MHCC

Minnesota Health Care Commission

Report

January 1997

Update on MHCC and Community Efforts to Reduce or Prevent the Adverse Impacts of Tobacco Use and Violence

The mission of the Minnesota Health Care Commission is to help Minnesota communities, providers, group purchasers, employers, employees, and consumers improve the affordability, quality, and accessibility of health care.

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Update on MHCC and Community Efforts to Reduce or Prevent the Adverse Impacts of Tobacco Use and Violence

Introduction

- The Commission has had long standing interests in prevention and public health to help meet health care cost-containment goals, while improving health and access to care.
- This year the Commission asked two members, Gayle Hallin and Jasper Daube, to meet with other groups to discuss mutual prevention and public health interests, and to explore possible opportunities for coordination and collaboration.
- Based on initial discussions with other groups, the Commission agreed to focus its coordination and collaboration efforts this year on reducing or preventing the adverse public health impacts of tobacco use and violence. Our progress to date is briefly summarized below.

Round table discussions with other community groups

- The first in a possible series of ongoing roundtable discussions with other organizations to learn about their activities in reducing tobacco use and violence, and to begin planning possible coordination of efforts, were launched with two meetings in early November. There have been subsequent follow-up meetings. A list of the organizations which have participated in the meetings is attached as Appendix 1.
- At each meeting, we discussed: the strategies and goals of the other groups to address these problems; common themes, goals, and strategies; possible coordination and formation of larger coalitions. Brief notes on priorities and strategies discussed by the various groups at the meetings were recorded on flip charts and displayed at the meetings. A summary of the flip charts is attached as Appendix 2.

Strategies to reduce or prevent tobacco use

- The groups which assembled to discuss preventing or reducing tobacco use quickly found common ground in efforts to decrease tobacco use among youth, including support for an increase in the cigarette tax.

- This consensus was communicated to the Governor's office, along with a request to meet with a representative of the Governor. The purpose of the meeting would be to show that there is a large coalition of many influential groups in support of efforts to reduce tobacco consumption, especially among youth.

- The letter to the Governor's office requesting a meeting briefly outlined the public health problems associated with tobacco use and the need for a comprehensive strategy to address tobacco use.

  - In particular, the comprehensive strategy suggested in the letter should include:

    - restrictions on youth access to tobacco;

    - educational campaigns which support nonsmoking among young people; and

    - increasing the excise tax on tobacco to keep it out of the hands of children.

    The letter did not indicate how revenues from the increased cigarette tax should be used, but did suggest that there are a number of ways in which the tobacco tax increase might fit with the Governor's priorities.

- To date, there has been no response to the request for a meeting from the Governor's office. Efforts will continue to be made to bring about appropriate awareness and support for a concerted strategy to address tobacco use, especially among youth.

- Information summarizing the rationale for the three-prong strategy above is attached as Appendix 3. Further information on the significant adverse public health and economic impacts of tobacco use is provided in Appendix 4.

Strategies for violence prevention and violence reduction

- Our Round table discussions included from a variety of groups, and reflected a strong concern over the corrosive influence of violence in society, as well as a variety of initiatives and strategies to address violence.

- A number of salient issues emerged in the discussions, suggesting a potential agenda for future additional policy and program development. These are briefly summarized below:

  - While violence has reached levels that make it an acknowledged public health problem, more progress is needed in understanding the epidemiology of violence. More and better data on violence as a public health concern is needed.

- There are a variety of initiatives to address violence, at a variety of levels. While awareness and coordination of the various initiatives is growing, a statewide "violence center" should be considered to better inform and link anti-violence efforts. Issues of local need and local efforts should be taken into account when planning the statewide violence center.

- The Commission's Consumer Incentives and Prevention Committee previously recommended increased funding for a home visiting program to expand public health home visiting services for the prevention of child abuse and neglect. A number of other groups have also indicated support for testing the concept of universal home visiting in a number of pilot test sites.

- Adequate funding is crucial to meet the needs above.

  - The groups participating in one Round table discussion reviewed a program of the state of Illinois to fund some of its violence reduction and violence prevention activities "off-budget" through the sale of special license plates with a peace motif. The sale of the peace plates have raised over $500,000 this year toward anti-violence activities, and have increased awareness of the violence issue. (A brief description of the Illinois license "peace" plates is attached as Appendix 5.) However, this particular off-budget funding approach is likely to be less relevant in Minnesota, because of our smaller population, and because the state's experience with other special license plates is that they have typically not sold well.

  - Even if some off-budget financing is possible, the level of need to meaningfully address violence will require a more coherent funding strategy.

Summary

- The Commission has established closer links with a number of organizations to more effectively coordinate and collaborate on reducing and preventing two major public health problems in Minnesota: tobacco use and violence.

- Public health problems are rarely addressed by single event or initiative -- it is a process. It is important to continue the linkages which have been developed, and to continue working with other groups on common interests in reducing or preventing tobacco use and violence. The Commission needs further interaction with other groups to effectively contribute in this area.

Recommendations

The following recommendations were approved by the Commission at their January 15, 1997 meeting:

Reduction of Tobacco Use

- The Commission recommends that policies be implemented to reduce sales of tobacco to minors through the use of federal, state and local laws.

- The Commission recommends that the tobacco tax be increased sufficiently to price cigarettes out of the hands of children, and to generate revenues to fund educational campaigns and the Commission's financing recommendations.

- The Commission recommends that a portion of the tobacco tax be used to support educational campaigns to reduce smoking among young people.

Violence Prevention

- The Commission recommends that a universal home visiting nurse program be developed on a statewide basis. There are currently many projects underway and an inventory and coordination of these projects is needed initially.

- The Commission recommends that the Department of Health be directed to conduct a study on the epidemic of violence. The study should focus on the feasibility of establishing vehicles to measure conditions which both cause and prevent violence and the interventions which should be initiated to reach positive, measurable outcomes.

List of Appendices

Appendix 1 -- Organizations which provided information or attended MHCC planning meetings to reduce or prevent the adverse affects of tobacco use and violence

Organizations which provided information or attended MHCC planning meetings to reduce or prevent the adverse affects of tobacco use and violence

- Allina
- American Cancer Society
- Blue Cross and Blue Shield of Minnesota
- Council of Health Plans
- Department of Public Safety
- Governor's office
- Health Care Coalition on Violence
- HealthPartners
- Minneapolis Department of Health
- Minnesota Medical Association
- Minnesota Hospital and Health Care Partnership
- Minnesota Department of Commerce
- Minnesota Department of Health
- Minnesota Deptment of Human Services
- Public Health Association
- Ramsey County Department of Health
- Regional Coordinating Boards
- St. Paul Department of Health
- Smoke Free Coalition 2000
- Urban Coalition

Appendix 2 -- Brief summary of priorities and strategies from round table discussions

Summary of Flip Chart Notes Recorded at November 1, 1996 Tobacco Reduction Meeting

A number of groups met on November 1, 1996 to discuss efforts to reduce tobacco use. Below are notes from comments recorded on flip charts regarding tobacco reduction activities, priorities, and strategies of groups represented at the Nov. 1 meeting.

The notes below are very abbreviated. Please contact MHCC staff for further information.

