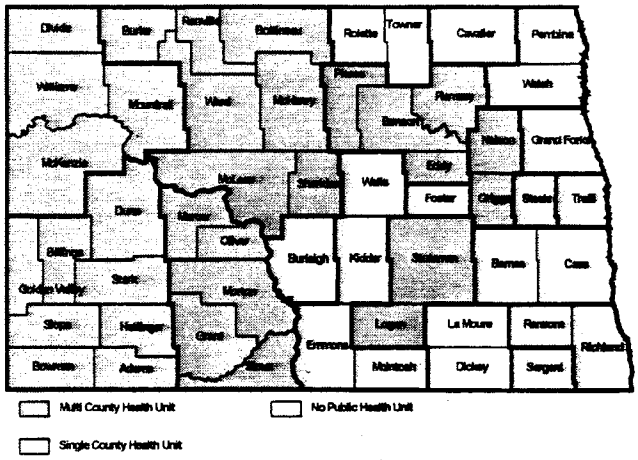
The first problems to be tackled are the assessment of continuity and effectiveness of public health services in a rural state. Redefining public health's mission, role and responsibilities will set the stage for a healthier future for our citizens.

As one local public health administrator said at a grant proposal planning meeting, *you can't do much planning when there's a fire in your waiting room.* This Letter of Intent explains how the North Dakota Department of Health plans to put out that fire.

Assessing North Dakota's Public Health Practices

The North Dakota Department of Health and multiple local public health departments make up the state's public health system. The Indian Health Service (IHS) provides health care for five Native American tribes, including public health services. This basic structure has been in place for about 50 years.

Local Public Health Units



Forty-nine of the state's 53 counties are served by local public health departments; these counties are divided into 24 single and multi-county health districts. Services vary, based on a combination of local needs as determined by community assessments, emergency response, and state and federal funding priorities. Few services are provided consistently across the state. For example, some local public health departments provide environmental services while others contract for these services with the state health department. Four counties have no formal public health structure at all. In these counties, the state health department provides services directly or serves as a consultant to private providers to support local public health functions.

Overall activities of the state health department are supervised by the State Health Council, a nine-member, governor-appointed advisory group. The health department provides community, county, regional and tribal assessments for many local public health departments. It also provides organizational and technical assistance, as well as program and funding services. The North Dakota Department of Health's mission statement reads:

> *"We, as public employees, are dedicated to the goal of assuring that North Dakota is a healthy place to live and to the belief that each person should have an equal opportunity to enjoy good health. To accomplish this mission, we are committed to the promotion of healthy lifestyles, protection and enhancement of the environment, and provision of quality health care services for the people of North Dakota."*

The North Dakota Department of Health is divided into four sections:

Health Resources serves a licensing and quality control function for hospitals, nursing homes, home health agencies and hospice programs. They also manage the state emergency medical services program.

Preventive Health provides vaccines, disease control, restaurant inspection, sexually transmitted disease monitoring, maternal and child health programs, Women, Infant and Children (WIC) services, public health laboratory services, and health promotion and education programs in tobacco control, cancer control, cardiovascular disease prevention and school health.

Environmental Health manages Environmental Protection Agency (EPA) programs in the state. Air, water, solid and hazardous waste, radiation, municipal water and sewage treatment, and laboratory functions are part of this section.

Administrative Services provides personnel and accounting support to the health department and manages vital statistics and health information systems, as well as the state crime laboratory.

The budget for the state health department is determined on a biennial basis; legislative sessions are held in odd-numbered years. The current two-year budget is $78 million, and the proposed budget for 1997-1999 is $82 million. About 70 percent of the department budget comes from federal funding with the balance from state general funds and fees. Local public health departments are funded by federal, state and local monies.

The North Dakota private health care system is predominantly fee-for-service. Ninety percent of the population is covered by some form of private or government health care coverage, with managed care comprising only 2 percent of the health care market.

Blue Cross Blue Shield of North Dakota, the dominant insurer, covers more than 70 percent of the privately insured. It now offers Preferred Provider Organization (PPO) and Exclusive Provider Organization (EPO) managed care products in some areas. Many rural North Dakotans, however, currently do not have access to these managed care options.

Medicaid covers about 10 percent of the population, with most enrollees receiving care through a primary care case management waiver. Medicaid is in the process of implementing a single-county pilot capitated care arrangement with a North Dakota managed care organization.

IHS, private insurance and Medicaid provide health care for the 4 percent of North Dakotans who are Native American. These programs are predominantly federally funded, thus

the four reservations and one service area have direct relationships with the federal government. North Dakota's Native Americans often are not well served by the state public health system due to poor coordination of services and historical, financial and cultural differences. Health statistics among Native Americans have not kept pace with the rest of the state.

The private health care sector is composed primarily of large medical provider groups; 85 percent of the state's physicians practice within seven such groups. Most of these provider groups maintain close hospital affiliations, and many have networks that extend from North Dakota's urban areas into the rural communities. These outreach services are essential because no physicians reside within 13 of the state's 53 counties. The North Dakota Department of Health provides the private sector with consulting services in regard to disease outbreaks and recommendations for treatment protocols. The department also supplies immunization information and vaccine.

Relationships between the private sector and local public health departments vary greatly. Some have no connection, while Fargo Cass Public Health is located in the same facility as a community health center and family practice residency training program. Some rural local public departments and hospitals collaborate on community health planning.

The University of North Dakota (UND) School of Medicine and Health Sciences places heavy emphasis on primary care. It graduates one of the highest percentages of family medicine practitioners in the country. The school supports residency programs in family medicine, internal medicine, psychiatry and surgery, placing these residents in community hospitals across the state.

The state health department and the UND medical school are closely affiliated. The medical school's Center for Rural Health provides contract services for the health department. A joint annual meeting on rural and public health is held each year. UND Family Practice Center residents gain hands-on experience in public health through rotation in the North Dakota Department of Health, family planning programs and other public health programs.

In cooperation with Blue Cross Blue Shield of North Dakota, the state health department has constructed a North Dakota Immunization Information System (NDIIS). This partnership connects state and local public health departments and the state's private health care providers, allowing each to enter and receive immunization and insurance information, e-mail and bulletins.

The Proposed Project

This grant would provide valuable opportunities for our state -- opportunities to reassess the needs of 640,000 people spread out over 70,000 square miles. Public health delivery in such a rural setting poses many unique challenges. These challenges drive our strategic development process. When this process is complete, three key objectives will be attained:

1. **A summary of services currently provided** by local public health departments and public health-related agencies in North Dakota, as well as in private sector health care, will be developed. Assessment of the current status is an essential building block of the strategic planning process.
2. **A list of basic public health services that should be provided** in all counties will be completed.
3. **A plan to provide these basic services** will be formulated. This plan will be presented to the health care community and the "grass roots" population of our state, then modified through a facilitated group process to achieve general consensus. The plan will have two components -- implementation and legislation:
   A. Implementation plan. This plan will be designed to coincide with legislation, and key activities will be identified and prioritized. Implementation plans will be developed, and a timeline will be established.
   B. Legislation. It is anticipated that legislative changes will be needed to modify the way services are delivered and funded and to make public health activities more uniform across the state.

State and local partners will provide guidance and input throughout the planning process. But these innovative partnerships will not end when the planning process is complete. Sustained relationships among these stakeholders will result in a healthier future for the citizens of our state. Overall objectives of the strategic planning process will include improved consistency of services, better access to the health care system and improved health outcomes. The emphasis will be on public health core functions and prevention. Changes in funding mechanisms may be required in order to accomplish these objectives. Placing resources on the basis of needs assessment may be more appropriate, as well as consistent with future block grant funding activities.

North Dakota's Readiness: Preparing for the 21st Century

Governor Schafer enthusiastically supports this strategic planning process. In his "State of the State" address before the combined legislative session Jan. 10, 1997, he said:

> *"I am asking the health department to develop a strategic plan for the future of public health in North Dakota. We will involve local public health departments, health care providers, academic institutions and the public to construct a coordinated approach for promoting long-term health and wellness in our citizens as no other state is doing."*

The development of a shared vision to fulfill the governor's mandate has begun. It includes enhanced dialogue among the stakeholders in this process. Local public health departments, state agencies, tribal program leaders, the UND medical school and health organizations statewide are beginning to see the future of our health care system through one another's eyes. The governor has opened new doors to collaboration, inviting our state to take the lead in creating the nation's most effective public health care system.

To achieve these goals and objectives, an eight-step process is proposed:

1. A partnership of people and organizations interested in public health will be convened. These partners will be the coordinating force of the planning process.
2. An assessment of current public health services will be conducted. Input will be sought from the American Public Health Association, and comparisons to national standards will be made. A comprehensive list of current and potential services will be developed. A ranking system for the provision of these services will be formulated and reviewed by the partners.
3. On-site assessments will be conducted at each of the local public health departments.
4. A list of basic services will be developed, incorporating health statistics and community assessments.
5. Input on the list of basic services will be sought through surveys, community meetings and focus groups. Included will be public health providers and clients, private health care providers, and local and state government entities.
6. State partners will use information gathered in steps two through five to develop a draft plan for the restructuring of public health. This will be done by facilitated discussion, subcommittee work and consultation. Again, input from key audiences will be sought.
7. Implementation plans and legislation will be developed with community and provider input.

8. The implementation plan and resource documents will be activated through the State Health Council and Governor Schafer.

Timeline*

Because North Dakota's biennial legislative sessions are held in odd-numbered years, much of the health department's strategic planning process must be completed in one year in order to draft proposed legislation for the 1999 legislative session.

A brief overview of the timeline planned to accomplish this ambitious task includes:

January 1998: Assemble state partners for an overview of the project.

February through March 1998: Assessment of public health services will be conducted.

May through July 1998: Conduct site visits. Each visit would include the project coordinator, a representative of the state partners and the state health officer or an appointee closely related to this project. Input will be sought through surveys, focus groups and community meetings.

August 1998: Conduct a two-day retreat for all state partners. Results from the site visits and research tools will be reviewed. A summary of current services will be discussed, and a list of basic services will be developed. An initial plan for the restructure of public health will be drafted.

September and October 1998: Present plan to the health care community and to the citizens of North Dakota through a series of public forums. Revisions will be made according to their input.

November 1998: Break state partners into subcommittees to draft legislation, prioritize projects and develop the restructuring plan. Several meetings will be held.

December 1998: Reconvene state partners and present subcommittee work. A consensus for the future of public health in the state should be reached at this meeting. This plan will be presented to Governor Schafer and the State Health Council.

January 1999: Present legislation through legislators on the steering committee.

* *This is an ambitious plan, but we believe it is attainable within this time frame. However, development of a highly effective public health system is our top priority, and legislation will be delayed until the 2001 legislative session if necessary.*

Advancing Public Health Performance

The success of this strategic planning process will be defined by the following outcomes, which are critical to the future of North Dakota and the health of its citizens:

The state health department's mission will be emphasized. (See Page 4.) Equal opportunity to enjoy good health will be enhanced by the provision of a basic set of public health services in all 53 counties.

