IDAHO ASSOCIATION OF DISTRICT BOARDS OF HEALTH

2022 Annual Conference

Public Health
Prevent. Promote. Protect.

Location:
Online and
707 N Armstrong Pl
Boise ID

June 9, 2022
1:30 PM/MT (12:30 PM/PT)

2022 Annual Conference Business Meeting Agenda

Thursday, June 9, 2022 | 1:30 PM MT/12:30 PM PT

Hosted by Central Health District
707 N Armstrong Place, Boise, ID 83704 | Syringa Conference Room
Online Access/Video call link: Teams Link for IADBH or
Audio Only +1 469-423-055 | Conference #: 973993098#

Call to Order at 1:30 pm .... Betty Ann Nettleton

- IADBH Members 2022 Roll Call/ Call for Proxies .... Russ Duke

Changes to the Agenda (Action Item) .... Betty Ann Nettleton

Approval of Meeting Minutes of 2021 IADBH (Action Item) .... Betty Ann Nettleton

Idaho Association of Counties (IAC) Legislative Update .... Seth Grigg/Kelli Brassfield

IAC Contract Review and Discussion (Action Item). .... Betty Ann Nettleton

Budget Review and Approval (Action Item) .... Carol Moehrle

- Assessment to Districts

Review of Guidelines for Developing Resolutions (Action Item) .... Betty Ann Nettleton

Review of Expiring Resolutions (Action Item) .... Betty Ann Nettleton

- Resolution to Support Evidence-Based Home Visitation in Idaho
- Resolution Supporting Immunizations
- Resolution to Support Raising the Minimum Age of Legal Access and Use of Tobacco/Nicotine Products in Idaho to Age 21
- Resolution Opposing the Legalization of Recreational (Non-Medical) Marijuana
- Resolution to Support the Recognition of Senior Cognitive Health as a Public Health Issue
- Resolution to Support Awareness, Education and Prevention of Suicide

Review and vote on Proposed Resolutions (Action Item) .... Betty Ann Nettleton

- Resolution to Support an Excise Tax on Electronic Nicotine Delivery Systems
- Resolution to Remove the Food Establishment License Fee in Idaho Code
- Resolution to Support Raising the Minimum Age of Legal Access and Use of Mitragyna Speciosa (Kratom) Products in Idaho to Age 21
- Resolution to Support Vaping Prevention in Schools
- Resolution to Support Innovative Funding Streams to Support Awareness, Education, and Prevention of Suicide

State Association of Local Boards of Health (SALBOH) Update…............. Representative Megan Blanksma

Recommendation from the Executive Council on Continuing to have a SALBOH Representative to the National Association of Local Boards of Health and Decision by IADBH on this Position Including Election of this Position if Needed (Action Item) .... Commissioner Elt Hasbrouck

Next IADBH – Panhandle Health District in 2023 .... Betty Ann Nettleton/Glen Bailey

Adjourn .... Betty Ann Nettleton

IDAHO ASSOCIATION OF BOARDS OF HEALTH BOARD MEMBERS

BOARD MEMBER	ROLE	COUNTY	APPOINTMENT DATE
HEALTH DISTRICT 1			
Don Duffy, Secretary	District Director		
Marlow Thompson, Chair	County Appointed Representative	Benewah	1993
Tim Bertling, Vice Chair	County Appointed Representative	Boundary	2021
Glen Bailey, Trustee/Executive Council Representative	County Appointed Representative	Bonner	2013
Jessica Jameson, MD	County Appointed Representative	Kootenai	2021
Thomas Fletcher, MD	County Appointed Representative	Bonner	2022
Mike Fitzgerald	County Appointed Representative	Shoshone	2017
Richard McLandress, MD	County Appointed Representative	Kootenai	1985
HEALTH DISTRICT 2			
Carol Moehrle, Secretary	District Director		
Dave McGraw, Chair	Commissioner	Latah	2011
Doug Zenner, Vice Chair	Commissioner	Nez Perce	2011
Greg Johnson, Trustee/ Executive Council Representative	Commissioner	Lewis	2017
Glenn Jefferson, MD	Medical Consultant County Appointed Representative	Nez Perce	2013
Connie Osborn	County Appointed Representative	Latah	2016
Rick Winkel	Commissioner	Clearwater	2017
Denis Duman	Commissioner	Idaho	2021
HEALTH DISTRICT 3			
Nikole Zogg, Secretary	District Director		
Bryan Elliott, Chair	Commissioner	Gem	2017
Kelly Aberasturi, Vice Chair	Commissioner	Owyhee	2011
Georgia Hanigan, Trustee/ Executive Council Representative	Commissioner	Payette	2019
Keri Smith	Commissioner	Canyon	2021
Sam Summers, MD	Medical Consultant	Canyon	2017
Lyndon Haines	Commissioner	Washington	2021
Viki Purdy	Commissioner	Adams	2019
HEALTH DISTRICT 4			
Russell A. Duke, Secretary	District Director		
Betty Ann Nettleton, Chair	County Appointed Representative	Elmore	2003
Megan Blanksma, Vice Chair	County Appointed Representative	Elmore	2015
Elt Hasbrouck, Trustee/ Executive Council Representative	Commissioner	Valley	2015
Ryan Cole, MD	Medical Consultant/County Appointed Representative	Ada	2021
Raúl Labrador	County Appointed Representative	Ada	2021
Jane Young, CRN-P, DNP	County Appointed Representative	Ada	1995
Ryan Stirm	Commissioner	Boise	2019