Tobacco notes from Friday November 1, 1996

American Lung Association (Heart, Cancer Associations)
- $2.00/pack tax increase
- Active support on tax
- Education efforts
- Support on youth access ordinances

Smoke-free Coaltion
- Working on youth access bill for up to six years
- Many organizations, cities supported
- Pre-emption at local level
- Briefing book
- Tax difficult?
- 3-fold focus
  Lowering youth access
  Restore funding at MDH
  Significant tobacco excise tax
- Will have bill this year
- RWJ grant to promote legislation

BCBSM, Managed Care Industry
- Capitol, clinic, community, courtroom
- Clinical-Help members stop smoking (education, services, non-smoking discount)
- Capitol-Support smoke-free, support tobacco tax increase (earmark money to education and access)
- Community-Active support of smoke-free, American Cancer Society, produce educational video
- Courtroom

Council of Health Plans
- Support tax increase, youth access bill
- Support Coalition
- Bring all health plans together (as well as individual plan help)

MHHP

- 1996-Support youth access
- 1997-Support youth access bill, support raising tobacco tax
- STAT Campaign- bring about local ordinances
  9 strong local ordinances, 60 members involved locally, local efforts important

DHS

- Enforce Synar amendment
- Every state: random survey of how available tobacco is to youth
  RFP for study (looking for noncompliance $\leq$20%, Now 30%)
- Monitoring legislative action on access bill
- Support smoke-free legislation
- Conditions on grantees
- Educate tax community

MDH

- Program cut earlier
- Refurbish program
  Children's health program
  Governor in: 1) Raise Tax
  2) Integrated education; mass-media statewide program
- Smoking is "pediatric disease"
- Raise funding for education, outreach, communication programs (including in budget to Governor
- Assist-19 local coalitions funded
  Youth access, youth advocacy
  Environmental tobacco smoke
- Stronger focus on assessment-get data to subcontractors
- Emphasis on communities of color

Attorney General

- Youth access legislation (one of highest priorities)
- tobacco litigation
  Settlement?
  Want to solve as public health problem
  Need every voice possible to support
  17 states, cities of New York and San Francisco, and more in lawsuit
- Clarify data practices act
- Good co-op from agencies on lawsuit

Minnesota Public Health Association

- 1993-raise tax (designated use?)
- Ultimate goal-smoke free society

- Limit youth access
  Opposed to pre-emption
- Education
- Support of smoke-free
- Priority: raise tax

RCBs

- RCB3-preventing youth tobacco use (task force)
  Develop trust, educate
  Prevent middle school kids from smoking (peer training)
- Goal-1998 student survey at or below state average smoking rate
- "Partners"-schools, cities, plans
  -Financial, in-kind support
  -MDH (C'S)-request RWJ & meet with regional legislators

Urban Coalition

- Support for smoke-free, legislative proposals
- Assist project previously
  Continue to work on youth access
- Data analyses of student surveys
- Rate of use among African-Americans (?) Higher? Lower?
- Do follow up studies
- African-American students smoke less in schools predominantly with African-American student enrollment

Common Goals

- Eliminate youth smoking
  A) Local control (state floor of control)
  B) Raise tax
  C) Education

How

- 1) How influence Governor
  -need to act soon
  -"fall back"-"tax swap"
  -revenue neutral
  -Message: this is public health issue

Jennifer	Small group
Dan	Nan
Judy	Bert
Bert	Talk to Governor
Mike	Talk to John Gunyou
Keyah	

Poll group within 2 weeks
Reconvene
message: Broad support
Can address business concern

Examples: US Military, Target

Summary of Flip Chart Notes Recorded at November 4, 1996 Violence Prevention and Reduction Meeting

A number of groups met on November 4, 1996 to discuss efforts to prevent and address violence. Below are notes from comments recorded on flip charts regarding violence prevention and reduction activities, priorities, and strategies of the groups represented at the Nov. 4 meeting.

The notes below are very abbreviated. Please contact MHCC staff for further information.

MDH - Center for Health Protection

- Working with Department of Corrections
  - -money for rape prevention centers
  - - more focus on primary prevention (male attitudes)
  - -study shift from prisons to prevention

MDH - MN Healthy Beginnings

- 2 year program- universal home health visiting
  - - address lead, alcohol, etc in home.

MDH - Center for Health Promotion

- Vol. Program for home visiting
- Traumatic brain injury, spinal chord injuries recorded.
- Develop gunshot wound registry
  - - develop pilot project
- Analysis: Suicide, youth homocide, family violence
- 100K at TBI, BRFSS data

Urban Coalition

- Convener and catalyst to address violence
  - - address socio-economic problems
  - - Minneapolis youth - homicide/access to guns (research)
  - - MN Coalition on Battered Women re: legislation
  - - Grass-roots organizations with communities of color
    - Nov. 9th : "Acts of Kindness" Meeting
  - - positive community initiatives
- Community policy level solutions
- sponsor dialogues address prejudice, lack of understanding

Minnesota Health Care Coalition on Violence

1. Best practices for identification/intervention
2. Coverage and reimbursement
3. Report "E" Codes
4. Family violence in all prenatal education
5. Awareness and education
   - endorse statewide multi-media campaign
6. Pilot - universal home visiting with wiolence assessment
7. Healthy, abuse-free workplace
8. Assess effectiveness of interventions
9. Incorporate defns of primary prevention
10. Eval effects of Coalition effort

- Link with Minnesota Health Care Commission
- Research and use of "E" Codes (cause of injury)
- Workplace violence issues (Zero tolerance of abuse or violence)
- Statewide workshops
  - training, education

MHHP

- Need leadership on user taxes to pay for public health issues
- "E" Codes
  - urban hospitals interested
  - rural hospitals interested as well
- Workplace, community violence
  - meetings, conferences, mailings
- Distributing "assault Packets"
- Need coordination on violence issues

MMA

"Stop the violence"
- Targets domestic violence
- Guidelines to phusicians
  - identify, refer
- Public relations
  campaign, awards
- Guidelines- how to deal with media violence
  public relations campaign
- Firearm safety
- Stop the violence day at the Metrodome

AMA- takes up MMA approach at the National level

<u>Strategies/Goals</u>
- Address portrayal of violence (in news, entertainment)
- Health care system deal with problems of violence

AMA

"Community coordination teams" - coordinate law enforcement, social services, etc.
Started 4 teams in Minnesota

Office of Minority Health

- Violence as public health issue
- Keep families together, keep students in school, provide employment opportunities.
- A single task force- coordinate efforts, agenda

Chemical Dependency Program, DHS

- Importance of CD
  - domestic violence
- consider family CD/drug issues
- CD link to violence generally

BCBSM

- Comunications, education

Minnesota Council on Health Plans

- Share practice guidelines among members
- research
- changing practices
- problem of coordination

research home visiting program

- how kids get a start
- need support for new parents
- Do not abandon parents, adults

Summary

Specific recs to legislature this session?

1. Need data, information
   - legislative $
   - pilot studies

MHCC Earlier Report-

1. Info.
2. Home visiting
3. Community based efforts

New: "Violence Center"

- How address problems locally
- user tax ?
- get $ for research
- Basic issue is socio-economic (as part of prevention)

Appendix 3 -- Information summarizing the rationale for a comprehensive, three-prong strategy on tobacco use, particularly among youth.