Efforts will be coordinated. Eliminating any duplication of efforts will result in more efficient use of limited resources. Existing resources then will be redirected to meet high-priority public health needs.

Evaluation will be conducted. An anticipated outcome is improvement in the health of North Dakotans. An environment is envisioned in which all citizens have access to services, as well as health promotion and prevention activities. Various indicators will be determined and used to measure our success.

Strengthening Relationships Between State and Local Health

Enhanced empowerment of the local public health departments by the state health department will be critical to strengthening the public health infrastructure.

This empowerment will include:

- Encouraging more direct involvement of local partners in decision-making processes;
- Providing training, resources, technical support and evaluation to enhance the efficiency of local operations; and
- Providing analysis and interpretation of health data to assist local partners in the development of priorities and needs assessments.

In turn, local public health departments will:

- Provide local community recommendations to the state's ongoing planning process;
- Determine the best way to deliver the newly defined core services; and
- Provide detailed reports and evaluation of their work.

Emphasis will be placed on meeting local objectives while maintaining state goals. Local public health departments must have the autonomy to address local needs; more decision-making responsibilities should rest at the local level.

Close communication between state and local public health departments will ensure that public health functions are carried out effectively and that comparable services are provided statewide. The clear definition of roles and expectations will result in a strengthened public health infrastructure.

BISMARCK-BURLEIGH NURSING SERVICE

COLLABORATING FOR A NEW CENTURY IN PUBLIC HEALTH

TITLE: Service Coordination for Vulnerable Adults.

I.

GOAL: Develop a community health improvement plan to enhance and ensure coordination of services to vulnerable adults.

OBJECTIVES: Coordinate with agencies that serve disadvantaged, uninsured, and underinsured, and underserved as well as incapacitated, neglected, and abused adults; to identify the risk factors and necessary interventions.

POTENTIAL ACTIVITIES:

1. Organizational meetings will be held with partners such as social services, public administrator's office, senior center outreach workers, police and sheriff departments, West Central Human Service Center, Bismarck Environmental Department, Community Action, Aging Services, private agencies, Native American Service Center (Peace Pipe), and social workers form the private sector, as well as their physician or the Health Officer.

2. A project consultant will be selected and/or hired for this future position. The consultant will coordinate meetings and consult with the identified agencies, family, clergy, guardian/conservator, or any other significant person of the vulnerable adult.

3. The expectations of the proposed process will be:

   A. to improve access to community services;
   B. to provide collaboration and referral of needed community services;
   C. to overcome identified barriers;
   D. to develop viable interventions and positive effective outcome strategies;
   E. to advocate strengthening legislative issues that affect the vulnerable adult;
   F. to advocate quality of life;
   G. to determine impact on rate of institutionalization;
   H. to ensure quality assurance of long term case management.

ANTICIPATED FINANCIAL/IN-KIND SUPPORT:

1. For Bismarck-Burleigh Nursing Service - In-kind please see budget page attached.

II.

The accountability and decision-making structure will be managed through the members through collaborative efforts of the partners.

III.

ESTIMATED TIME FRAME:

1. Within the first six months of receiving the proposed W.K. Kellogg and The Robert Wood Johnson Foundation Grant, this agency will have the following in place:

   A. project coordinator assigned;
   B. consultant hired;
   C. local partnership organized;
   D. networking meetings with partners scheduled according to partnership's identified guidelines;
   E. system for data collection identified.

2. Within the next two to three years, the following will be accomplished:

   A. actively involve the private and public community partners with identifying the vulnerable adult population, i.e., advocate partners on criteria for referral;
   B. identify what the barriers are for quality care for this population
      i) develop viable interventions
      ii) develop positive effective measurable outcome strategies
   C. implement a system of coordinating and networking to provide quality services for vulnerable adults;
   D. collect outcome statistical data for identifying the vulnerable adult population in the community and the effectiveness of the proposed system.

IV.

EDUCATION AND EXPERIENCE OF PROJECT DIRECTOR:

Doris Fischer is an R.N. with a Bachelor of Science Degree with 14 years of hospital experience and 27 years of public health experience.

KELLOGG FOUNDATION
TURNING POINT GRANT PROPOSAL

Section I:

Central Valley Health Unit is applying for a grant from the Kellogg Foundation to reduce risk behaviors in the youth of our community through the development of the Asset Building Program in Jamestown, North Dakota. Central Valley Health Unit is the Public Health Department, which serves Stutsman and Logan counties in South Central North Dakota. The population for this area is 25,088, with the major population center being in Jamestown whose population is approximately 16,0000. Jamestown is the community where we will begin the Asset Building Program. Eventually we plan to expand this program to our entire service area. The square mileage of our two county area is 3,312.

Assets are protective factors and the more assets youth have the less likely it is they will be involved in risk behaviors, such as alcohol use, sexually activity, violence, or suicide. Building assets requires a unified community effort and requires the involvement of key players from businesses, church groups, school, parents, professional agencies, and organization.

This need was identified because of a high teen usage rate of tobacco and alcohol, low percentage of teens involved in regular physical activity, high rate of perceived poor body image in teens, increasing percentage of teens drinking and driving, and a high percentage of students carrying weapons and being involved in physical fighting. These statistics are indicated in the North Dakota Youth Risk behavior survey results of 1995.

If we received this grant, we plan to develop a steering committee and structure as defined in Section II, which will involve all interested community leaders. We will survey all students grades five through eleven to determine our current level of assets for youth. Based on the survey results, we will develop a plan to increase assets. Asset building is not a quick fix and will take a long term commitment to implement.

Based on this philosophy, Central Valley Health Unit proposes to secure a consultant to coordinate the development of the asset building project.

Our objectives for use of these funds would be:

- 1. Organize a community steering committee, whose function would be to assess the youth assets and needs within our community.
- 2. Determine the key public health functions and services necessary to address the current and future needs of the youth through 18 years in our community.
- 3. Develop an action plan to foster the building of assets for all youth, including youth with more severe problems. As needs are identified, the community as a whole will be made aware of the needs. The asset partners will develop an action plan to address the specific needs.
- 4. Improve community awareness of existing assets and the need to build additional assets to reduce risk behaviors and improve overall community health.
- 5. Increase community assets through local partnerships, including all health care systems

and other health related fields, which will result in a healthier community.

Central Valley Health Unit Board has verbally committed to this project. In addition to funds requested by this proposal, we will be requesting monies through Region VI Childrens Services Coordinating Committee. Key community leaders have indicated they will provide in-kind support for the project and may fund specific asset building projects.

Section II:

The decision making structure of the Asset Building Project will be a steering committee made up from representatives of each of the eight partner groups. These eight partner groups are:

- 1. Business - Chamber of Commerce, retail.
- 2. Health - clinics, public health, hospital, chiropractors, dentists, eye doctors.
- 3. Education - public and private schools and colleges.
- 4. Human Services - public and private agencies.
- 5. Service Clubs - Rotary, Optimists, Kiwanis, Sertoma.
- 6. Faith Communities - ministerial association, churches, youth groups, women's ministries.
- 7. Other Community Agencies - County Extension, Child Care Resource and Referral.
- 8. Coalition - Teen Pregnancy Prevention, Parent Education, and Tobacco.

Section III:

- 1. A consultant will be secured to assist with this project by February 28, 1998.
- 2. By June 1998, surveys and focus groups will be completed to determine risk behaviors of the youth in Jamestown.
- 3. By June 1998, local partner groups will be established and will have representation on the steering committee.
- 4. By June 1998, a steering committee will be formed to meet regularly.
- 5. By December 31, 1998, a community plan will be developed for the Jamestown community.
- 6. By December 31, 1999, the consultant will have met with all partner groups to develop a plan to address the specific risk behaviors.
- 7. By January 1, 2000, the consultant will begin to implement the community plan.
- 8. By December 31, 2000, a repeat Youth Survey will be completed to determine effectiveness of the plan.

Section IV:

Sharon Unruh, Project Director, has 27 years experience in public health and has served as its administrator since 1973. She has a bachelor's degree in nursing and has extensive knowledge and expertise in strategic planning and is very active in community projects. Her address is 310 10th Street SE, P. O. Box 880, Jamestown, ND 58402-0880, 701-252-8130.

City-County Health Dept-District Unit

BARNES COUNTY COURT HOUSE
230 4th Street NW Room 102
Valley City, ND 58072

Telephone 701-845-8518
FAX 701-845-8542

CERTIFIED HOME HEALTH AGENCY
PUBLIC HEALTH SERVICES
SERVING BARNES COUNTY

KELLOG FOUNDATION TURNING POINT GRANT: LOCAL PARTNERSHIP SECTION OF THE TURNING POINT COLLABORATING FOR A NEW CENTURY IN PUBLIC HEALTH PROGRAM

The title of our project is: **Healthy Communities, Healthy Youth: Building Assets in Youth**

Barnes County, located in eastern North Dakota, has a population of approximately 12,700. The county seat, Valley City, has a population of 7,300. Agriculture is the primary economic resource for the county.

City-County Health Department is a single county health district which provides an extensive variety of public health services. The executive director of the agency is Marcy Grant. She has 30 years of nursing experience, is a nurse practitioner, and has been in her position for 8 years. She has extensive training and experience in the coordination of childrens programs. She is involved in a wide variety of community programs and sits on many boards. She works collaboratively with all area service agencies on an ongoing basis.

The planning and implementation of this project will motivate and empower individuals, organizations, and community leaders to join together in nuturing competent, caring and responsible children and adolescents. This will be accomplished through research, evaluation, resource materials, training and networking within the community team, and with the North Dakota State Health Department.

Local partners in this project are the public health unit, county social services, juvenile office, service clubs, states attorney's office, Valley City State University, the Barnes County Consortium (a coordinated program involving all county schools), area churches and the ministerial association, Chamber of Commerce, South Central Senior Services, Peer Facilities (youth leaders in the school) county extension office, Headstart, parent-teacher organization, law enforcement, local hospital, local clinic, the local newspaper, the daycare association, and individual lay community representatives.

In communities across America, including our own, we see the developmental infrastructure crumbling. Too few young people grow up experiencing the key ingredients for their healthy development. Thus, we are facing rising rates of teen pregnancy, school drop-outs, substance abuse, violence, and crime. We must change this! We must empower our youth and build within them, assets that will encourage them to engage in positive behaviors, such as volunteering, and succeeding in school. We must take action to promote in our youth the development of a positive self-esteem -- the development of the skills to become a successful and responsible adult.

We will develop guidelines to unite our community, to strengthen the assets in our youth.

By the end of year one we will:

* Develop and implement a steering committee.

* Identify needs and concerns among youth in our community.

By the end of year 2 we will:

* Shape a vision for our own community.

* Develop our plan of action from individual action to community-wide collaboration.

Year 3 will include the implementation of the action plan. We will have in place:

* Interactive group activities for youth led by peer facilitators.

* Specific youth programs implemented by a collaborative effort of service organizations (ie., health fair, bike rodeo, etc.).

* An integrated intergenerational faith community that will be catalysts and advocates for our youth.