BOARD MEMBER	ROLE	COUNTY	APPOINTMENT DATE
HEALTH DISTRICT 5			
Melody Bowyer, Secretary	District Director		
Linda Montgomery, Chair	County Appointed Representative	Jerome	1994
Don Hall, Vice Chair	Commissioner	Twin Falls	2021
Bob Kunau, Trustee/ Executive Council Representative	Commissioner	Cassia	2014
Helen Edwards	County Appointed Representative Former Commissioner	Gooding	2017
Roy Hubert	Commissioner	Lincoln	2018
Angenie McCleary	Commissioner	Blaine	2009
Sherly Koyle	Commissioner	Minidoka	2021
Pam Jones	County Appointed Representative	Camas	2014
Dr. Keith Davis	Medical Consultant		2019
HEALTH DISTRICT 6			
Maggie Mann, Secretary	District Director		
Vaughn Rasmussen, Chair/Trustee/ Executive Council Representative	Commissioner	Bear Lake	2011
Whitney Manwaring, Vice Chair	Commissioner	Bingham	2014
Ernie Moser	Commissioner	Bannock	2020
Susan Collins	County Appointed Representative	Butte	2008
Marty McCullough	Commissioner	Caribou	2021
Robert Swainston	Commissioner	Franklin	2017
Bob Christophersen	Commissioner	Oneida	2019
Ron Funk	Commissioner	Power	2021
HEALTH DISTRICT 7			
James Corbett, Secretary	District Director		
Bryon Reed, Chair	Commissioner	Bonneville	2017
Brent Mendenhall, Vice Chair/ Trustee/Executive Council Representative	Commissioner	Madison	2018
Aaron Gardner, MD	Medical Consultant		2021
Bill Leake	County Appointed Representative Former Commissioner	Teton	2015
Wayne Butts	Commissioner	Custer	2017
Blair Dance	Commissioner	Fremont	2021
Leah Madsen	Commissioner	Lemhi	2021
Greg Shenton	Commissioner	Clark	2001
Shayne Young	Commissioner	Jefferson	2019

IDAHO ASSOCIATION OF BOARDS OF HEALTH
Attendance | Proxies Held Record for 2022

HEALTH DISTRICT 1

Name	Present	Not Present	Proxies Held
Don Duffy, Secretary			
Marlow Thompson, Chair			
Tim Bertling, Vice Chair			
Glen Bailey, Trustee Executive Council Representative			
Jessica Jameson, MD			
Thomas Fletcher, MD			
Mike Fitzgerald			
Richard McLandress, MD			

HEALTH DISTRICT 2

Name	Present	Not Present	Proxies Held
Carol Moehrle, Secretary			
Dave McGraw, Chair			
Doug Zenner, Vice Chair			
Greg Johnson, Trustee Executive Council Representative			
Glenn Jefferson, MD			
Connie Osborn			
Rick Winkel			
Denis Duman			

HEALTH DISTRICT 3

Name	Present	Not Present	Proxies Held
Nikole Zogg, Secretary			
Bryan Elliott, Chair			
Kelly Aberasturi, Vice Chair			
Georgia Hanigan, Trustee Executive Council Representative			
Keri Smith			
Sam Summers, MD			
Lyndon Haines			
Viki Purdy			