SMOKE FREE 2000 COALITION

Restoring State Funding for Tobacco Control Education

- One of the most effective ways to influence youth tobacco use initiation is through public education efforts. Earmarking a small percentage of revenues collected from a tobacco excise tax would allow the Minnesota Department of Health to resume the public education campaign and research it began in 1985. Since the budget for tobacco control education was gradually reduced from an annual budget of $1.6 million in 1985 to the current $200,000, smoking rates among teenagers in Minnesota have been rising. Weekly tobacco use among 12th graders is up from 22% in 1989 to 29% in 1995.[1]

- Tobacco control public education campaigns have been quite successful in preventing teenagers from starting to smoke. In Vermont, students exposed to media campaigns were 35 percent less likely to have smoked in the past week than were students exposed only to a school-based program. This preventive effect continued for at least two years following the end of the programs.[2]

- In California, lawmakers increased the tobacco tax by 5 cents in 1988. One-fourth of the revenue was earmarked for tobacco control public education. This campaign resulted in a 28 percent decrease in smoking prevalence since 1989, although the influence would have been greater without aggressive counter-programs conducted by the tobacco industry.[3] Additionally, the public information campaign influenced more than 200,000 people to stop smoking in 1990-1991.[4]

- In 1993, Massachusetts increased its tobacco tax from 26 to 51 cents per pack. All of the revenue generated by this increase is dedicated to education. As a result, cigarette sales in Massachusetts decreased by 12 percent in the first year and have continued to decrease annually.[5] Additionally, smoking rates in Massachusetts have declined by 20 percent since 1993.[6]

- In November, 1996, Oregon increased its tobacco tax by 30 cents, which will earmark $7 million a year to prevent kids from using tobacco.[7]

- Over 90 percent of Minnesotans believe that tobacco taxes should be used for youth smoking prevention programs.[8]

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[1]1995 Minnesota Student Survey of 133,000 public school students conducted by the Minnesota Department of Children, Families and Learning.

[2]Flynn B.S. et al., "Prevention of Cigarette Smoking Through Mass Media Intervention and School Programs," *American Journal of Public Health*, 1992: Vol. 82; Flynn BS, "Mass Media and Smoking Interventions for Cigarette Smoking Prevention: Effects Two Years After Completion," *American Journal of Public Health*, 1994: Vol. 84.

[3]Elder JP, et al., "Independent Evaluation of the California Tobacco Education Program," *Public Health Reports*, July/August 1996: Volume 111, p.353-358.

[4]Popham WJ, et al., "Do Anti-smoking Media Campaigns Help Smokers Quit?" *Public Health Reports*, 1993: Vol 108.

[5]Taken from the American Cancer Society's Tobacco Tax Policy Project, Washington, D.C., 1994.

[6]News Services, "CDC Says 5 Million Underage Smokers Risking Early Death," *Minneapolis Star Tribune*, November 8, 1996, p.A4.

[7]American Heart Association, Oregon Affiliate, Inc., November, 1996.

[8]Mathematica Policy Research, Inc., 1994.

SMOKE FREE 2000 COALITION

Increasing the Tobacco Excise Tax

- Studies show that higher excise taxes on cigarettes would significantly reduce the number of youth who smoke and decrease the likelihood that children would begin smoking.[1]

- Cigarette price increases impact youth cigarette purchasing patterns about three times more than they affect the purchases of adults.[2]

- Every 10 percent increase in cigarette prices results in a 12-14 percent decrease in youth consumption, increasing both the number of youth who quit smoking and those who don't start.[3]

- Studies suggest that nearly two-thirds of the decrease in smoking resulting from excise tax increases is the result of people choosing not to smoke at all.[4]

- Results from several U.S. states and other nations that have levied a significant tobacco excise tax show that cigarette consumption decreases when an excise tax is part of a comprehensive tobacco control program. Between 1980 and 1991, Canada raised its tobacco taxes from rates comparable to current U.S. rates to about $3.00 (U.S.) per pack. Youth smoking declined by more than 60 percent in Canada during this period, while it remained level in the U.S. After California passed a 25 cent tax increase in 1989 and earmarked revenue for education and prevention, smoking prevalence decreased by 17 percent.[5] Massachusetts followed suit in 1993. Their 25 cent tax increase resulted in a 20 percent drop in smoking rates.[6]

- A 1994 survey showed that 65 percent of Minnesota households support an increase in the tobacco tax as a means to fund increased health care costs. Even 46 percent of smokers approve of an increased tobacco tax if it will help reduce teen smoking.[7]

- Nationally, 70 percent of the public, including people who smoke, support higher tobacco excise taxes, according to a 1993 survey by the Coalition for Smoking OR Health.

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[1] Frank J. Chaloupka and Michael Grossman, "Price, Tobacco Control Policies and Youth Smoking," Presentation to the 71st Annual Conference of the Western Economic Association International, July 1,1996.

[2] Chaloupka and Grossman, etc.

[3] As cited in Coalition on Smoking OR Health Fact Sheet, "Tobacco Taxes and Kids," 1994.

[4] J. Wasserman, et al., "The Effects of Excise Taxes and Regulations on Cigarette Smoking," *Journal of Health Economics*, 1991, Vol. 10 p. 43-65; E.M. Lewit and D. Coate, "The Potential for Using Excise Taxes to Reduce Smoking," *Journal of Health Economics*, 1982, p. 121-145.

[5] As cited in Coalition on Smoking OR Health Fact Sheet, "Tobacco Taxes and Kids," 1994.

[6] *Morbidity and Mortality Weekly Report*, Centers for Disease Control and Prevention, November 8, 1996.

[7] Results of survey conducted by Mathmatica Policy Research, Inc., 1994.

SMOKE FREE 2000 COALITION

Reducing Youth Access to Tobacco

- Tobacco use among Minnesota teens is increasing rapidly. Weekly tobacco use among 12th graders is up from 22% in 1989 to 29% in 1995.[1]

- Most people who smoke began doing so during adolescence. The average age people first try smoking is 14.5 years, and 88% of persons who have ever tried a cigarette have done so by age 18. 71% of those adults who currently smoke every day started smoking by age 18.[2]

- The easy illegal access that teenagers have to tobacco products contributes to the rising rate of tobacco use. A recent study in Minnesota found that cites without a local ordinance to reduce illegal tobacco sales had a violation rate of 45%. Cities with a local ordinance had a violation rate of 21%. Therefore, stores in communities *without* local ordinances were twice as likely to sell tobacco to minors than stores in communities *with* ordinances.[3]

- In recent years, the tobacco industry has been extremely aggressive at the state level. The number one national tobacco industry tactic has been to take away local control of policy affecting youth access to tobacco. In 1996, 24 out of 26 states defeated the tobacco industry tactic of preemption, including Minnesota.[4]

- A national poll found that 81% of those surveyed believe that state laws should allow local communities to maintain the option of passing local ordinances to protect children from tobacco.[5]

- More than 100 cities have enacted local tobacco control ordinances in the last five years. Twenty-one of those have been passed in 1996. Another 20 cities are in the process of adopting an ordinance.[6]

- The Minnesota Smoke-Free Coalition supports a state bill that includes the following provisions: requires vendors to have a tobacco license; requires compliance checks of all tobacco vendors; sets administrative penalties for merchants and clerks that illegally sell tobacco to minors; establishes an administrative penalty system with mild penalties for first-time offenders and more strict penalties for subsequent violations; bans self-service of tobacco products; and no preemption of local control.

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[1]1995 Minnesota Student Survey of 133,000 public school students conducted by the Minnesota Department of Children, Families and Learning.

[2]U.S. Department of Health and Human Services. *Preventing Tobacco Use Among Young People: A Report of the Surgeon General.* U.S. Department of Health and Human Services, 1994.