* A unified school system involving daycares, elementary, junior high school and high school, and college students and staff that will build a bridge with parents and others in the community.

* An ongoing parenting program that will promote effective parenting and discipline styles.

* A unified interagency community team that will sponsor healthy and productive youth extra-curricular programs (ie., community service, volunteering).

* An active Advisory Committee that will:
  1. Continue to monitor the various groups to assure that the goals and objectives are being met on an ongoing basis;
  2. Coordinate various educational opportunities (ie., inservices, workshops, speakers, etc.) for all age groups.

* Active support groups, ie., Attention Deficit Disorder, single parenting, families with children with chronic health problems, families experiencing grieving.

We have the manpower and resources in our community to strengthen the assets in our youth - we have the ability to empower our youth to succeed. To do this, we MUST be a unified team. Kellog Foundation Turning Point funds will enable us to achieve this goal. We need to be a state partner to make this happen!

PUBLIC HEALTH AND THE COMMUNITY - Bringing New Life to an Old Partnership

Proposing Agency
Custer District Health Unit
210 2nd Ave. NW
Mandan, ND 58554

February 21, 1997

Custer District Health Unit intends to be a partner with the State of North Dakota in the redefinition of public health. Comprised of five counties in south-central North Dakota, our area includes a very large rural area, one city of 15,000, one Indian reservation, and several smaller towns.

We have formed partnerships already with the schools in our area, in the form of school health coalitions. We have also partnered with Sakakawea Medical Center in Hazen, a small rural hospital and clinic consortium. We are putting together a partnership with Medcenter One in Mandan, since our health officer is a doctor with Medcenter One. We have spoken with the Youth at Risk Task Force in Hazen, and are in the process of putting together a similar group in Mandan.

We propose to do the following things:

1. Form working groups with the above-mentioned groups. Partnership with Sakakawea Medical Center will also bring in community chamber, business, police, and senior citizen participation, due to a previous partnership with the hospital that was formed to accomplish similar ends related to managed care.

2. With our partners, define factors of morbidity and mortality that our cooperative effort could improve. This will require some planning help to obtain the needed data and to organize it.

3. Define and implement cooperative efforts to address the areas that the data points to being the greatest needs. Explore how our working together can improve and invigorate those efforts.

More specifically, preliminary meetings show that significant opportunities exist in our teenage

population for recovery of years of life lost. The data is still lacking, but our current working group thinks that a positive "asset building" project for the youth of our area is needed. Another significant factor affecting both quality of life and health care costs is the need for in home care of the elderly, with or without third party compensation for such care. The long-term savings of keeping these people out of nursing homes, coupled with the improvement in their perception of their quality of life when they stay at home, makes this area a likely winner in the joint redefinition of health.

Managed care has brought the hospitals into the arena of public health. In the interest of keeping their population out of the hospital, they want to learn from us how to prevent illness. We want to learn from them how to assess and motivate their population of prospective patients. The people of our area want us to approach the management of health care costs by keeping the patient healthy, rather than the mere capitation of payments and refusal of service as a cost containment measure. It is in our interest, and in the health care community's interest, to deliver on that expectation. The will to do so is there, on both sides of the aisle. We just need some organization. Custer District will commit portions of its Environmental Health Practitioners, nursing staff, agricultural health nurses and administration to this project as in kind match. Sakakawea Medical Center has committed the time of one R.N. to this project. We will work with the State Health Department planners to implement the project. After initial data gathering, we will contract for more planning help locally if it is needed. The time line for this project is as follows:

July 1997 to July 1998 - Form working groups, define roles in partnership with State. Use State planning help to define populations and data gathering instruments.

July 1998 to July 1999 - Gather morbidity and mortality data, analyze with help of State and local planners. Gain consensus on implementation and intervention strategies with partners.

July 1999 to July 2000 - Implement agreed upon strategies and begin the measuring of intervention success or failure.

The manager's address for this project can be found below. He is the Administrator of Custer District Health Unit and a Registered Sanitarian, in the employ of the District since 1977. Thank you for your consideration of our partnership in this project.

Keith Johnson, Administrator
210 2nd Ave. NW
Mandan, ND 58554 Phone 701-667-3370

OR

Keith Johnson, Administrator
Mercer County Courthouse
Stanton, ND 58571 Phone 701-745-3678

TURNING POINT PARTNERSHIP SECTION: FARGO CASS PUBLIC HEALTH

1. OBJECTIVES, POTENTIAL ACTIVITIES, PROPOSED PROCESS:

Our main goal with the Turning Point Program is to establish our role as a public health department within the Fargo/Cass community in relation to the state health department, local service providers and the public. Cass County is the most populous county and Fargo the largest metropolitan area in North Dakota, with a county population of 102,874 (16% of ND's population). As part of the Turning Point Program, we plan to meet the following objectives by the beginning of the year 2000:

1. Establish and promote a shared understanding of our role in the community with department staff and with the state health department.
2. Work with both public and private providers to establish clearly defined roles and supportive relationships
3. Enhance the public's knowledge and perception of public health functions and priority public health issues.

The above objectives will be accomplished by the following activities:

1. Establish shared understanding of our role within the agency and with the state health department:
   - Conduct an internal strategic planning process to establish agency priorities in relation to core public health functions
   - Continued evaluation of existing health promotion, protection and disease prevention efforts of our agency
   - Work with the state health department to identify priority public health services
2. Define roles with partners:
   - Work closely with current partners and pursue partnering efforts with key community organizations such as Project Health (a health research and planning organization serving Cass and Clay Counties) Clay County Public Health (Moorhead, MN) Region Five Children's Coordinating Committee (plans and coordinates children's services in a 5 county region), etc. in continuing the health improvement process for Cass County through research, planning and implementing plans to improve the community's health status.
   - Work toward clarifying roles with private/health service sector to avoid duplication and maximize efforts, particularly with the local federally funded community health center. (Family HealthCare Center)
   - Cass County is an area of rapid industrial and residential growth which increases environmental health challenges. Within our environmental services department, we will attempt to enhance current relationships and build on new relationships with partners in areas such as industry and agriculture to maintain our high environmental health standards.
3. Enhancing public's knowledge/perception of public health:
   - Involve the public in conducting primary research (e.g. focus groups) to further define priority public health issues and practical approaches to addressing these issues.
   - Educate public regarding service provider roles.

The above activities will be carried out in the following processes:

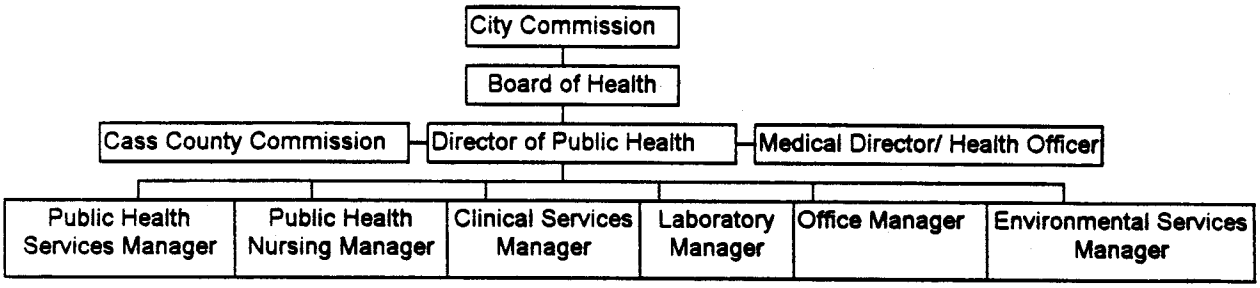
1. Internal strategic planning process will be conducted to identify agency organizational capacity strengths and weakness in carrying out the core functions of public health and establish plans to address priority weaknesses. Included in this process will be working with the state health department to identify priority public health services.
2. Work with partnership committee and the state health department to define priority public health issues and to develop action plans to address issues. This includes identifying areas of

service duplication, identifying underserved populations and addressing these issues by establishing agreements with local public and private providers

3. Build on 1996-97 community health improvement plan by continuing our involvement with Project Health. Specifically focus on gathering both primary and secondary data to fill gaps in 96-97 efforts. Based on data collection activities, design primary research objectives to further define priority public health issues for our community.

We expect that the process will greatly impact our role in the community, as we move from a generally program-specific, service oriented unit to concentrating on assurance through partnerships, continued assessment activities and policy development. We anticipate committing at least one half time staff person (currently employed) to coordinate the activities involved in this grant.

2. ACCOUNTABILITY/DECISION MAKING STRUCTURE



3. ESTIMATED TIMELINE

Internal Strategic Planning Process	June, 1998	Data Collection Process	July, 1998
Analysis and Planning	Dec., 1998	Implement Improvement Plans	Jan-Dec 2000
Establish Partnership Committee	June, 1998	Establish roles	June, 1999

4. QUALIFICATIONS AND EXPERTISE OF KEY STAFF

Cheryl Hagen, RN, MSN Public Health Services Manager/ Project Director
(701) 241-8193/401 3rd Ave N/Fargo ND 58102

For the past sixteen years, Ms. Hagen has worked in various community health settings such as school health, public heath, and occupational health, most recently as an agricultural health nurse. She has researched the effectiveness of public health promotion programs in the field of agricultural health and safety. She now oversees the public health services division which consists of Assessment/ Education, Nutrition, Immunizations/TB, Agricultural Injury, Cancer Control, Health Services to County Jail, and Health Care for the Homeless. She has a Masters in Public Health Nursing.

Dawn Pauls Assessment/Health Education Coordinator
(701) 241-8575/401 3rd Ave N/Fargo ND 58102

Ms. Pauls has been involved for the past year and a half in facilitating the Assessment Protocol for Excellence in Public Health (APEXPH) and community health improvement process in Cass County. She has coordinated several primary research efforts and had a substantial part in collecting, organizing and analyzing both secondary and primary data. She leads the agency Assessment Team and is an active member of the research team on Project Health. She has a Bachelor of Individualized Studies from the University of Minnesota.

FIRST DISTRICT HEALTH UNIT

Proposal to W.K. Kellogg Foundation

Please accept our letter of intent to the W.K. Kellogg Foundation to improve the performance of the First District Health Unit (FDHU) through strategic development and implementation processes.

The FDHU was organized in 1943 after enabling legislation was passed to allow for multi-county public health departments. The geographic area of the FDHU includes seven counties extending from the Canadian border south 125 miles to Wilton. The widest east-west area extends 130 miles from east of Willow City to west of Powers Lake on the northern tier. Twelve offices are located throughout the seven county area to serve a population of 89,206 people.

On February 20, 1997, the FDHU Board of Health took action and directed the Executive Officer to proceed with the development of a strategic plan based on the core functions of public health. The FDHU has established partners with several entities and will enlist others.

A partner in the proposed planning process will be the Garrison Community Hospital and Family Clinic, which represents a large Native American population and provides services to a nearby reservation. The Minot State University Rural Health Institute will serve as a partner as a resource of local health needs and risk behaviors. A primary partner of this proposal is the Region II Children's Services Committee (RCSCC). The RCSCC is a non-profit organization whose mission is to "support and develop community based services." Private and public providers of mental health services, Trinity hospital, Unimed hospital, public and private social service agencies, Minot State University, Job Service, business owners, and schools are presented on the RCSCC by both administrators and front line staff. Members of the RCSCC will be involved in the planning process which will allow FDHU to partner with most providers of health services, and representatives of advocacy groups from all age groups.