HEALTH DISTRICT 4

Name	Present	Not Present	Proxies Held
Russell A. Duke, Secretary			
Betty Ann Nettleton, Chair			
Megan Blanksma, Vice Chair			
Elt Hasbrouck, Trustee Executive Council Representative			
Ryan Cole, MD			
Raúl Labrador			
Jane Young, CRN-P, DNP			
Ryan Stirm			

HEALTH DISTRICT 5			
Name	**Present**	**Not Present**	**Proxies Held**
Melody Bowyer, Secretary			
Linda Montgomery, Chair			
Don Hall, Vice Chair			
Bob Kunau, Trustee Executive Council Representative			
Roy Hubert			
Angenie McCleary			
Sherly Koyle			
Pam Jones			
Dr. Keith Davis			

HEALTH DISTRICT 6			
Name	**Present**	**Not Present**	**Proxies Held**
Maggie Mann, Secretary			
Vaughn Rasmussen, Chair Trustee/Executive Council Representative			
Whitney Manwaring, Vice Chair			
Ernie Moser			
Susan Collins			
Marty McCullough			
Robert Swainston			
Bob Christophersen			
Ron Funk			

HEALTH DISTRICT 7			
Name	**Present**	**Not Present**	**Proxies Held**
James Corbett, Secretary			
Bryon Reed, Chair			
Brent Mendenhall, Vice Chair Trustee/Executive Council Representative			
Aaron Gardner, MD			
Bill Leake			
Wayne Butts			
Blair Dance			
Leah Madsen			
Greg Shenton			
Shayne Young			

2021 Annual Conference Business Meeting Minutes

Thursday, June 17, 2021 at 1:30 p.m.
South Central Public Health District's Twin Falls Office
1020 Washington Street North (on College of Southern Idaho campus)
Online Access/Video call link: https://meet.google.com/mje-dopn-gjx
Or dial: 1 978-272-0298 PIN: 964 672 289#

Attendance:

HEALTH DISTRICT 1			
Name	**Present/Virtual**	**Not Present**	**Proxy**
Lora Whalen, Secretary	x		
Don Duffy (Interim Director)	x		
Marlow Thompson, Chairman	x		
Tim Bertling, Vice Chairman			x
Glen Bailey, Trustee	x		
Jessica Jameson, MD			x
Allen Banks, PhD	x		
Mike Fitzgerald			x
Richard McLandress, MD			x
HEALTH DISTRICT 2			
Name	**Present**	**Not Present**	**Proxy**
Carol Moehrle, Secretary	x		
Dave McGraw, Chairman			x
Doug Zenner, Vice Chairman	x		
Greg Johnson, Trustee	x		
Glenn Jefferson, MD		x	
Connie Osborn			x
Rick Winkel		x	
Denis Duman		x	
HEALTH DISTRICT 3			
Name	**Present**	**Not Present**	**Proxy**
Nikole Zogg, Secretary	x		
Bryan Elliott, Chairman	x		
Kelly Aberasturi, Vice Chairman	x		
Keri Smith	x		
Sam Summers, MD	x		

Georgia Hanigan, Trustee	x		
Lyndon Haines	x		
Viki Purdy	x		
HEALTH DISTRICT 4			
Name	**Present/Virtual**	**Not Present**	**Proxy**
Russell Duke, Secretary	X		
Betty Ann Nettleton, RN, Chairman			x
Megan Blanksma, Vice Chairman			x
Elt Hasbrouck	x		
Ted Epperly, MD, Trustee			x
Raúl Labrador		x	
Jane Young, CRN-P, DNP			x
Ryan Stirm			x
HEALTH DISTRICT 5			
Name	**Present/Virtual**	**Not Present**	**Proxy**
Melody Bowyer, Secretary	x		
Linda Montgomery, Chairman	x		
Helen Edwards, Vice Chairman	x		
Roy Hubert	x		
Angenie McCleary	x		
Bob Kunau, Trustee	x		
Sherly Koyle			x
Don Hall	x		
Pam Jones	x		
Dr. Keith Davis			x
HEALTH DISTRICT 6			
Name	**Present/Virtual**	**Not Present**	**Proxy**
Maggie Mann, Secretary	x		
Vaughn Rasmussen, Chairman/Trustee	x		
Whitney Manwaring, Vice Chairman			x
Ernie Moser	x		
Susan Collins			x
Marty McCullough			x
Robert Swainston		x	
Bob Christophersen		x	
Ron Funk			x
HEALTH DISTRICT 7			
Name	**Present/Virtual**	**Not Present**	**Proxy**
Geri Rackow, Secretary	x		
Bryon Reed, Chairman	x		
Barbara Nelson, MD Vice Chairman		x	
Bill Leake, Trustee	x		

Wayne Butts		x	
Blair Dance		x	
Leah Madsen	x		
Brent Mendenhall	x		
Greg Shenton			x
Shayne Young	x		

Meeting Call to Order____ _ ___Bob Kunau

Commissioner Kunau called the meeting to order at 1:35 p.m. MT

Roll Call____Melody Bowyer

Director Melody Bowyer conducted the roll call.