[3]Forster, JL, Hourigan, M, Kelder, S. "Evaluation of a City Ordinance Requiring Locking Devices on Cigarette Vending Machines." *American Journal of Public Health* 1992;82(9):1217-1219.

[4]Actions Speak Louder Than Words: The Tobacco Industry's Stealth Strategies in State Legislatures. A report prepared by the American Cancer Society, American Heart Association, American Lung Association, Americans for Nonsmokers' Rights and the National Center for Tobacco-Free Kids, May, 1996.

[5]Actions Speak Louder Than Words: The Tobacco Industry's Stealth Strategies in State Legislatures. A Report prepared by the American Cancer Society, American Heart Association, American Lung Association, Americans for Nonsmokers' Rights and the National Center for Tobacco-Free Kids, May 28, 1996.

[6]Minnesota Smoke-Free Coalition, November, 1996.

Appendix 4 -- Further information on the significant adverse public health and economic impacts of tobacco use

news release

FROM THE MINNESOTA DEPARTMENT OF HEALTH

FOR IMMEDIATE USE
November 20, 1996

Contact: Janet Olstad
Family Health Division
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MDH Communications
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69,000 POTENTIAL YEARS OF LIFE LOST TO SMOKING IN MINNESOTA IN 1995

New figures show importance of Great American SmokeOut, November 21

Deaths from smoking are preventable. Yet, Minnesotans lost an estimated 69,000 potential years of life in 1995 due to smoking-related causes. The Minnesota Department of Health (MDH) estimates that smoking was responsible for 6,400 premature deaths (17 percent of all deaths) in Minnesota in 1995, up from 5,900 deaths in 1992. The estimates are based on smoking rates and the known risks of death from smoking-attributable causes. Tobacco is known to contribute to eight types of cancer and more than a dozen cardiovascular and respiratory ailments.

Health care costs resulting from smoking also are excessive—an estimated $513 million in 1995, compared to $470 million in 1992. Income lost due to smoking-related deaths and disability was estimated to have been $766 million. The two estimates add up to a total cost from smoking of $1.3 billion, or $277 for every Minnesotan, in 1995.

Minnesota Commissioner of Health Anne Barry said the human and economic costs of smoking are alarming. "Too many Minnesotans are dying needlessly from smoking-related causes," Barry said. "We're proud that Minnesota ranks number one in health according to the recent ReliaStar rankings, but increases in youth smoking endanger our number-one ranking. Public health officials, lawmakers and communities must work harder together to combat smoking, especially among young people," Barry said.

-more-

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Most people begin smoking when they are teenagers, according to Dr. Bert Hirschhorn, director of the Division of Family Health at the Minnesota Department of Health. "If we can convince more young people to say no to tobacco, we can reduce the number of Minnesotans who will die prematurely from this lethal habit," Hirschhorn said.

Hirschhorn added that in 1995, approximately 25 percent of twelfth-graders in Minnesota reported smoking, while 20.5 percent of Minnesota adults smoke. "To have any long-term impact on the devastating effects of smoking, we need to eliminate tobacco advertising targeted at youth, reduce youth access to tobacco, and create financial and social disincentives for kids to start smoking."

Although not reflected in the 1995 estimates, second-hand smoke also contributes to the rising costs of smoking. "If we had included second-hand smoke in our estimates, the costs would have been even more staggering," said Hirschhorn. The U.S. Environmental Protection Agency has classified second-hand smoke as a Group A carcinogen. Such carcinogens (which include benzene, asbestos and radon) are known to cause cancer in humans.

For people who wish to quit smoking, the Minnesota Department of Health recommends contacting the American Cancer Society at 1-800-ACS-2345, the American Lung Association at 1-800-LUNG USA, or their primary care physician.

The department calculated the 1995 estimates using a sophisticated computer program called SAMMEC 2.1 (Smoking-Attributable Mortality, Morbidity and Economic Costs) from the national Centers for Disease Control. The scientifically accepted program is used throughout the U.S. for calculating smoking costs.

-MDH-

Please see attached fact sheet.

Minnesota Estimates of Mortality and Economic Costs Due to Smoking, Based on 1995 Data

Background

About every two years the Minnesota Department of Health estimates the number of Minnesotans who died from smoking-attributable causes and the smoking-related economic costs Minnesota has incurred. These estimates were calculated using the most recent data available.

1995 Deaths Attributable to Smoking

- 6,400 deaths, representing 17% of all Minnesota deaths (totaling 37,430) in 1995, were smoking-attributable. This estimate is based on 1994 smoking rates and on the known increased risk of death for smokers from more than 20 individual smoking-attributable causes. Of these 6,400 deaths:

  - 2,600 (41%) were due to cardiovascular diseases, including heart attack and stroke.
  - 2,200 (34%) were due to cancers, including cancer of the lung, uterine cervix, bladder, pancreas, and kidney.
  - 1,600 (24%) were due to respiratory diseases such as pneumonia, asthma, bronchitis, and emphysema.
  - 41 (0.6%) were the result of cigarette-ignited fires.

- Of the more than 2,000 people who died from lung cancer in Minnesota in 1995, more than 1,600 (81%) can be attributed to smoking.

- Smoking-attributable deaths are premature deaths. In Minnesota these deaths represent the loss of nearly 69,000 potential years of life, or about 11 years lost for each person who died in 1995 from a smoking-attributable cause.

Estimated Economic Costs Attributable to Smoking, 1995

- Estimated health care costs for smoking-attributable diseases, including costs of hospitals, physicians and health care professionals, nursing homes, and medications, based on 1995 Minnesota population estimate of 4,609,548, were more than $513 million for 1995. This amounts to:

  - $1.35 for every pack of cigarettes sold in Minnesota or
  - $111 per Minnesota resident for the year.

more, next page

November 1996
Minnesota Department of Health
Division of Family Health
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Estimated Costs of Smoking, 1995 — continued

- Estimated income lost as a result of premature death or disability (including short-term work absences) attributable to smoking is $766 million, which amounts to:

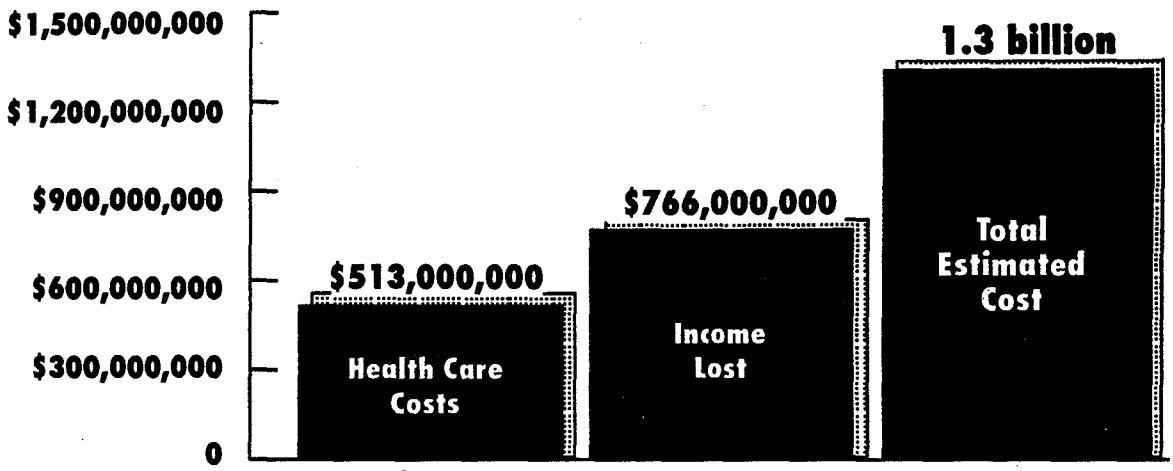
- $2.01 for every pack of cigarettes sold in Minnesota or
- $166 per Minnesota resident for the year.