The Planning Process will involve six steps.

1. September 1997: A presenter will be hired to educate the FDHU staff and Board of Health on the core functions of public health and how they relate to health care reform and Healthy People 2000 objectives.

2. January 1998: The process of community assessment will take place. FDHU has the computer technology and software that allows us to generate data on the community

served by FDHU, and provide us information on risk behaviors; cost effectiveness, quality, and accessibility of health services; and effectiveness of intervention efforts.

3. June 1998: A Facilitator/Consultant will be hired to conduct planning sessions that would result in a strategic plan for FDHU. The planning sessions will include, but is not limited to Policy makers, Board of Health members, staff, representatives from agriculture, business owners, health care providers, mental health providers, and community representatives from each county served by FDHU. The plan will include goals, objectives, and action steps that will provide a work plan for the staff and Board of Health. Time lines and responsibilities will be assigned.

4. January 1999: The FDHU Board of Health will adopt the Strategic Plan and utilize it for public policy development, resource allocation, and staff development planning.

5. March 1999: A staff development plan will be implemented with the intention of training staff towards their new responsibilities as defined by the strategic plan.

6. October 1999: An evaluation process of the efforts of FDHU will provide accountability. The action steps in the strategic plan will be evaluated for process, outcome, and impact on community health. The Process Evaluation will demonstrate the conditions that existed before the plan was implemented, how the plan was implemented, and who was involved in the implementation. The Outcome Evaluation will demonstrate how the goals and objectives are measured. Measurable changes in knowledge, attitudes, skills, and behaviors will be identified. The Impact evaluation will demonstrate the long-term effect of the Plan on individuals and communities within the geographic area served by FDHU. The evaluation will include analysis of the data generated by the technology presently in place. A yearly review and revision of the plan will allow the Board of Health and staff to redirect their efforts based on an ongoing community assessment.

The Executive Officer of FDHU, Lisa Clute, will serve as the Project Director. Ms. Clute has been employed by First District Health Unit since 1994. She earned her B.S. degree from Minot State University in 1981. She has developed organizational strategic plans and facilitated and developed the RCSCC strategic plan for children and family services.

Ms. Clute may be reached at:

First District Health Unit
P.O. Box 1268
Minot, North Dakota 58702

Phone: (701)852-1376
Fax: (701)852-5043
E-Mail: lrclute@minot.ndak.net

Thank you for your consideration of this important project!

Turning Point Grant - Greater Grand Forks Community Partnership

In 1994, 100 representatives from 70 Grand Forks, North Dakota and Polk County, Minnesota (health and allied service) agencies worked collaboratively to complete a community wide health assessment. This area is the major population center in northeast North Dakota and northwest Minnesota. Based on this work a prioritized list of objectives, or community health needs, was developed that pointed to possible action steps that would be needed to address these concerns.

Conversations with key health organizations representing the city and county indicate that obstacles remain in developing strategies that are effective in addressing priority health problems. The lack of a responsible entity through which collaboration and implementation can be monitored was identified as one of the primary hurdles in successfully realizing the goals outlined in the Community Health Assessment. This void points towards the need to create a new partnership that will provide the oversight and responsibility to produce measurable results, and authority (internally) to direct partners to roles that are best suited to producing tangible results.

Community Partnership Objective

The objective of this effort is to develop a organization that is accountable for the preventive health outcomes of the community and provides the decision-making structure to address the logistical and organizational components inherent in disease prevention and health promotion. As such the organization will serve as an umbrella organization for all the member/partners. It will be able to provide entry points into the healthcare system regardless of an individual's social or economic status. In essence it will provide access to seamless healthcare access regardless of geographic location within the community. It will coordinate (and be accountable for) all activities in providing prevention education and outreach. It will work collaboratively with it's members to identify specific roles and responsibilities of each partner in providing "public health" related services.

The development of a community health cooperative is the turning point for the Greater Grand Forks community. This cooperative will build on the work completed in 1994 that identified priority health issues within the community and started to develop strategies to address these concerns. The cooperative will identify problems, implement action steps (prioritizing those issues that provide the most "bang for the buck") and conduct regular needs assessments. The cooperative will coordinate health service providers within the community - providing outreach and education within schools and businesses. This coordination will reduce overall costs of individual service providers by reducing duplication of services and guaranteeing consistent quality information to the public at large.

Greater Grand Forks Community Health Cooperative

The cooperative's mission will be to enhance the well-being of residents within Grand Forks County by providing quality, cost-effective disease prevention and health promotion services. An underlying mission will be to develop the best structure to ensure collaboration of all interested parties in determining the goals within the community. The cooperative will assume a leadership role within the community to ensure access to appropriate healthcare for all, and to support innovation and research methods to improve healthcare and its delivery.

To become a member of the Greater Grand Forks Community Health Cooperative, member/partners will be asked to participate by providing a membership fee ($200 annually) and an in-kind contribution (2 hours per month/24 hours annually) - in addition to existing individual budgets and programs. Sliding fees will be used for hardship cases. Fees will be used to produce educational and outreach materials on priority issues and offset costs of disease prevention and health promotion services. In-kind contributions will be used both in planning sessions and outreach opportunities. Again, by coordinating all preventive health activities, we hope to reduce costs by eliminating duplication of services.

Noting the level of investment on the part of the Cooperative's members, anticipated resources for this three year planning and implementation effort include $42,000 cash - to offset outreach efforts, program specific costs and implementation, and 5,040 hours of in-kind personnel time which will be used in the implementation of the health promotion activities of the Cooperative.

Members of the community will be asked to join the cooperative as non-voting members to ensure that the needs of the community at large are met. Residents may join through any recognized cooperative voting member. Input from the community will be integral in developing priorities and needs from within the community.

The organizational structure of the cooperative, governed by members and serving the community's needs, includes: a 7 member Board of Trustees, the members/voters, and the president/chair identified as the Director of the Public Health Department for Grand Forks County.

The Director of the Grand Forks Community Health Cooperative will be Donald Shields, MHA, CHE. Mr. Shields serves as the Director of the Grand Forks Public Health Department and is a board certified Healthcare Executive. Don's twenty years of proactive disease prevention and health promotion experience and expertise will provide the Cooperative the commitment of leadership required in this strategic development process.

Other community member/partners that have expressed interest in becoming active voting members of the Cooperative (and as such could serve on the Board of Trustees) include (select): Altru Health Systems, University of North Dakota School of Medicine, the UND Center of Rural Health, Northeast Human Service Center, Northern Plains Health Plan (an HMO), Valley Health and WIC, Grand Forks Rescue Mission, Grand Forks Public Schools, members of the faith community, the United Health Foundation and the Trail District Health Unit. These organizations, and 60 other primary and allied health service organizations within the County will provide the expertise, accountability and decision-making structure to successfully implement this program.

Year One efforts include defining the organizational structure of the cooperative, installation of the Board of Trustees, and reassessing priority health issues with member input. Based on this prioritization- action teams, with specific disease prevention and health promotion plans or mandates, will be implemented.

Year Two and Three efforts will include refinement of the organizational structure, continued assessment of priority health issues, and monitoring of successes. Additional recruitment of other community members (industry, business, education) will be a ongoing effort. These groups will provide additional insight into priority issues from within the community including agriculture (a mainstay of the local economy) and environmental protection.

McIntosh District Health Unit

County Assessment of Health Services

Proposal for Turning Point Grant

The McIntosh District Health Unit, serving the McIntosh County area (population 4,021), consisting of the communities of Ashley, Wishek, Zeeland, Lehr, and Venturia, is interested in forming a partnership with the N.D. Department of Health in meeting their goal of strategic planning for the future of Public Health. The Health Unit, established in 1991, now operating with only two and one-half county mills ($20,000), does not have the financial resources to conduct a county assessment of services available and needed by the people. Therefore, a limited amount of services are provided by the Health Unit. Also the residents of this rural county, primarily elderly, have limited access to the kind of services available in larger communities such as Bismarck, ND which is located 100 or more miles away.

Our objectives are to define the needs of this service area, determine whether these needs are being met, and implement programs to assure an optimal level of health for all residents, regardless of sex, race, or ability to pay. The objectives will be met through committee action involving the McIntosh District Health Unit, health care facilities, clinics, ambulance squads, schools, economic development organizations, county commissioners, extension services, social services, chamber of commerce, and farmers from this county. In addition to survey outcomes, specific areas to be addressed will be the lack of health educational classes offered, the lack of school nursing services, the lack of environmental services, and the lack of ambulance squad volunteers in this area.

Within the first six months, the committee will develop a community/county assessment to gather data regarding prior and current illnesses/injuries, resident's perception of health, desired services, existing programs, programs needed to generate comprehensive health, and what functions will be provided by public health. These functions will be coordinated with the N.D. Department of Health using "Healthy People 2000" as a guideline.

By the end of year one, the McIntosh District Health Unit will define core services needed, develop policies and implement health prevention, promotion, and protection services not offered by other health facilities in this area. An evaluation will be conducted at the end of the second and third years to determine the useage and perception of services provided and implement changes to programs to meet resident needs. Prior to the end of the third year, funds will be sought to continue any programs which were initiated under this grant.

The McIntosh District Health Unit will strive to obtain the following goals within the listed time-frame:

Time-Frame	Goal
October 1997 - April 1998	Committee meetings to develop survey
May 1998 - July 1998	Distribute surveys and gather data
August 1998 - October 1998	Analyze surveys
November 1998 - March 1999	Develop programs needed
April 1999 - October 2000	Implement programs needed
October 1999 - December 1999	Evaluate programs and change as needed
January 2000 - March 2000	Seek continued funding for programs
October 2000 - December 2000	Evaluate programs and change as needed

Support will be sought from the N.D. Department of Health for information and surveillance. The McIntosh County Courthouse will provide space and office equipment needed to coordinate the project as local matching funds.

The project will be coordinated by Twila Heinrich, RN/Administrator of the McIntosh District Health Unit, Box 25, Ashley, ND 58413, and may be reached by phone at work #(701)288-3957 or home #(701)374-5511. Qualifications for the position include Administrator of the Health Unit for the past year, Chief Financial Officer of the Ashley Medical Center for 10 years prior to that, a board member of the Region VI Children's Services Coordinating Committee, and also involved in local economic development projects in Ashley.