Proxy Votes____ ____Melody Bowyer

Eighteen proxy votes were collected.

IAC/Legislative Update____Seth Grigg

Seth Grigg, Executive Director of the Idaho Association of Counties, gave a legislative update to the group. He explained the potential impact of H0316 on counties' Indigency and State's CAT programs. He also fielded questions from the audience regarding the undocumented population, involuntary commitment, and the authority level of the district boards of health pertaining to setting district directors' pay and changing in employee compensation for district staff. Seth clarified the authority granted by H0316 regarding compensation. Director Moehrle from District 2 commented that DHR's AG had a different interpretation of the matter and warned us that we may see some push back from the AG during the next legislative session.

H0316____Mike Kane

Mike Kane, IAB's legal counsel/lobbyist, thanked the district directors and the Executive Council (EC) Committee representatives for working closely with him to get H0316 passed during the last legislative session. He responded to Director Moehrle's comment about DHR's interpretation of H0316 pertaining to compensation for district directors and staff. Mike also brought up some important issues to be addressed once H0316 goes into effect. They are: 1) changes in relationships between the public health districts and the Idaho Department of Health and Welfare, and the Department of Environmental Quality, 2) financial auditing function, and 3) District 1's rules. Mike fielded questions from the audience.

Approval of the June 11, 2020 Meeting Minutes (Action Item)___________________________________All

MOTION: Commissioner Reed moved to approve the June 11, 2020 meeting minutes as presented. Commissioner Johnson seconded the motion. The motion passed with Commissioner Hall abstaining.

IAB Budget Review and Approval (Action Item)_____________________________________Carol Moehrle

Director Moehrle presented the fiscal year 2022 budget in detail, informing the members that the budget includes a $35,000 assessment to public health districts. She also addressed questions.

MOTION: Commissioner Hasbrouck moved to approve the FY2022 Association Office Budget as presented. Commissioner Reed seconded the motion. The motion passed by unanimous consent.

Review of Expiring Resolutions (Action tem) **All**

- Resolution to Support an Excise Tax on Electronic Nicotine Delivery Systems
  MOTION: Linda Montgomery moved to keep the resolution as presented and active. Commissioner Hall seconded the motion. The motion passed with majority of the votes.

- Resolution to Support a Tobacco Tax Increase in the State of Idaho
  MOTION: Linda Montgomery moved to archive the resolution. Commissioner Hubert seconded the motion. Further discussion was held. Motion failed on a roll call vote, with 11 Aye, 25 Nay, and 2 abstain.

- Resolution Supporting Prevention of Excessive Alcohol Use
  MOTION: Helen Edwards moved to keep the resolution as presented and active. Commissioner Hall seconded the motion. Motion passed with majority of the votes.

- Resolution Concerning the Prevention of Opioid Drug Overdose through Prescriber Education
  MOTION: Commissioner Moser moved to keep the resolution as presented and active. Linda Montgomery seconded the motion. Motion passed unanimously.

Ratify All Current/Active Resolutions (Action Item) **All**

Linda Montgomery moved to ratify all current/active resolutions. Commissioner Moser seconded the motion. Roll call vote: 26 Aye, 6 Nay, and 3 Abstain. Motion carried.

IAC Contract Review and Discussion (Action Item) **All**

The IAC contract was updated. The members reviewed and approved the contract. As a full disclosure, Commissioner Hall commented that many IAB members are also IAC members, due to their roles as county commissioners. It was understood that there was no conflict of interest in this case.

MOTION: Commissioner Reed moved to approve the IAC contract as presented. Commissioner Moser seconded the motion. The motion passed by unanimous consent.