- The total estimated cost of smoking in Minnesota in 1995 comes to $1.3 billion, which amounts to:

- $3.36 for every pack of cigarettes sold in Minnesota or

- $277 per Minnesota resident for the year.

Estimated Smoking-Attributable Costs, Minnesota, 1995



- In Minnesota, fiscal year 1995 excise tax revenue on cigarettes alone totaled $182,874,460 or 48 cents per pack sold. This revenue is dwarfed by the total cost of smoking (disability and health care costs) borne by all Minnesota residents — $1.3 billion — which is seven times greater than the tax revenue.

Sources

Minnesota Department of Health, 1996, using Smoking-Attributable Mortality, Morbidity, and Economic Costs (SAMMEC 2.1 software program, 1992, Centers for Disease Control) with: 1995 Minnesota population estimate (Bureau of the Census); 1995 Minnesota mortality and 1994 smoking prevalence data (MN Center for Health Statistics); estimated 1993 direct health care costs (Health Care Finance Administration) adjusted to 1995 dollars; estimated 1989 indirect costs (U.S. Bureau of Labor Statistics) adjusted to 1995 dollars; and with 1995 cigarette tax revenue data (MN Dept. of Revenue).

Appendix 5 -- Notes on Illinois "peace plates"

Notes on Illinois "Peace Plates"

Summary of "Violence Prevention Notes, Vol 1, No. 7"

The Illinois Violence Prevention Act of 1995 created the Illinois Violence Prevention Authority to "plan, coordinate, fund, and evaluate public health and public safety approaches to violence prevention in the state." The Act also created a "violence prevention fund". The initial funding for the program will come from the sale of violence prevention license plates.

The Act directs the Violence Prevention Authority to administer a grants program to fund community-based and statewide collaboration efforts to address:

- Community-based youth violence prevention programs;
- Comprehensive pre-K-12 school based violence prevention programs;
- Early childhood intervention programs;
- Family violence and sexual assault initiatives;
- Programs to integrate violence prevention with health care and alcohol and substance abuse prevention efforts;
- Innovative community policy/law enforcement approaches to violence prevention.

Notes from discussion with Barb Shaw, Executive Director, Ill. Council for Violence Prevention, regarding "peace plates".

1. The peace license plates went on sale in Jan 96.

2. There has been relatively little publicity about the license plates. Starting mid-June of this year, motorists started receiving a reminder of the option to purchase the peace plates when they received their license plate renewal notifications.

3. Over 22,000 plates have been sold, with $25.00 per plate going to the Ill. Violence Prevention Authority -- for a total of over $550,000.

4. The goal in two years is to sell 80,000 plates a year, to raise over $2 million annually.

5. The initial costs of designing and producing the plates are also recouped in the cost of the plate. People buying peace plates for the first time spend about $40.00 more than the cost of regular plates. $25.00 goes to the Ill. Violence Prevention Authority; $15.00 goes to the production of the plates. Renewal plates cost $27.00 -- $25.00 to the Prevention Authority, and $2.00 to cover the processing cost of the renewal.

6. The money raised through the license plates sales will be used to fund a number of grants. The Authority is actually meeting today to look at disbursement of the funds. They are developing a 3-year plan, and a first year plan. In the first year they think they will fund $100,000 toward an anti-violence media campaign, with a tie-in to marketing of the peace plates. The other $400,000 will be used on local and statewide collaborations in a variety of areas.

7. The bill authorizing all this passed without a dissenting vote. The Illinois legislature recently went Republican, and the state medical society was instrumental in finding a Republican sponsor of the bill. It helped not to be asking for $$ from the general fund. It further helped to have the state's attorney general, representing the state's criminal justice system, involved. The AG's presence made central messages about the need for prevention, rather than a "get tough stance" of just jailing younger and younger criminals for longer and longer periods, more credible.

8. Illinois' larger population and urban concentration around Chicago probably contributed to the relatively large number of plates sold; MN is not likely to have the same degree of success.

9. Illinois' other leading special license plate is for the environment; the peace plate has now surpassed the environmental plate in sales (but has not affected the sales of the environmental plate). The Council notes that the environmental plate protects the physical environment; the peace plate protects the social environment.

Appendix 6 -- Health Plan Information on Public Health Iniitiatives

Included in this appendix is just a sample of the public health initiatives of some of Minnesota's health plans. These health plans as well as other health related organizations have spent considerable time and money to achieve public health goals. For more information on these and other public health initiatives, either contact the health plans directly or contact the Commission.

ALLINA
HEALTH SYSTEM

A Commitment to Improving Public Health

Allina Health System's vision is *to be the recognized innovator in improving the health of communities we serve.* To this end, Allina and the Allina Foundation (an independent, affiliated foundation) have launched Allina-wide health improvement initiatives and have invested in numerous community-led health improvement projects.

Allina's model for community health improvement is comprehensive: it supports coordinated and mutually reinforcing interventions with individuals, communities and systems. In this way, we hope to create lasting, measurable health improvement. The following is a brief sample of the many public health activities in which Allina Health System is engaged. For more information, call Jan Malcolm, system vice president, Public Affairs, (612) 992-3481.

Violence Prevention

Violence is a major public health threat in which the health care system is uniquely positioned to intervene. Health care providers are often the first point of contact for victims following an incidence of violence. As such, they have an opportunity to intervene, make appropriate referrals, and accurately document the incident. Allina's system-wide violence prevention initiative includes support for research; increasing use of E-codes in its 14 owned hospital emergency rooms; adopting workplace violence policies; participating on the Governor's Task Force on Violence as a Public Health Problem and the Health Care Coalition on Violence Prevention; supporting efforts to reduce media violence; supporting public policies to reduce and prevent violence; and modifying health plan coverage policies to better meet the needs of victims.

Tobacco Control

Allina has launched a comprehensive tobacco control initiative. To intervene at the individual level, Allina is engaged in a pilot project to test Agency for Health Care Policy and Research (AHCPR) recommendations for clinical interventions in 20 Allina Medical Group clinics. Allina has received a grant from the Robert Wood Johnson Foundation to evaluate this project. Additionally, to support community interventions, Allina will partner with schools, employers and communities to reduce tobacco use. To support system-level tobacco interventions, Allina supports tobacco-control legislation and two Allina hospitals (Shakopee and New Ulm) have led successful efforts to pass local tobacco-control ordinances. Also at the system-level, the Allina Foundation is supporting a Public Health Advisor working with the Minnesota Attorney General to bring a public health perspective to decisions regarding tobacco litigation.

Project REACH

Project REACH (Research Education And Community Health) was designed and funded by the Allina Foundation to help understand what makes population-based health improvement activities successful. Launched in 1996, Project REACH is a $1 million, 4-year initiative. Specifically, the initiative seeks to determine if, and how, population-based health improvement programs are affected by a variety of factors including: the organizing model, (what are the differences between projects internal to Allina and community-based ones?); the health issue (is it more effective to target asthma or teen access to tobacco?); and health care system involvement (as a participant or funder?).