SOUTHWESTERN DISTRICT HEALTH UNIT
LOCAL PARTNERSHIP

Southwestern District Health Unit is a local public health agency serving the eight southwestern counties of North Dakota of Adams, Billings, Bowman, Dunn, Golden Valley, Hettinger, Slope and Stark, covering a rural area of approximately 10,000 square miles with a population of 41,175. County population densities present a unique problem in our region. For our eight counties, the population densities per square mile are as follows: Stark, 17.3; Adams, 3.2; Bowman 3.1; Hettinger 3.0; Golden Valley 2.1; Dunn, 2.0; Billings, 1.0; Slope 0.7. Health services will need to be provided in a manner that maximizes comprehensiveness and effectiveness for our citizens, many of which do not have convenient accessibility to health services. Because our average eight county per capita income is lower than the state average, limited financial resources make it difficult to obtain and retain needed health providers. The Unit's goal and mission is to provide a variety of programs and services that improve and/or maintain the health status of the general population through Community Health Nursing, Environmental Health and Nutrition Services. We are striving for healthy communities and have a commitment to promoting physical and mental health, preventing disease, injury and disability. To meet its commitment, the Health Unit already networks with many community agencies and would through this planning process plan to work with the following local partners: local hospitals, long term care nursing homes, health care professional groups, local university/school of nursing, Human Services, Social Services, local Chamber of Commerce, Job Service, local Region VIII Children's Services Coordinating Committee, local schools, Community Action Program, Extension Services, County Commissions, Legislators, and American Association for Retired Persons (local Aging Services agencies/coordinator).

Our local partnership envisions strengthened and new partnerships for our communities, assessing and redefining local public health roles and services, developing and implementing a local plan that furthers the public's health.

Our objectives, activities and processes are as follows:

1. Identify and convene local partners.
2. Assess current public health services at Southwestern District Health Unit and services related to public health that are provided in the communities of our eight counties to determine what is being provided to include similarities, scope of service, target populations and geographical coverage.
3. Utilize existing current needs assessment data and/or develop and conduct needs assessment where no assessment data is available to identify knowledge of existing services, perceived needs, priorities and access to services.
4. Analyze data from assessment identifying needs, priorities and develop a rank system for the level of provision of identified services.
5. Convene partners to develop a community based plan that redefines health promotion, health protection and preventive health care services and identifies potential providers and their duties and responsibilities.
6. Conduct community wide forums to solicit input on the plan.
7. Develop an implementation plan and evaluation process in cooperation with partners.
8. Implement plan.

Expectations from this process are that local partnerships will create enhanced lines of communication between agencies providing community health services. As a result of the process, the community based health promotion, health protection and disease prevention plan will empower the community to take responsibility for their health and will help manage the demand for health services. With declining available health care dollars, this process can help assure that funds are being utilized efficiently, responsibly and to the utmost benefit of the community. Local partnerships and the planning process will assure that the community has heightened awareness and knowledge of available health care services.

The local role is to initiate, facilitate and coordinate a comprehensive study and plan to improve and enhance health care services in cooperation and collaboration with local and state communities.

In kind contributions will be generated through local partnership commitments of time and travel costs to the local study and planning processes.

Southwestern District Health Unit will be accountable for initiating, facilitating and coordinating the comprehensive study and plan processes. The local Unit will work in conjunction with the State Health Department in the identification of minimal standards for public health. The decision making structure for our local partnership will be based on a consensus of the working group of partners who will, in turn, bring these decisions to each local partners' policy/decision making boards for action.

An estimated time line for our local partnership study and planning process is:

Year One: Convene partners and assess current public health services and develop and conduct a needs assessment process.
Year Two: Analyze assessment data, develop a community based plan and conduct community wide forums for input.
Year Three: Develop an implementation process, evaluation process and begin plan implementation.

Project Director: Carlotta Ehlis, Executive Officer, Southwestern District Health Unit, (701) 227-0171, 2869 Third Avenue West, Dickinson, ND 58601.

Carlotta Ehlis has been employed in Public Health at Southwestern District Health Unit since 1975 serving as Executive Officer for the District since 1991. She is an active member of the North Dakota Public Health Association and has been active in many community activities. She is a member of the Chamber of Commerce's Southwest Health Commission; AARP Community Council, Region VIII and Stark County Councils on Aging; Healthy Eight Community Council; Region VIII Children's Services Coordinating Committee and serves as Chairperson for the Health Subcommittee; a member of St. Joseph's Hospital Life Care Foundation Public Relations Committee; American Heart Association - Heart Walk and Stark County Emergency Management Team.

Healthy Start In North Dakota
Spirit Lake Tribal Site and surrounding region and cooperating tribal communities

Partnership in Public Health

The Spirit Lake Nation consists of 4,800 enrolled members. 400> families reside within a land base which is approximately 30 miles East to West and about 15 miles North to South with approximately 245,000 acres. The Reservation is located 110 miles west of Grand Forks and 15 miles south of Devils Lake.

The Spirit Lake Healthy Start site is one of the five Tribal sites within Healthy Start in North Dakota, Inc. (HSND) is a non-profit organization which promotes a statewide methodology and accountability system to individual tribal communities in their effort to reduce health risks which ultimately impact the health and well-being of Native American families.

The primary goal of this corporation is to utilize preventive strategies in a holistic manner to reduce disease and/or unhealthy environments that affect the health of Native American families living in rural and remote areas of North Dakota. Recognition is given to the necessity of maintaining mental, spiritual, emotional, and physical balance within individuals with collaboration across the nuclear family, extended family, tribe, and community.

Healthy Start brings a six-year history of inter/intra tribal collaboration through a shared vision in addressing health risk to families. Holistic prevention strategies must be utilized during this time of changing health care. The reason for including HSND in the state partnership is the fact this inclusion means all five tribal North Dakota sites are represented and a part of the planning process to improve health status of people in North Dakota.

The following are a list of objectives to improve health:

- Increase the number of people accessing health care.
- Increase positive health behaviors by decreasing unhealthy personal habits such as substance abuse or addiction, unhealthy eating habits and lack of exercise.
- Increase community education preventive health methods.
- Facilitate community identification of environmental health risks and development of methods to address the risks.

Replicate these objectives and activities in the other four HSND sites during the implementation phase following the planning phase.

Activities to accomplish our objectives:

- Collaborate with appropriate entities to identify persons in need of health care and methods to access care.
- Develop the strategies to address personal health behaviors, collaborating with key stakeholders in health care.
- Hold focus groups and forums within each of the tribal communities to identify barriers to access of health care.
- Develop and provide culturally appropriate education to address behaviors to improve unhealthy personal habits.
- Develop a tool to evaluate and monitor progress of our objectives.

The Healthy Start in North Dakota Board of Directors will provide management, governance, provide guidance to the implementation, tracking and monitoring progress and accomplishments. Local partnerships consists of the Board of Directors including representatives from the following: North Dakota State Department of Human Services; Legal Assistance of North Dakota; Tribal representation from Spirit Lake Sioux Tribe, Turtle Mountain Band of Chippewa, Standing Rock Sioux Nation, Three Affiliated Tribes, Trenton Indian Service Area; North Dakota Office of Indian Affairs, North Dakota Consensus Counsel, Northern Plains Healthy Start.

Other partners participating in the Consortium include: the North Dakota State Health Department, North Dakota Maternal & Child Health Department, Tribal Health Service Unit Directors, Tribal Chairman, Indian Health Service.

TIME LINE

- Complete meetings with health care providers to identify persons in need of access to health care by 4/1/98.
- Complete initial focus groups and community forums to identify barriers by 7/1/98.
- Complete development of educational components by 10/1/98.
- Complete strategy of Healthy Start in North Dakota plan including local partnership reviews by 10/1/98.
- Complete health plan by 1/1/99.
- Complete development of evaluation process by 1/1/2000.

Gloria Lefthand is the Northern Plains Healthy Start Coordinator for the Spirit Lake Sioux Nation. She is a licensed social worker and has been with the program since it began six years ago.

Upper Missouri District Health Unit
Divide, McKenzie, Mountrail, and Williams Counties, North Dakota

Partnerships in Public Health for the Twenty-First Century!

Looking to the twenty-first century with excitement, we health care professionals and other citizens in the four counties that comprise North Dakota's Upper Missouri District Health Unit (UMDHU) envision dramatic changes in health care with an emphasis on prevention. Those four counties cover 7,918 miles, 11 percent of North Dakota's total geographic area, and 37,432 people, 6 percent of North Dakota's population. From this rural environment we seek a future where people engage in more health promoting activities, where every citizen can access quality health care, and where the environment poses minimal risk to people's health.

As we in the public health sector change our emphasis from clinical services to population-wide approaches to health care, our objectives change to meet these new challenges. The objectives we developed create a list of lofty but attainable goals, reflecting our evolving public health focus.

- ✓ Reduce by 100% the number of people lacking access to health care.
- ✓ Diminish the environmental hazards of the agricultural, oil and reprocessing industries.
- ✓ Decrease personal risk behaviors such as smoking, physical inactivity, and overeating by 50% and increase positive health behaviors.
- ✓ Develop the leadership skills of health professionals.
- ✓ Increase innovative programs by encouraging visionary discussions and listening carefully to the needs of fellow citizens.

Activities provide the vehicle to realize our objectives. The activities listed below reflect that connection and highlight the need to continue, and expand, our partnerships with other health care providers and community members.

- ✓ Collaborate with the Departments of Health and Agriculture, the North Dakota State University Extension Service, and local farmers and ranchers to define environmental hazards, promote safe practices, and maintain on-going vigilance. Meet, set goals and create evaluation processes with energy extraction industry officials, the Department of Health, and Environmental Protection Agency representatives to clarify potential hazards and define the role of health care professionals from both the public and private sectors, in maintaining a safe environment.
- ✓ Develop public awareness campaigns that address personal risk behaviors. In cooperation with schools, provide comprehensive kindergarten through twelfth grade health curricula and practice sound health habits throughout the school systems.
- ✓ Work with the chambers of commerce, University of North Dakota-Williston, the North Dakota Extension Service, and health care providers to establish a formal health advocacy leadership program.
- ✓ Develop a series of workshops for health care providers to help retool for the twenty-first century and to generate the enthusiasm required to plunge into a changing and prevention-focused health delivery system.

The processes for our changing health care system will engage systems that may be new, or may take advantage of current systems that evolve to ever changing health care needs in our

communities.

- ✓ Establish focus groups in every community in our district. The six communities of 1,000 or more people will host focus groups to expand our information base regarding the health care needs of our citizens.
- ✓ Engage community forums to further develop the ideas of the focus groups. The periodic meeting of the forums will provide the on-going information essential to keep our health care services evolving, meeting the changing needs of our communities. A written plan containing the objectives, activities and partners involved in our district's health care system will be created based on the input of focus groups, community forums, and state guidelines.
- ✓ Working through the district's board of health, establish guidelines to promote collaboration that insures health care needs of every citizen in the four counties are met.
- ✓ Develop a policy making mechanism involving local public officials, private sector representatives and health care providers.
- ✓ Strengthen the current network of public and private health care providers and broaden their role as they respond to the population wide health care needs of our district.

The accountability for the efficacy of our system lies at the core of its impact in our communities. The district board of health will serve as the entity responsible for following the progress of health care in our communities, using the written plan developed as a measure of success and a tool to determine areas needing more attention. The review of progress will be on-going, with quarterly and annual reports of progress. The board of health will serve as the decision making structure, providing the guidance to adjust the district health care plan to meet the changing needs of our citizens.