Discussion of Privatizing District Financial Audits **Elt Hasbrouck**

Commissioner Hasbrouck stated that District 4 looked into privatizing financial audits two years ago. Since then, Districts 3 and 4 obtained a waiver from the Legislative Council to privatize their audits. Prior to privatization, D4’s financial audits were done by the Legislative Services Office (LSO). LSO charged twice as much and took twice as long as they do now. Commissioner Hasbrouck expressed the desire for a consensus from the IAB membership to support the privatization of financial audits for all health districts. To that end, IAB would need to work with some legislators, with Mike Kane’s help, to change the language in H073. Commissioner Hall asked if each district could opt-in or opt-out on privatization. Commissioner Hasbrouck suggested that the Executive Council meet to discuss the matter further. Additionally, Commissioner Hasbrouck felt that health districts need to start discussing food fee legislation, since counties now shoulder more support for the districts.

SALBOH Update — Geri Rackow

Director Rackow gave the update on Dr. Nelson's behalf. Dr. Nelson participated in the monthly SALBOH calls, which primarily focused on COVID-19 response during the last year.

SALBOH Representative — Bob Kunau

Because of the resignation of Dr. Nelson, IAB's SALBOH representative, a discussion of her replacement took place. Currently, Representative Blanksma, D4's board member, is the back-up. Given that only three out of seven districts are NALBOH members, questions were raised about qualifications, funding for training-related travel, and the value of having a SALBOH representative. Commissioner Hall and Linda Montgomery suggested that the district directors research the value of SALBOH and report to their respective boards. Then each district's Executive Council representative will relay the input from their board to the Executive Council Committee for further discussion and action. The Executive Council Committee will make a recommendation for the IAB members to consider at the next annual meeting.

Public Health Recognition of Service — Bob Kunau

Commissioner Kunau recognized the following board of health members for their service to public health. These 11 members were unable to attend today's meeting. This recognition goes to:

- Commissioner Walter Kirby, District 1
- Commissioner Jai Nelson, District 1
- Dr. Jefferson, District 2
- Former Commissioner Tom Dale, District 3
- Commissioner Nate Marvin, District 3
- Tracy Haskin, District 5
- Commissioner Brent Reinke, District 5
- Ken Estep, District 6
- Dr. Barbara Nelson, District 7
- Commissioner Lee Miller, District 7
- Commissioner Miner, District 7

Bill Leake, D7 board member, announced that Commissioner Mendenhall will replace him as District 7's Executive Council Representative/Trustee. Mr. Leake will continue to stay engaged as a board member for D7.

Next Meeting

2022 IAB Annual Conference will be hosted by Central District Health. Date and location to be announced by D4.

Adjourn — Bob Kunau

Commissioner Kunau adjourned the meeting at 4:23 p.m.

AGREEMENT
BETWEEN THE
IDAHO ASSOCIATION OF COUNTIES
AND THE
IDAHO PUBLIC HEALTH DISTRICTS

THIS AGREEMENT updated the 17th day of June 2021 by and between the IDAHO ASSOCIATION OF COUNTIES (hereafter "IAC"), and the IDAHO PUBLIC HEALTH DISTRICTS (hereafter "Health Districts").

WHEREAS, IAC is a non-profit corporation organized under the laws of the state of Idaho, owned and operated by Idaho's forty-four counties, and whose counties participate in the funding of Idaho's seven public health districts; and

WHEREAS, the Public Health Districts are created by the laws of the state of Idaho;

WHEREAS, the Public Health Districts function under the direction of the Idaho Association of District Boards of Health;

NOW, THEREFORE, for and in consideration of the mutual promises and agreements contained herein, the parties hereto agree as follows:

DUTIES OF IDAHO PUBLIC HEALTH DISTRICTS

1. The Executive Council of the Idaho Association of District Boards of Health shall designate a liaison for IAC to coordinate and work with prior to and during the annual Idaho Legislative Session.

2. The liaison for the Health Districts shall notify IAC of issues that require tracking, monitoring, lobbying and/or testifying on behalf of the Health Districts.

3. The Health Districts shall provide Board of Health members and local public health staff necessary to testify or otherwise contact legislators on public health issues.

4. The Health Districts, through the finance office at District 2, shall pay the sum of $12,000.00 to IAC for the services set forth below. Payments shall be made as follows: January 31, the sum of $3,000.00; February 28, the sum of $3,000.00; March 31, the sum of $3,000.00; and April 30, the sum of $3,000.00. Payments shall be sent to the IAC office at 3100 S. Vista Ave., Suite 200, Boise, ID 83705.

5. The Health Districts shall meet with IAC for strategic planning of yearly legislative issues prior to the IAC legislative planning meeting.

6. The Health Districts shall designate two contact persons to serve as ex-officio Members of the IAC Health and Human Service and the Energy, Environment, and Land Use committees.