TOWARD A TOBACCO-FREE MINNESOTA

BlueCross BlueShield of Minnesota
An independent licensee of the Blue Cross and Blue Shield Association

Blue Cross and Blue Shield of Minnesota (BCBSM) is teaming up with other Minnesota organizations to reduce tobacco use in the state. BCBSM is one of the state's leading advocates of reducing tobacco use. Tobacco prevention strategies take place within the community, in clinics, at the Capitol, and in the courtroom. Some of these strategies are part of BluePrints® for Health, a series of programs to help Minnesotans take control of their health.

THE PROBLEM

Tobacco use is the No. 1 preventable cause of premature illness and death for Minnesotans. The Minnesota Department of Health estimates that the use of tobacco adds at least $513 million a year to the cost of health care. Smoking kills more people each year than AIDS, alcohol, drunk driving, cocaine, drug abuse, and accidents combined. In Minnesota alone, smoking accounted for 6,400 premature deaths in 1995. Department of Health research estimates the total cost of smoking in Minnesota in 1995 comes to $1.3 billion, or $3.36 for every pack of cigarettes sold in Minnesota.

ADDRESSING THE PROBLEM

BCBSM works with community organizations, public health agencies, schools, government, and others to develop communitywide solutions to reducing tobacco use. Our involvement includes efforts to improve community health, to support healthy worksites and healthy individuals, and to influence public policy.

Public and corporate policy

Tobacco litigation

In 1994, BCBSM became the first health plan in the nation to take the tobacco industry to court for violations of state consumer protection and anti-trust laws. BCBSM has entered this suit together with the state of Minnesota.

In 1996, BCBSM won a major victory when the Minnesota Supreme Court ruled that BCBSM will remain as a co-plaintiff in the litigation. The case is

continued on back

scheduled to go to trial in January 1998.

Youth access legislation

BCBSM provides support and direction for grassroots efforts to promote meaningful statewide and local youth access laws. The objective is to establish effective laws that make it difficult for kids to illegally buy cigarettes and other tobacco products.

Tobacco Tax Initiative

BCBSM helped establish the Tobacco Tax Coalition for a Healthy Minnesota, later renamed the Tobacco Tax Initiative of the Smoke-Free 2000 Coalition.

■ *For more about youth access legislation and the Tobacco Tax Initiative, contact the Minnesota Smoke-Free Coalition at (612) 641-1223.*

Investment policy

We exclude from our investment portfolio companies that profit from the sales of tobacco.

Improving community health

Young Enough to Know Better: Stop Smoking Before It Starts

Young Enough to Know Better: Stop Smoking Before It Starts is a BCBSM program launched in November 1996. The project includes an award-winning video, produced by the American Cancer Society (ACS) and funded by the BCBSM Foundation. The video is designed for kids in grades K-3, and includes a teacher's guide. BCBSM also developed a family discussion brochure that includes tips on how parents can effectively address the issue of tobacco usage with kids in grades K-3. BCBSM also partnered with broadcast and cable stations to air the video and a follow-up panel discussion with kids and adults.

■ *For more information about Young Enough to Know Better, contact ACS at 1-800-582-5152.*

Fitness Fever

Being fit means being tobacco free. So when BCBSM rolled out its fitness challenge to kids across Minnesota in grades 1-6, tobacco prevention materials were included.

■ *For more information on Fitness Fever, call (612) 456-1579.*

Minnesota Smoke-Free 2000 Coalition

BCBSM supports tobacco prevention community organizations such as the American Cancer Society, Minnesota Smoke-Free 2000 Coalition, and the Association for Nonsmokers' Rights (ANSR) -Minnesota. These organizations help people quit smoking, protect Minnesotans from secondhand smoke and educate kids about tobacco hazards.

■ *For more information, contact the Minnesota Smoke-Free 2000 Coalition at (612) 641-1223; ACS at 1-800-582-5152; and ANSR at (612) 646-3005.*

Supporting healthy worksites and healthy individuals

Smoke-free facilities

BCBSM was one of Minnesota's first major employers to establish a smoke-free workplace at all of our facilities.

Discount for nonsmokers

BCBSM was one of the first health plans in the nation to offer individual subscribers an incentive not to smoke by granting a rate discount to nonsmokers.

Helping smokers kick the habit

Providers in our Blue Plus and Blue Care clinics use the Doctors Helping Smokers program and IMPROVE project to help their patients quit smoking.

VIOLENCE PREVENTION

BlueCross BlueShield of Minnesota
An independent licensee of the Blue Cross and Blue Shield Association

Helping people work together to prevent violence is one way that Blue Cross and Blue Shield of Minnesota (BCBSM) strives to improve the health of Minnesota communities. BCBSM helps find public/private health care solutions to reducing violence through broad-based collaborations. Our violence prevention efforts are part of BluePrints® for Health, a comprehensive series of programs designed to help Minnesotans take control of their health.

THE PROBLEM

The growing number and impact of violent crimes in Minnesota has made violence a serious public health problem. Homicide has become the leading cause of death for some demographic segments of Minnesota. For kids ages 15 and older, violence is their worst health threat. The costs of violence are difficult to measure. In addition to pain and suffering, Minnesota pays roughly $200 million in violence-related health care costs. In 1992, Hennepin County Medical Center, for example, treated 165 gun shot wounds totaling $2.5 million in hospital charges.

ADDRESSING THE PROBLEM

BCBSM works with community organizations, public health agencies, the media, and others to develop communitywide solutions to reducing violence. Our involvement includes the following programs:

Minnesota Action Plan to End Gun Violence

BCBSM developed the Minnesota Action Plan to End Gun Violence in partnership with the Blandin Foundation and Minnesota Public Radio. The Action Plan engaged Minnesotans in finding solutions to the effects of gun violence in their lives and communities. A series of statewide town meetings attracted more than 1,000 participants who brought with them many innovative, grassroots solutions. The results were published in Minnesota Monthly magazine and distributed across Minnesota and the rest of the country. The Action Plan mobilized groups across the state to take specific steps to stem violence in their communities. These steps include an awareness campaign and toll-free tip line to help teens get

continued on back

guns out of their schools and the formation of the Governor's Task Force on Violence as a Public Health Problem and the Minnesota Health Care Coalition on Violence.

The Minnesota Action Plan to End Gun Violence has received local and national honors.

- ✓ 1995 Greater Minneapolis Chamber of Commerce Quality of Life Award
- ✓ 1996 American Association of Health Plans' Community Leadership Award finalist
- ✓ Recognition by the Public Health Foundation of Washington, D.C., as an exemplary public health/health plan collaboration
- ✓ 1996 American Bar Association's Gavel Award Certificate of Merit, recognizing outstanding efforts to foster public understanding of the law.

■ *For a copy of the Action Plan, call (612) 371-5880.*

Students Stop Guns: An Initiative for Gun-Free Schools

Students Stop Guns was developed from the Action Plan and represents a powerful new weapon to help keep Minnesota schools safe. The program incorporates a hard-hitting, student-directed awareness campaign with an anonymous tip line so students can report a gun in school without fear of being identified. The project extends BCBSM's partnership with Blandin Foundation to include Allina Health System and Carmichael Lynch.

■ *For more information on Students Stop Guns, call 612-371-9391.*

Governor's Task Force on Violence as a Public Health Problem

BCBSM actively participates on the Governor's Task Force on Violence. The task force developed a plan that focuses on better violence data, prevention programs, guidelines for providers who treat violence victims, and reduction of workplace violence. The plan also calls for the health care community to work more closely with community groups on violence prevention programs.