The resources available to us to realize our goals include professional time, in-kind contributions and financial support. The UMDHU lies as the center of available resource, but is joined generously by local health clinics, hospitals, local media, private sector contributors, and service organizations. The extent of each participant's contributions will fluctuate with the status of the program and the resources each has available. Our public health unit currently works closely with other groups to serve our communities. The demands of the major shift in the provision of health care to our area outweigh the resources currently available, but each entity continues to provide assistance within their own fiscal constraints.

TIME LINE: Our estimated time line for our projects includes:

March 1, 1998	Completed initial series of focus groups and community forums Establishment of health network to draft health plan
September 1, 1998	Draft of District Health Plan
January 1, 1999	Completion of health plan, including review by forums and district board of health
July 1, 1999	Leadership and capacity building efforts implemented
January 1, 2000	Completed initial evaluation process

KEY STAFF:

Janice Trimmer serves as director of the UMDHU. She has a MS degree in Health Care Administration and over 20 years experience in health care administration in both the public and private sector. The UMDHU three key staff people, with a combination of over 60 years experience in public health, represent the professions of environmental health, nursing, and nutrition.

Healthy Start In North Dakota
Turtle Mountain Band of Chippewa Site and surrounding region and cooperating tribal communities

Partnership in Public Health

The project area exists within Rolette County and jurisdiction includes both Couture and Ingebretson Townships in the boundaries of the North Dakota, seven miles north of the Canadian Border. The total land base is on reservation land/46,080 square miles; trust land/33,835 square miles and taxable on reservation land/12,160 square miles. The land base of this rural area has an incredible diversity of climate, and distance between local Indian communities and health care facilities. Our population of enrolled members is now at a growing rate of 25,000> Indian people; 15,000 of which are living in the project area.

The Turtle Mountain Healthy Start site is one of the five Tribal sites within Healthy Start in North Dakota, Inc. (HSND) is a non-profit organization which promotes a statewide methodology and accountability system to individual tribal communities in their effort to reduce health risks which ultimately impact the health and well-being of Native American families.

The primary goal of this corporation is to utilize preventive strategies in a holistic manner to reduce disease and/or unhealthy environments that affect the health of Native American families living in rural and remote areas of North Dakota. Recognition is given to the necessity of maintaining mental, spiritual, emotional, and physical balance within individuals with collaboration across the nuclear family, extended family, tribe, and community.

Healthy Start brings a six-year history of inter/intra tribal collaboration through a shared vision in addressing health risk to families. Holistic prevention strategies must be utilized during this time of changing health care. The reason for including HSND in the state partnership is the fact this inclusion means all five tribal North Dakota sites are represented and a part of the planning process to improve health status of people in North Dakota.

The following are a list of objectives to improve health:

- Increase the number of people accessing health care.
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- Increase community education preventive health methods.
- Facilitate community identification of environmental health risks and development of methods to address the risks.

Replicate these objectives and activities in the other four HSND sites during the implementation phase following the planning phase.

Activities to accomplish our objectives:

- Collaborate with appropriate entities to identify persons in need of health care and methods to access care.
- Develop the strategies to address personal health behaviors, collaborating with key stakeholders in health care.
- Hold focus groups and forums within each of the tribal communities to identify barriers to access of health care.
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- Develop a tool to evaluate and monitor progress of our objectives.

The Healthy Start in North Dakota Board of Directors will provide management, governance, provide guidance to the implementation, tracking and monitoring progress and accomplishments. Local partnerships consists of the Board of Directors including representatives from the following: North Dakota State Department of Human Services; Legal Assistance of North Dakota; Tribal representation from Spirit Lake Sioux Tribe, Turtle Mountain Band of Chippewa, Standing Rock Sioux Nation, Three Affiliated Tribes, Trenton Indian Service Area; North Dakota Office of Indian Affairs, North Dakota Consensus Counsel, Northern Plains Healthy Start.

Other partners participating in the Consortium include: the North Dakota State Health Department, North Dakota Maternal & Child Health Department, Tribal Health Service Unit Directors, Tribal Chairman, Indian Health Service.

TIME LINE

- Complete meetings with health care providers to identify persons in need of access to health care by 4/1/98.
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- Complete development of educational components by 10/1/98.
- Complete strategy of Healthy Start in North Dakota plan including local partnership reviews by 10/1/98.
- Complete health plan by 1/1/99.
- Complete development of evaluation process by 1/1/2000.

Joyce Vivier is the Northern Plains Healthy Start Coordinator for the Turtle Mountain Band of Chippewa. She is a licensed social workers and has been with the program since it began six years ago. Joyce also has two years of experience as a public school social worker.

Wells County District Health Unit
Kellogg Foundation Turning Point Grant Proposal

Wells County is located in central North Dakota. There are 5,864 citizens. The average age of county residents is 41.6 years. The leading causes of death are heart disease and malignant neoplasm. There are 1,680 families in Wells County. According to 1990 data, the median household income in Wells County is $18,568 compared to the North Dakota median household income of $23,213.

Wells County is a frontier county which means eight people reside per square mile. Wells County is designated a health care profession shortage area. There is one hospital in the county with the two largest communities hosting clinics. There are two family nurse practitioners/physician assistants, two family practice physicians (one leaving 4-15-97) and one surgeon.

Our local community has a newly formed (in the past five years) single county district health unit that has not been involved with strategic planning and developing. A community assessment is currently being undertaken to identify health needs and concerns.

Wells County District Health Unit is eager to partner with local agencies and resources (public and private) and the state government to strengthen the public health. Wells County District Health Unit has partnered with several local and state agencies in the past to enhance and provide local projects but has not explored the private sector and other than health-related agencies. By receiving Turning Point funding, Wells County District Health Unit will have the necessary financial and technical support to establish partnerships to continue to build a healthy community.

TIME LINE - FIRST YEAR

With state government assistance public health core functions, minimum standards, and services currently available will be identified. Potential services will be explored. This may be done at an on-site visit, teleconferences, and/or meetings. Wells County District Health Unit will conduct needs assessment and opinion survey and utilize across the county for input. The state department survey tool would be utilized. This would be a six-month process following the protocol set by the state health survey tool. Wells County District Health Unit will conduct local forums at the five largest local communities to address each community's unique needs and opportunities. Local leaders will be notified and encouraged to attend. All prospective partners would attend. Various times and food would be promoted to increase the likelihood of attendance.

TIME LINE - SECOND YEAR

Establish a steering partnership with state health department and local citizens to meet and decide on provision of service, method and structure of delivery. The partnership would meet monthly to review forum information, brainstorm and collaborate. These meetings

would be held at the various communities to facilitate members attending. Community partners will develop a community health plan, community based, with community input, assistance, and collaboration. The community plan will address all populations, differing health promotions, preventive, and primary services. This process will involve several meetings - three months minimum to achieve.

TIME LINE - THIRD YEAR

Meetings with community leaders, community partners regarding implementation of the plan will be held. This process would take three to six months. Establish an advisory partnership to sustain the changes and share the responsibility for building a healthy community. This would be an ongoing partnership.

Some of the types of organizations Wells County District Health Unit will partner with are: local schools and their boards, local legislators, Lonetree Special Education Unit, Wells County Extension, Prairieland Home Health Agency, St. Aloisius Medical Center, ND Department of Health, Harvey Economic Development Council, Soo Line Railroad, B.J. Ford (car dealership), Green Vision (farm implement business), Harvey-Martin Ministerial Association, Farmers Cooperative located at Fessenden and Harvey, Wells County WIC (nutritional program), Wells-Sheridan Aging Council (senior meals/bus service), Wells County Commissioners and Hav-It (adults with developmental disabilities).

Wells County District Health Unit should be chosen as a State partner because: We are a newly formed unit, innovative in our delivery system. Wells County District Health Unit looks for new and different services, staff are not afraid to explore new methods and new partnerships for our county citizens. We are interested in team work, providing the best, most appropriate health services in our community to make our county healthy and safe for all.

The project director will be Karen Volk, Nurse Administrator of the Wells County District Health Unit. Ms. Volk received her B.S.N. from Marycrest University at Davenport, Iowa. Ms. Volk has been in public health nursing for 16 years. Community activities include: North Dakota Public Health Association First Vice-President, Past North Dakota Director of Nursing Chairperson, American Cancer Society District Board Member, Children's Services Coordinating Committee Regional Board Member, and Wells County Unit of the American Cancer Society Co-chairman. Ms. Volk was named Outstanding Public Health Worker of North Dakota in 1994.

State Partners

Agriculture

North Dakota State University (NDSU) Extension Service extends educational outreach programs in farm, family and community economics; agriculture and youth development; human development; and nutrition, food safety and health. Karen Zotz, assistant director of human development, is experienced in program planning, leadership development and rural health issues.

Business

Greater North Dakota Association is the voice of business in North Dakota. Jess Cooper is the vice president of governmental affairs.

Children's Health

Children's Services Coordinating Committee plans for and coordinates the delivery of services to at-risk children. The committee fosters preventive strategies and early interventions to strengthen families in their capacity to parent children. Lt. Governor Rosemarie Myrdal chairs this committee made up of cabinet-level state officials. (See additional information listed under *Government Representation.*)

City and County Government

North Dakota Association of Counties provides membership services to counties and county government officials, such as administration of a workers compensation account, computer training, juvenile justice services, etc. Mark Johnson has been the association's executive director for 12 years. He brings strong leadership and lobbying experience to this project.

North Dakota League of Cities provides support, advocacy and leadership education to the state's incorporated cities. Of the 362 cities in the state, 90 percent belong to the

organization which gives voice to cities' collective concerns. Executive Director Connie Sprynczynatyk has served in local elective offices for 20 years.

Education

University of Mary School of Nursing offers the largest nursing program in western North Dakota, including bachelor's and master's degrees. Betty Rambur, DNSc, is chair of the division of nursing and director of nursing graduate programs. (See additional information listed under *Government Representation.*)

University of North Dakota School of Medicine and Health Sciences focuses on primary care and rural health. The medical school supports residency programs in family medicine, internal medicine, surgery and psychiatry. Bruce T. Briggs, director of special projects, has many years of experience in strategic planning and marketing.

University of North Dakota Medical School Center for Rural Health serves as a resource in identifying and researching contemporary rural health issues, in strengthening local community capabilities, in developing community-based solutions and in advocating for rural concerns. Associate Director Brad Gibbens has worked for the Center for Rural Health for 12 years and is experienced in health policy, planning and assessment.

Environmental

North Dakota Environmental Health Association promotes professional education in the core environmental health programs, including indoor air quality, food service, daycare and institutional care inspection, etc. Mel Fischer, sanitarian coordinator for Bismarck Fire and Inspections, will represent the association on this project.

Government Representation

Lt. Governor Rosemarie Myrdal represents the governor's office and the Children's Services Coordinating Committee. She has an educational and political background, as well as a strong interest in children's issues. The governor wants services to be provided in the most cost-effective manner. The early and continuous involvement of the governor's office will ensure the executive branch support needed to make modifications.