7. The Health Districts shall provide all funds as may be necessary for IAC to manage and pay for a designated lobbyist at the request of the Health Districts.

DUTIES OF IAC:

1. IAC shall designate staff for purposes of monitoring, and at the discretion of IAC, lobbying and or testifying on behalf of public health issues.

2. IAC shall monitor and advise of actions that may impact the Idaho Legislative Session and the actions of the Idaho Legislature and report to the Health Districts' contact person on those actions affecting public health issues. IAC shall advise of the necessity for action including testimony, lobbying, or making contacts by members of the Health Districts. ["Monitoring" may include but not be limited to reviewing germane committee schedules, legislation, and other activities to determine if there is an impact on public health issues.]

3. IAC shall provide in their regular Legislative Bulletin a highlighted or defined section, which reports on the Health Districts issues during the Idaho Legislative Session.

4. IAC shall meet at least quarterly with the Health Districts and its Executive Council Committee to address identified policy issues. During the Legislative Session, IAC shall meet at least biweekly with the Health Districts and its Executive Council Committee to address legislative issues affecting Health Districts.

5. In the event that the Health Districts have need to work on legislative issues that are in conflict with IAC and/or IAC policies, IAC will inform the Health Districts of such conflict and the Health Districts will remove such issue from this contract oversight and deal with the issue at the Health District level.

6. IAC, with the advice and consent of the Idaho Association of District Boards of Health, may designate an outside lobbyist to assist with lobbying for public health legislative issues. The management and fiscal oversight for this person will be provided through IAC and reimbursed by the Association office.

TERM:

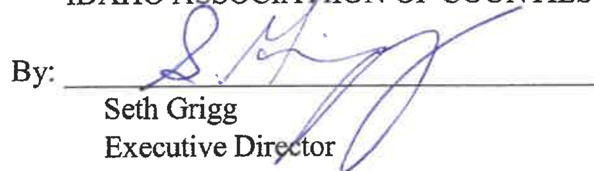
This Agreement shall commence on June 20, 2019 and shall continue on an annual basis until either party has given notice to terminate the contract prior to October 1 of each year.

AMENDMENTS:

Amendments to this Agreement, including the performance of additional services for new or special projects by the Idaho Public Health Districts and the costs associated with them, shall be agreed to in writing and made a part of this Agreement.

IN WITNESS WHEREOF, the parties have signed this Agreement the date above written, pursuant to approval by the Board of Directors of IAC and Idaho Association of Boards of Health.

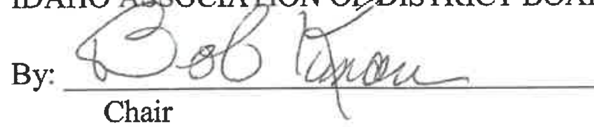
IDAHO ASSOCIATIION OF COUNTIES



By: ______________________

Seth Grigg
Executive Director

IDAHO ASSOCIATION OF DISTRICT BOARDS OF HEALTH



By: ______________________

Chair

ASSOCIATION OFFICE

SUMMARY OBJECT CODE	SUMMARY OBJECT	FY 22 BUDGET (Revised 06/22)	FY 22 ESTIMATE	FY 23 REQUEST
2001	FED GRANTS & CONTRIBS	-	-	
2101	ST GRANTS & CONTRIBUTIONS			
	Assessment to districts	35,000	49,980	
2201	CTY/CO GRTS & CONTR	-	-	
2701	RENT AND LEASE INCOME	-	-	
3601	MISCELLANEOUS REVENUE	-	-	
	IAB Registrations	8,000	-	
	Beginning Cash Balance	18,960	18,600	34,529
3999	*DISTRICT FUNDS*	-	-	-
	Total Revenue	61,960	68,580	34,529
5001	COMMUNICATION COSTS			
5051	EMPLOYEE DEVELOPMENT COSTS			
	IAC Membership	320	-	-
5101	GENERAL SERVICES			
5151	PROFESSIONAL SERVICES			
	Idaho Assoc of Counties	12,000	12,000	12,000
	Legal Services - Michael Kane & Assoc	20,000	19,640	10,000
	Legal Services - Opioid	12,000	2,300	5,000
	IAB speaker	-		-
5201	REPAIR & MAINT SVCS			
5251	ADMINISTRATIVE SERVICES			
5301	COMPUTER SERVICES (Domain)	500	489	500
5351	EMPLOYEE TRAVEL COSTS	2,220	-	
	Meals & mtg refreshments	1,000	-	
	IAB meals & refreshments	3,000	-	
5401	ADMINISTRATIVE SUPPLIES			
	IAB conf supplies	800	100	100
5451	FUEL & LUBRICANTS COSTS			
5551	COMPUTER SUPPLIES			
5601	REPAIR & MAINT SUPPLIES			
5701	SPECIFIC USE SUPPLIES			
5751	INSURANCE			
5851	UTILITY CHARGES			
5901	RENTALS & OPER LEASES			
	Bus, venue, etc rental for IAB conf	6,000		
5961	MISC EXPENDITURES	1,500	-	
	Total Operating Expenditures	59,340	34,529	27,600
	Total Expenditures	59,340	34,529	27,600