■ *For more information about the Governor's Task Force on Violence, call (612) 334-2640.*

Courageous Girls

BCBSM supports Courageous Girls, a group that trains and encourages girls to speak out against violence. Courageous Girls visit schools to promote positive attitudes and provide peer education. The group formed after students participated in the Action Plan town meeting at Brooklyn Center High School. It is a program of the Minneapolis Parks and Recreation board.

■ *For more information about Courageous Girls, contact Sherina Gibbs, Minneapolis Park Board, at (612) 370-4925.*

Health Care Coalition on Violence

BCBSM participates in the Health Care Coalition on Violence, a new coalition designed to focus on workplace violence, primary violence prevention, data collection, practice guidelines, education and training, and health plan coverage. The formation of this coalition brings to fruition one of the governor's task force recommendations.

■ *For more information, call (612) 623-2852.*

Unload It and Lock It

BCBSM supported developing a Minnesota Medical Association (MMA) brochure titled Unload It and Lock It. Distributed at clinics across the state, the brochure includes a Physician's Firearm Safety Checklist.

■ *To obtain a copy of Unload It and Lock It, contact MMA at 1-800-999-1875.*

Violence Prevention Community Meetings

BCBSM has sponsored community meetings to help find solutions to the problem of violence. Recent examples include the Youth Summit on Reducing Gun Violence held at the Capitol, and Building Non-Violent Communities, a statewide satellite conference of the Minnesota Partnership for Non-Violent Communities.

FOR IMMEDIATE RELEASE
For information:
Contact Mary Jo Malach
(612) 456-1579

FITNESS FEVER BUILDS ON FIRST-YEAR SUCCESS

Grant from CDC will assess impact of participation in the program

EAGAN, MN.—After a successful first year, Fitness Fever is back in Minnesota schools. In the 1995–96 school year, more than 220,000 students at 520 schools statewide participated in the program, which is designed to increase awareness of the importance of physical activity and encourage lifetime physical behaviors in children and their families. For 1996–97, 579 schools with 232,015 students are participating.

Fitness Fever is a Blue Cross and Blue Shield of Minnesota (BCBSM) BluePrints® for Health community partnership with the Minnesota Department of Health, Minnesota Department of Children, Families and Learning, Minnesota Service Cooperatives, the Minnesota Timberwolves and other supporters.

"Fitness Fever is a further demonstration of BCBSM's involvement in the communities it serves across Minnesota," said Andy Czajkowski, BCBSM president and CEO. " We're committed to improving the health of Minnesota children through successful public/private partnerships such as Fitness Fever."

Fitness Fever has two components and is coordinated through the schools: a four-week physical activity challenge and a four-week a nutrition project that encourages and develops good eating habits.

Minnesota Commissioner of Health Anne Barry said that Fitness Fever is a great example of a public/private partnership that works.

—*MORE*—

"Today, more than ever, it's important for public and private health agencies to work closely together," Barry said. "Fitness Fever is a great example of the kinds of partnerships we're encouraging to improve the public's health."

Monitoring behavior change

To assess the impact of the Fitness Fever program, the Minnesota Department of Health was awarded a $58,000 grant from the Centers for Disease Control and Prevention in Atlanta. The one-year grant will allow the department to survey 25 fifth graders at each of the 60 schools that were in the program for the second year, and 60 schools that are joining the program for the first time this year. Results should be available by fall of 1997.

New informational components

Based on comments from participants in the first year of the program, many new features have been added to Fitness Fever, including a Kid's Activity Pyramid, 5 A Day nutrition information and a World Wide Web site.

The Kid's Activity Pyramid will make it easy for children to understand just how much activity they need to fit into their daily and weekly schedules. The pyramid is used with permission from the Institute for Research and Education of HealthSystem Minnesota.

The 5 A Day nutrition messages will encourage students to eat at least five servings of fruits and vegetables every day. Fitness Fever journals will carry the 5 A Day theme and so will the take-home family brochures.

The Minnesota Department of Children, Families and Learning will include Fitness Fever on its World Wide Web site. The site will include Fitness Fever tips and information for teachers, families and students. The Web site will be activated in January so that schools can begin planning their campaigns.

Building on success

After the conclusion of Fitness Fever in its first year, more than 77 percent of 527 physical education teachers responded positively to a survey:

- 85 percent indicated they would use the program next year.
- 96 percent reported the student journal was important to the success of the program.

—MORE—

- 73 percent indicated that students had other family members participate in physical activity with them during Fitness Fever.

The survey results are good news considering all of the technology that entices kids to sit indoors after school and watch television and play with computers. When they do so, they are usually munching chips, candy and other junk foods. According to the U.S. Surgeon General's report on Physical Activity and Health released earlier this year, half of all kids are not physically active on a regular basis. According to the American Heart Association, at least 4 million American children have high blood pressure, one-third are obese and 27 million have high cholesterol.

Registration brochures for Fitness Fever were sent to schools during the first week of October.

Other supporters of Fitness Fever include the American Heart Association-Minnesota Affiliate, American Lung Association of Minnesota, Melpomene Institute, Minnesota Division of the American Cancer Society and the Minnesota Governor's Council on Physical Fitness and Sports. New supporters this year include Minnesota 5 A Day Coalition, School Nurse Organization of Minnesota and the Minnesota Association for Health, Physical Education, Recreation and Dance.

BCBSM, based in Eagan, a suburb of St. Paul, Minn., covers more than 1.5 million members through its own health plans or plans that it administers. BCBSM, a leader in developing innovative relationships with hospitals and physicians, is Minnesota's oldest and largest health plan. BCBSM's financial strength is demonstrated by its "A" (excellent) financial rating by A.M. Best. The company began operations in 1933. BCBSM is an independent licensee of the Blue Cross and Blue Shield Association, headquartered in Chicago.

—END—

Facts about Children's Health
From Fitness Fever, A BluePrints® for Health Community Health Program
October 11, 1996

General facts

- According to the American Heart Association, at least 4 million American children have high blood pressure, one-third are obese and 27 million have high cholesterol.

- Nearly two-thirds of the nation's elementary and secondary schools—many of them lacking space and funding—have cut daily physical education classes, according to the American Heart Association.

- Summarizing current research, the first surgeon general's report on physical activity and health released earlier this year, stated that regular exercise reduces the risk of developing heart disease, diabetes, colon cancer, osteoporosis and high blood pressure. Activity has also been shown to reduce the symptoms of depression and anxiety, improve moods and enhance the ability to perform daily tasks.

- As many as 60 percent of children by the age of 12 in the United States exhibit at least one risk factor for cardiovascular heart disease and that the risk factor remains into adulthood, according to a May 1996 article in *Physical Therapy*.

- The percentage of children who are unfit is unclear because different criterion-related standards are used in various fitness programs. However, in virtually all programs, 20 percent or more of the children fail to meet recommended fitness standards in one or more areas, according to research presented in the May 1996 issue of *Physical Therapy*.

- In the most recent research available regarding the association of obesity and television watching, children of aged 6 to 11 spent 22 hours per week viewing television. Studies have shown the prevalence of obesity was found to increase by 2 percent for each additional hour of television viewed.