Representative Merle Boucher is the House minority leader. He has a background in education and represents a district with a high population of Native Americans. He has had a strong voice in health care reform issues and children's issues in the Legislature.

Representative Ken Svedjan is a leading member of the majority party. He chaired the Human Services Committee in the last session and is currently a leader in the House Appropriations Committee. He has been instrumental in health care and welfare reform.

The input and recommendations of Lt. Governor Myrdal and Legislators Boucher and Svedjan will be essential for legislative change. Their knowledge of the process, the inputs and the results will make them valuable champions and supporters of future legislation.

The State Health Council is a governor-appointed, nine-member advisory body to the North Dakota Department of Health. The council has expressed support of strategic planning by approving a resolution to begin this process. Council member Dr. Betty Rambur represents the nursing profession on the health council. She has been actively involved in state health care reform issues and brings an academic, health policy and nursing perspective to the planning effort.

Health Care Industry

Blue Cross Blue Shield of North Dakota provides health care benefits to more than 70 percent of the state's privately insured. It offers PPO and EPO managed care products in some areas of the state. The company is interested in efficient integration of the public and private health care systems. As managed care evolves in the state, the company wants to make sure a "safety net" remains intact. Rod Larson, assistant vice president of government relations, is a former legislator and the former chairman of the House Human Services Committee.

Medcenter One Home Medical Resources provides a variety of home care services to 21 North Dakota counties. Donna Bosch is the executive director of Home Medical Resources and Hospice. She also is president of the North Dakota Home Health Care Association.

Health Care Associations

North Dakota Health Care Association represents the state's hospitals. Association members are involved in community health planning in some areas of North Dakota. Nancy Willis is the vice president of communications.

North Dakota Long Term Care Association is a professional association of community and long term care providers who enhance the lives of nursing and basic care facility residents through collaboration, education and advocacy. Executive Director Shelly E. Warner is active in state and federal government advocacy efforts. She is vice president of the Association of State Health Care Association Executives.

North Dakota Medical Association is the professional membership organization for more than 900 active physicians in the state; it is a member of the American Medical Association, a federation of state medical associations. The organization will be represented by David J. Peske, director of governmental relations. He will provide direct access to the state's medical community including clinic administrators. Cathy

Rydell, executive director, also will represent the association. She is a former legislator and acts as executive director of the North Dakota Primary Care Association and is the North Dakota liaison for the Dakota Association of Community Health Centers.

North Dakota Nurses Association is a professional association of registered nurses with a long interest in issues affecting consumers of health care. Executive Administrator Sharon Moos, R.N., is experienced in the delivery of home and rural health care.

Local Public Health

Local Public Health Administrators provide continuity and consistency in the delivery of the core functions of public health. Director Don Shields also is the director of Grand Forks Public Health Department. He is a board-certified health care executive with 23 years of health care experience.

North Dakota Public Health Association positively influences the health of North Dakotans through a statewide association of health-related professionals. Keith Johnson, immediate past president, is a registered sanitarian and has worked for Custer District Health Unit since 1977.

Religious

North Dakota Conference of Churches is an organization of the leaders of 11 religious denominations in North Dakota who work toward Christian unity. Sister Bernadette Bodine is a health care advocate with special interests in children's issues, mental health and vulnerable adults.

Tribal

Aberdeen Area Indian Health Services is dedicated to elevating the health status of Native Americans to the highest possible level. It works to ensure equity in the delivery of health care to Native Americans. Three-year agency director Bruce Bad Moccasin

will assess the impact of potential changes in the health care delivery system to the Native American population. His presence will assure the coordination of this strategic planning process with a similar process already underway in Indian Health Services.

Healthy Start in North Dakota provides case management for pregnant women and infants on North Dakota's four Indian reservations and in one service area. This includes home visits, education, referrals and transportation. Joyce Vivier is the Healthy Start coordinator for the Turtle Mountain Band of Chippewa. She represents all Healthy Start programs in North Dakota for this project.

State Agencies

North Dakota Department of Human Services, Division of Medical Services, administers the Medicaid Program which provides health care services to about 45,000 low-income citizens of the state. Medicaid Director David Zentner joined the department in 1978; he brings to this project extensive background knowledge of the Medicaid program, general health issues and service delivery.

North Dakota Department of Human Services, Division of Mental Health/Substance Abuse Services, provides technical assistance, licensure, planning and outcome evaluation to mental health and substance abuse practitioners. Division Director Karen Larson, R.N., has a strong background in substance abuse and mental health, as well as maternal and child health.

Local Partners

Bismarck-Burleigh Nursing Service serves the capital city of Bismarck, N.D., as well as the rest of Burleigh County. The health unit serves a substantial urban Native American population and provides services to many of the city's homeless people. Administrator Doris Fischer, R.N., has 14 years of hospital experience and 27 years of public health experience.

Central Valley Health Unit in Jamestown, N.D., serves Stutsman and Logan Counties in the south-central part of the state. Jamestown is experiencing increased economic development with the resultant financial and social implications. Administrator Sharon Unruh, R.N., has 27 years of experience in public health and extensive experience in strategic planning.

City-County Health Department serves Valley City, N.D., as well as the rest of Barnes County. It is the state's smallest city-county health district. Executive Director Marcy Grant, R.N., has 30 years of nursing experience and extensive experience in the coordination of children's programs.

Custer District Health Unit in Mandan, N.D., serves five counties in the south-central part of the state. Sioux County includes the northern portion of the Standing Rock Sioux Reservation; the remainder of the reservation is in South Dakota. Administrator Keith Johnson is a registered sanitarian and has worked for the health unit since 1977.

Fargo Cass Public Health in Fargo, N.D., serves the state's largest city, as well as the rest of Cass County. Situated in southeastern North Dakota, both the city and county border Minnesota. Fargo Cass serves about 90 percent of the 1,100 refugees who live in the state. Project Director Cheryl Hagen has a broad range of health care

experience including school health, public health, occupational health and agricultural health.

First District Health Unit in Minot, N.D., serves seven central North Dakota counties extending from the Canadian border to 125 miles south. First District has been directed by its Board of Health to develop a strategic plan based on the core functions of public health. Executive Director Lisa Clute has developed organizational strategic plans, as well as a strategic plan for children and family services.

Grand Forks Public Health Department serves Grand Forks, N.D., which is the state's second largest city, as well as the rest of Grand Forks County. Situated in east-central North Dakota, both the city and county border Minnesota. The Grand Forks Health Department and First District Health Unit in Minot are impacted by the ever-changing populations of nearby U.S. Air Force Bases. Grand Forks Director Don Shields is a board-certified health care executive and has 23 years of health care experience.

McIntosh District Health Unit in Ashley, N.D., serves McIntosh County. It is located in the south-central part of the state and borders South Dakota. This small, rural heath unit has been in existence for six years. It provides limited services and lacks the financial resources to assess public health needs. Administrator Twila Heinrich has 10 years of experience as the chief financial officer of a local hospital and is a board member of the Region VI Children's Services Coordinating Committee.

Southwestern District Health Unit in Dickinson, N.D., serves eight counties. Three counties border either Montana or South Dakota; one borders both. Covering 10,000 square miles with 41,175 people, this health unit has the lowest population density in the state. The area economy fluctuates due to oil and gas industry cycles. Executive Officer Carlotta Ehlis has worked for the district since 1975 and is active in numerous health-related organizations and committees.

Spirit Lake Sioux Nation in Fort Totten, N.D., includes 4,800 enrolled members, most of whom live on the reservation in northeastern North Dakota. The Spirit Lake Sioux Nation has a close working relationship with the state health department's Maternal and Child Health (MCH) Division. With MCH funding, a nurse practitioner works with the reservation's maternal and infant population. Gloria Lefthand is the Northern Plains Healthy Start coordinator for the tribe. She is a licensed social worker and has been with the program since it began six years ago.

The Turtle Mountain Band of Chippewa in Belcourt, N.D., has an enrollment of 25,000 people. Located on the Canadian border, no state public health structure exists in Rolette County. Indian Health Services is the primary health care provider on the reservation. Joyce Vivier is the Northern Plains Healthy Start coordinator for the tribe. She is a licensed social worker and has been with the program since it began six years ago. Joyce also has two years of experience as a public school social worker.

Upper Missouri District Health Unit in Williston, N.D., includes four counties in the northwestern corner of the state. Three counties border Montana; one also borders Canada. This health district has the second lowest population density in the state, and, like Southwestern District, the area economy fluctuates due to oil and gas industry cycles. Director Jan Trimmer has more than 20 years of experience in health care administration in both the public and private sectors.

Wells County District Health Unit in Fessenden, N.D., is a single-county health district in the central part of the state. Formed five years ago, it has not been involved in a strategic planning process. A health care needs assessment is currently underway. Administrator Karen Volk, R.N., has worked in public health nursing for 16 years. She was named Outstanding Public Health Worker in North Dakota in 1994.

NORTH DAKOTA DEPARTMENT OF HEALTH
PROPOSED TWO-YEAR BUDGET FOR TURNING POINT: COLLABORATION FOR A NEW CENTURY IN PUBLIC HEALTH

Category	Foundation Funds	Match	Total Budget
a. Personnel/Fringe Benefits	$ -	$ 72,000	$ 72,000
b. Travel/Retreat Expenses	15,000	4,000	19,000
c. Consultant (Fee + Expenses)	285,000	-	285,000
d. Operating Expenses/Other	-	6,500	6,500
TOTAL BUDGET	$ 300,000	$ 82,500	$ 382,500

Note: a. State Health Officer and Health Dept. personnel will be in-kind contribution. The State Partners will contribute their time to attend meetings, sub committee meetings, 2 day retreat to review data collections of local health units, prioritizing, drafting bills and developing plan of implementation.

b. Consultants will conduct on-site assessments of the local public health departments to develop the comprehensive list of current and potential services for each health department as well as Steps 3,4,5 of the planning process described in the narrative.

c. State Partners will be reimbursed for the 2 day retreat using state rates of $20/day meals, $38.50 lodging/night and .25/mileage. State Partners will provide in-kind for all other travel expenses.

d. The Department will provide printing, duplicating, telephone services, postage and other state level operating expenses as in-kind.