GUIDELINES FOR DEVELOPING RESOLUTIONS

DEFINITION

A resolution is a concise statement of the Association's stance towards a particular issue and serves as a call to action for the organization and its members. It describes and endorses a defined course of action directed towards a particular individual, organization, event, legislation or policy. Resolutions are used to educate and urge action by elected officials at all levels, other organizations, the media and the public about **IDAHO ASSOCIATION OF DISTRICT BOARDS OF HEALTH (Association)** position on important Public Health issues.

DEVELOPMENT OF RESOLUTIONS

1. Any active member may submit a resolution for consideration. This includes Trustees, Individual Board Members, or District Boards of Health.
2. Resolutions will be considered for adoption at the annual **Association** meeting.
3. Resolutions will be circulated to each individual Board at the local Board of Health meeting prior to the annual **Association** meeting.
4. Trustees will review proposed resolutions at the **Association** annual conference prior to the full IAB board discussion and vote.
5. Adoption of resolutions at **Association** meetings will require a majority vote of the quorum present and by proxy votes.
6. Late breaking resolutions may be adopted as "interim" with a 2/3 majority of the Trustees approving the resolution. The interim policy is pending subsequent ratification by the entire board at the annual **Association** meeting.

MAINTENANCE OF RESOLUTIONS

1. The normal life of an **Association** resolution is 3 years. The board, through its adoption process, may designate a longer "life" for any resolution.

2. A file of all policies, both active and archived will be maintained.

3. Annually, the District Directors will review policies which have reached their expiration. The directors shall recommend to the Trustees, which policies should be archived as inactive, which policies should be revised to reflect current information, and which policies should be continued as active. Major policy revisions require approval of the full Board.

Adopted by the Idaho Association of District Boards of Health
June 2006-updated June 2011; June 2012; 2013; May 2014; June 2015; June 2016; June 2017; June 2018, June 2019

GUIDELINES FOR DEVELOPING RESOLUTIONS - DRAFT

DEFINITION

A resolution is a concise statement of the Association's stance towards a particular issue and serves as a call to action for the organization and its members. It describes and endorses a defined course of action directed towards a particular individual, organization, event, legislation or policy. Resolutions are used to educate and urge action by elected officials at all levels, other organizations, the media and the public about **IDAHO ASSOCIATION OF DISTRICT BOARDS OF HEALTH (Association)** position on important Public Health issues.

DEVELOPMENT OF RESOLUTIONS

~~1.~~ Any active member or District Board of Health may submit a resolution for consideration. ~~This includes Trustees, Individual Board Members, or District Boards of Health.~~

2. Resolutions will be considered for adoption at the annual **Association** meeting.
3. Resolutions will be circulated to each individual Board at the local Board of Health meeting prior to the annual **Association** meeting.
4. ~~Trustees will review proposed resolutions at the **Association** annual conference prior to the full IAB board discussion and vote.~~
5. Adoption of resolutions at **Association** meetings will require a majority vote of the quorum present and by proxy votes.
6. Late breaking resolutions may be adopted at any time throughout the year as "interim" with a 2/3 majority of the Executive Council approving the resolution. The interim resolution is pending subsequent ~~ratification~~ approval by majority vote at the annual **Association** meeting.

MAINTENANCE OF RESOLUTIONS

1. The normal life of an **Association** resolution is 3 years. The board, through its adoption process, may designate a longer "life" for any resolution.

2. A file of all policies, both active and archived will be maintained.

3. Prior to each annual Association meeting, the District Directors will review resolutions which have reached their expiration. The directors shall recommend to the Association, which resolutions should be archived as inactive and which resolutions should be continued with or without revision. The Association will vote on expiring resolutions at the annual meeting.