- If approximately 20 percent of America's children are at risk because of low fitness, that means that nationally between 8 and 9 million school-age children are at risk. Responding to such a need as opportunities could be today's "best investment," wrote J. Morris in the 1994 edition of *Medical Science Sports Exercise*.

—*MORE*—

The 1996 Surgeon General's Report on Physical Activity and Health

- The report states that participation in all types of physical activity declines strikingly as age and grade in school increases.

- The report provides encouraging information, including the following facts:

  √ Well designed school-based interventions directed at increasing physical activity have been shown to be effective.

  √ Social support from family and friends has been consistently and positively related to physical activity.

- The report provides recommendations for communities to

  √ Create opportunities for physical activities that are enjoyable, that promote confidence in physical activities and that involve friends, peers and parents.

  √ Encourage health care providers to talk routinely to patients about the importance of incorporating physical activity into their lives.

—END—

For more information contact:
Blue Cross and Blue Shield of Minnesota
Karl Oestreich 612/456-1502
Greg Bury 612/456-6850
Judy Kerry 612/456-1515

Call anytime:

612-646-0994

You can call 24 hours a day. Collect calls are accepted. Services include

- Someone to listen
- Support groups
- Legal information
- Safe shelter
- Support for whatever decisions you make
- Confidentiality

A project of the Minnesota Coalition for Battered Women in partnership with the Minnesota Medical Association.

Minnesota Coalition for Battered Women
1619 Dayton Avenue, Suite 303
St. Paul, MN 55104
612 • 646 • 6177 v/tdd
612 • 646 • 0994 Metro Crisis Line v/tdd
1 • 800 • 289 • 6177 Statewide Referral

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HealthPartners
Center for Health Promotion

HEALING YOUR BODY & *SPIRIT*

It's okay to talk about family violence here.

Are you embarrassed or afraid to tell a doctor or nurse what caused your injuries or why you don't feel well? If you are here because someone hurt you, you are not alone.

Does someone you know hurt you?

Have you been choked, punched, hit, kicked, shoved, slammed into walls, pounded with things, cut, or threatened with weapons? If this has happened to you, think about telling your doctor or nurse or call the number(s) listed in this brochure.

Any woman can be abused.

A woman can be abused by a current or former husband, boyfriend, lesbian partner, caregiver, pimp, or by a father, brother, uncle, teenage or adult child, or roommate. A woman can be abused by anyone in her family.

"I feel embarrassed and stupid."

"Last time I said I fell and broke my arm. They're going to think I'm stupid if I say something like that again."

"I'm afraid to say why I'm here."

"He choked me until I passed out and said he'd kill me if I told anyone."

"He's got my kids. If I don't get outta here quick, he's gonna hurt 'em...real bad."

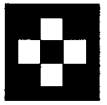
"They don't understand...she will call my boss and tell them I'm a lesbian if I ever tell someone what she did to me."

"I feel depressed."

Sometimes women tell doctors about depression, stress, anxiety, headaches, stomach aches, ulcers, or panic attacks instead of talking about abuse. If you get medicine for these symptoms it might help, but it won't make the abuse go away and there is a risk of becoming addicted.

"I'm pregnant."

Many women get abused during pregnancy and have miscarriages. If you've been hit or kicked in your abdomen there is a much higher health risk for you and your baby.



There is help.

The doctors and nurses here can help you. If it feels safe, try to tell them what happened to you.

They must keep everything you tell them **CONFIDENTIAL** except child abuse or abuse of a vulnerable adult which MUST be reported.

They can document injuries or symptoms caused by abuse. You may need these records one day.

They can tell you about local programs that can help **IMMEDIATELY** to get you and your children to a safe place.

What is Domestic Abuse?

Domestic abuse is the threat or infliction of physical, sexual or emotional/psychological harm between past or present social partners. Broadly speaking, it is any action that is an abuse of power or authority by a partner where the intent is to control by causing pain, fear or hurt. Without intervention and change, all forms of ongoing abuse escalate in frequency and severity over time, and have the potential to result in death.

Physical abuse is what is most commonly considered to be "domestic abuse." But most physically abusive acts occur within an ongoing pattern of emotional abuse in which the threat of violence is emphasized by occasions where physical violence is actually used.

HealthPartners' Domestic Abuse and Violence Prevention Goal:

HealthPartners is beginning to implement a long-range process to address the serious issue of domestic abuse and violence. HealthPartners seeks to:

Help identify members who may be victims of abuse and continually link them with appropriate services and prevention resources at HealthPartners and within the community.

- ▼ Define the scope of this serious issue – for the first time by a health plan – by collecting extensive baseline data on domestic abuse and violence. We want to create benchmark data to measure improvements.
- ▼ Work with community partners to develop and support programs within HealthPartners network clinics and the community to prevent family and workplace violence.
- ▼ Create innovative and effective programs to reduce the rate of violence among the populations we serve.

For more information, call the Partners for Better Health Phone Line at 612/883-7800

HealthPartners
8100 34th Avenue South, PO Box 1309
Minneapolis, MN 55440-1309

DOMESTIC ABUSE AND VIOLENCE

What is it, and what can be done to prevent it?

HealthPartners
Partners for Better Health

Facts About Domestic Abuse

Domestic violence is a medical, health care and public health issue of epidemic proportion.

- ▼ Abuse by a male partner is the single major cause of injury to women in the United States — more frequent than auto accidents, muggings and stranger rapes combined.
- ▼ Each year in this country, between 2 and 8 million women are battered.
- ▼ Up to 35 percent of women visiting hospital emergency rooms present with symptoms related to ongoing abuse.
- ▼ According to the Federal Bureau of Investigation, 30 percent of women who were murdered in 1990 were killed by husbands or boyfriends. It is estimated that 52 percent of female murder victims were killed by a current partner or ex-husband.
- ▼ The United States ranks first among industrialized nations in violent death rates — literally off the charts compared with other industrialized countries.

Common Myths About Domestic Abuse

Myth #1:

Domestic abuse affects only a small percentage of the population and isn't an important health care issue.

FACTS:

Domestic violence is an "equal opportunity" crime. Victims/survivors and perpetrators come from every walk of life and cut across all socioeconomic, religious, educational, ethnic and racial backgrounds. Between 2 and 8 million females are battered each year in this country. Over a lifetime, an estimated 25 to 37 percent of all women experience partner abuse.

Domestic violence costs on the health care system are staggering, totaling $3 to 5 billion every year. In addition, domestic violence results in workplace costs of at least $100 million in lost wages, sick leave, non-productivity and absenteeism.

Myth #2:

Alcohol and drugs cause abusive behavior.

FACTS:

Chemical dependency and domestic violence are two separate problems. Addressing only one of them will not solve the other.

Myth #3:

A woman in an abusive relationship can simply choose to leave the relationship.

FACTS:

Many factors combine to keep a person in a battering relationship, including the fear of injury, losing children, lack of economic or emotional alternatives and societal expectations. Typically, a battered woman will leave a relationship five to seven times before she is able to effectively establish suitable resources to make the final break. Because a perpetrator is most violent when he perceives that his partner is leaving him, abused women must be very cautious in their preparations and in their leaving.

Myth #4

The problem is really "spouse abuse" — couples who assault each other.

FACTS:

Domestic abuse is about an imbalance of power, and is rarely mutual. In 98 percent of cases, it is the male who abuses the female partner.

Myth #5:

The abuser is just "out of control."

FACTS:

The abuser is not out of control. He is choosing to use a learned behavior — violence — to control who he chooses, when he chooses and where he chooses.