LOCAL PARTNERSHIP THREE YEAR BUDGETS
PROPOSED THREE-YEAR BUDGET FOR TURNING POINT: COLLABORATION FOR A NEW CENTURY IN PUBLIC HEALTH

BISMARCK-BURLEIGH NURSING SERVICES

Category	Foundation Funds	Match	Total Budget
a. Personnel/Fringe Benefits		$ 17,813	$ 17,813
b. Travel	1,200	1,000	2,200
c. Consultant (Fee + Expenses)	42,624	100	42,724
d. Professional Development/ Conferences	2,500		2,500
e. Supplies/Printing/duplicating	2,600	198	2,798
f. Equipment -computer	3,500		3,500
g. Operating Expenses/Other	-	5,674	5,674
TOTAL BUDGET	$ 52,424	$ 24,785	$ 77,209

Note: a. 15% Project Coordinator

CENTRAL VALLEY HEALTH UNIT

Category	Foundation Funds	Match	Total Budget
a. Personnel/Fringe Benefits		$ 3,000	$ 3,000
b. Travel	1,740		1,740
c. Consultant (Fee + Expenses)	49,326		49,326
d. Professional Development/ Conferences	1,000		1,000
e. Supplies/Printing/duplicating	1,814		1,814
f. Evaluation -Survey of 1700 kids		3,400	3,400
g. Public Education	2,400		2,400
h. Operating Expenses/Postage	3,720	800	4,520
TOTAL BUDGET	$ 60,000	$ 7,200	$ 67,200

Note: a. 5% Project Coordinator
b. Consultant 1040 hrs. @ $15.81

CITY COUNTY HEALTH UNIT

Category	Foundation Funds	Match	Total Budget
a. Personnel/Fringe Benefits		$ 25,740	$ 25,740
b. Travel		2,040	2,040
c. Consultant (Fee + Expenses)	60,000	8,100	68,100
d. Supplies/Printing/duplicating	-	900	900
TOTAL BUDGET	$ 60,000	$ 36,780	$ 96,780

Note: a. Director @ 6 hrs/wk
b. Consultant 20 hrs wks/$15 per hr.

CUSTER DISTRICT HEALTH UNIT

Category	Foundation Funds	Match	Total Budget
a. Personnel/Fringe Benefits		$ 25,344	$ 25,344
b. Travel	10,000		10,000
c. Consultant (Fee + Expenses),Technical Assistar	14,000		14,000
d. Convening Processes	10,000		
e. Professional Development/ Conferences	10,000		10,000
f. Supplies/Printing/duplicating/displays	8,000		8,000
g. Operating Expenses/Other	8,000	-	8,000
TOTAL BUDGET	$ 60,000	$ 25,344	$ 75,344

FARGO CASS COMMUNITY HEALTH CENTER

Category	Foundation Funds	Match	Total Budget
a. Personnel/Fringe Benefits		$ 21,096	$ 21,096
b. Travel	5,000		5,000
c. Consultant/ Tech. Assistance (Fee + Expenses)	35,000		35,000
d. Professional Development/ Conferences	5,000		5,000
e. Working Sessions with Partners	5,000		5,000
f. Equipment (Computer)			-
g. Public Education	10,000	-	10,000
TOTAL BUDGET	$ 60,000	$ 21,096	$ 81,096

Note: a. Assessment Coordinator & Clerical

FIRST DISTRICT HEALTH UNIT

Category	Foundation Funds	Match	Total Budget
a. Personnel/Fringe Benefits	$ -	$ -	$ -
b. Convening Costs	8,000		8,000
c. Consultant (Fee + Expenses)/Facilitator	20,000		20,000
d. Professional Development/ Conferences	30,000		30,000
e. Supplies/Printing/duplicating	2,000	4,000	6,000
f. Technology Costs	-	52,978	52,978
TOTAL BUDGET	$ 60,000	$ 56,978	$ 116,978

Note: d. Training Costs for staff during the implementation of the plan $20,000, Conference on Core functions $10,000

f. The Health unit was granted funds to purchase computers & new network system, train staff to generate the data needed for ongoing community assessment.

GRAND FORKS COMMUNITY HEALTH

Category	Foundation Funds	Match	Total Budget
a. Personnel/Fringe Benefits		$ 252,000	$ 252,000
b. Convening Processes	6,000	5,000	$ 11,000
c. Consultant/ Tech. Assistance (Fee + Expenses)	6,000	5,000	$ 11,000
d. Professional Development/ Conferences	16,000	10,000	$ 26,000
e. Supplies/Printing/duplicating	12,000	7,500	$ 19,500
f. Evaluations	16,000	12,000	28,000
g. Operating Expenses/Other	4,000	2,500	6,500
TOTAL BUDGET	$ 60,000	$ 294,000	$ 354,000

Note: a. In-Kind Personnel 5040 hrs @ $50/hr.

MCINTOSH DISTRICT HEALTH UNIT

Category	Foundation Funds	Match	Total Budget
a. Travel	8,500		8,500
b. Consultant/ Tech. Assistance (Fee + Expenses)	29,700		29,700
c. Supplies/Printing/duplicating	6,700		6,700
d. Operating Expenses/Other	15,100	5,400	20,500
TOTAL BUDGET	$ 60,000	$ 5,400	$ 65,400

SOUTHWESTERN DISTRICT HEALTH UNIT

Category	Foundation Funds	Match	Total Budget
a. Personnel/Fringe Benefits		$ 74,160	$ 74,160
b. Convening Processes	9,000	6,300	15,300
c. Consultant (Fee + Expenses)/Technical Assistar	48,000		48,000
d. Evaluation-Development of Process	3,000	-	3,000
TOTAL BUDGET	$ 60,000	$ 80,460	$ 140,460

SPIRIT LAKE SIOUX TRIBE

Category	Foundation Funds	Match	Total Budget
a. Consultant (Fee + Expenses)/Technical Assistar	45,000		45,000
b. Travel (Staff/Local Partners)	6,800		6,800
c. Staff Documentation	1,200		1,200
d. Community Meetings (5)	1,000		1,000
e. Evaluation-Development of Process	6,000	-	6,000
TOTAL BUDGET	$ 60,000	$ -	$ 60,000

TURTLE MOUNTAIN CHIPPEWA

Category	Foundation Funds	Match	Total Budget
a. Consultant (Fee + Expenses)/Technical Assistar	45,000		$ 45,000
b. Travel (Staff/Local Partners)	6,800		6,800
c. Staff Documentation	1,200		1,200
d. Community Meetings (5)	1,000		1,000
e. Evaluation-Development of Process	6,000	-	6,000
TOTAL BUDGET	$ 60,000	$ -	$ 60,000

UPPER MISSOURI DISTRICT HEALTH UNIT

Category	Foundation Funds	Match	Total Budget
a. Administration	$ 10,000	$ 10,000	$ 20,000
b. Data Collection/Analysis	1,500	1,500	3,000
c. Consultant (Fee + Expenses)	28,500	20,900	49,400
d. Professional Development/ Conferences	10,950	5,700	16,650
e. Development of Public Campaigns	4,550	21,600	26,150
f. Forums	4,500	10,800	15,300
TOTAL BUDGET	$ 60,000	$ 70,500	$ 130,500

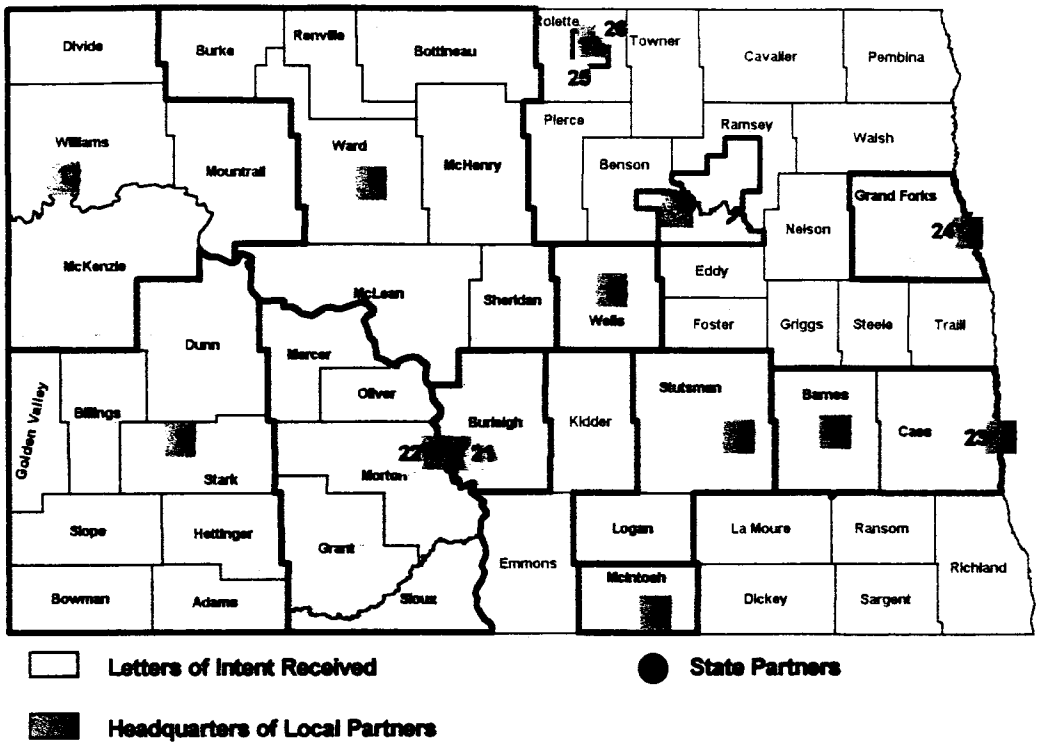
WELLS COUNTY HEALTH UNIT

Category	Foundation Funds	Match	Total Budget
a. Personnel/Fringe Benefits	$ 11,153	$ 33,727	$ 44,880
b. Consultant/ Tech. Assistance (Fee + Expenses)	17,760		$ 17,760
c. Professional Development/ Conferences	5,200		$ 5,200
d. Travel	4,248		$ 4,248
e. Supplies/Printing/duplicating	10,574		$ 10,574
f. Equipment	5,804		$ 5,804
g. Operating Expenses/Other	5,261	-	$ 5,261
TOTAL BUDGET	$ 60,000	$ 33,727	$ 93,727

Note: a. In-Kind Personnel $15 Administrator @ 8 hr/wk

Robert Wood Johnson Turning Point Application

State and Local Partners



Local Partners

1 Bismarck-Burleigh Nursing Service
2 Central Valley Health Unit
3 City-County Health Department
4 Custer District Health Unit
5 Fargo Cass Public Health
6 First District Health Unit
7 Grand Forks Public Health Department
8 McIntosh District Health Unit
9 Southwestern District Health Unit
10 Spirit Lake Sioux Nation
11 Turtle Mountain Band of Chippewa
12 Upper Missouri District Health Unit
13 Wells County District Health Unit

State Partners

21 Bismarck, ND
- ND Medical Association
- ND Health Care Association
- ND Dept. of Human Services, Medical Services
- ND Nurses Association
- ND Dept. of Human Services, Mental Health/Substance Abuse
- ND Association of Counties
- ND League of Cities
- Dakota Association of Community Health Centers

State Partners

21 Bismarck, ND *(Con't)*
- ND Primary Care Association Community Health Centers
- ND State Health Council
- University of Mary School of Nursing
- Children's Services Coordinating Committee
- Greater North Dakota Association
- ND Conference of Churches
- ND Long Term Care Association
- Medcenter One Home Medical Resources
- ND Environmental Health Association

22 Mandan, ND
- ND Public Health Association

23 Fargo, ND
- Blue Cross Blue Shield of North Dakota
- North Dakota State University Extension Service

24 Grand Forks, ND
- Local Health Departments
- Legislator
- University of North Dakota, School of Medicine
- UND Center for Rural Health

25 Rolette, ND
- Legislator

26 Belcourt, ND
- Turtle Mountain Band of Chippewa