Adopted by the Idaho Association of District Boards of Health
June 2006-updated June 2011; June 2012; 2013; May 2014; June 2015; June 2016; June 2017; June 2018, June 2019

Children's Health

19-02 Resolution to Support Evidence-Based Home Visitation in Idaho
19-06 Resolution Supporting Immunizations

Resolution 19-02
(18-02 updated)

RESOLUTION TO SUPPORT EVIDENCE-BASED HOME VISITATION[i] IN IDAHO

WHEREAS, home visitation programs such as Nurse Family Partnership (NFP), Parents as Teachers (PAT) and other evidence-based home visitation programs improve maternal and child health, prevent child abuse and neglect, encourage positive parenting, and promote child development and school readiness[ii]; and

WHEREAS, home visitation helps women improve their health behaviors related to substance abuse and nutrition, significant risk factors for pre-term delivery, low birth weight, and infant neuro-developmental impairment[iii]; these improvements include reductions in preterm delivery for women who smoke; reductions in high-risk pregnancies as a result of birth-spacing; and children's cognitive, social, and behavioral skills and development[iv]; and

WHEREAS, the CDC's Task Force on Community Preventive Services found that home visiting programs reduced child abuse and neglect by approximately 40 percent as compared to control groups not receiving home visiting services[v]; and

WHEREAS, children participating in Parents as Teachers are less likely to go to the emergency room to be treated for injury[vi]; and Parents as Teachers participation was related to 50 percent fewer cases of suspected abuse and/or neglect[vii]; and

WHEREAS, a study of 19-year-old girls who were born to high-risk mothers, found that home visiting during their mother's pregnancy and their first two years of life reduced their lifetime risk of arrest or conviction by more than 80 percent, teen pregnancy by 65 percent, and led to reduced enrollment in Medicaid by 60 percent[viii]; and

WHEREAS, every dollar invested in home visiting programs generates up to $5.70 in savings resulting from reduced health services utilization – including emergency department visits – and decreased special education placements and grade repetition, which leads to higher educational attainment and economic success later in life[ix]; and

WHEREAS, there is no single dedicated funding source available for home visiting services, federal funding streams can be paired with state and local funds – such as partnering with local health organizations - to support home visiting for pregnant women, families, infants, and young children[x]; and

WHEREAS, Medicaid finances 40% of all births in the U.S.[xi], Medicaid can provide a critical role in identifying and supporting mothers and infants at this critical stage, which can affect the child's future growth and development;

THEREFORE BE IT RESOLVED that the Idaho Association of District Boards of Health supports the expanded development and maintenance of evidence-based home visitation

programs and policies to provide and establish funding or a mechanism for reimbursement for services delivered through these programs; and

BE IT FURTHER RESOLVED that the Idaho Association of District Boards of Health support submission of a Medicaid state plan amendment to ensure federal financial participation is available for home visiting services that fit within the Medicaid definition of coverable services.

Adopted by the Idaho Association of District Boards of Health
May 30, 2008; Revised June 9, 2016, Revised June 2018, Revised June 2019

[1] National Association of County & City Health Officials (NACCHO), Statement of Policy 07-13. (July, 2010) Retrieved April 16, 2019 from https://www.naccho.org/uploads/downloadable-resources/07-13-Nurse-Home-Visiting-Programs.pdf

[1] Washington State Institute of Public Policy. Benefit-Cost Results. Available at: http://www.wsipp.wa.gov/BenefitCost?topicId=9

[1] Office of Planning, Research, & Evaluation. Home Visiting Evidence of Effectiveness Review: Executive Summary & Brief - April 2017. Retrieved on November 21, 2007 from https://www.acf.hhs.gov/opre/resource/home-visiting-evidence-of-effectiveness-review-executive-summary-brief-april-2017

[1] Ibid.

[1] MMWR Recommendations and Reports. (October, 2003). First reports evaluating the effectiveness of strategies for preventing violence: early childhood home visitation: Findings from the Task Force on Community Preventive Services. Retrieved on April 16, 2019 from https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5214a1.htm

[1] Wagner M, L.E. (2001). *The multisite evaluation of the Parents as Teachers home visiting program: three-year findings from on community.* Menlo Park, CA: SRI International.

[1] Drazen S, H. M. (1993). *Raising reading readiness in low-income children.* Ithaca, NY: Cornell University.

[1] Eckenrode J, Campa M, Luckey DW, Henderson CR Jr, Cole R, Kitzman H, ansopn E, Sidora-Aroleo K, Powers J, Olds D, “Long-term effects of prenatal and infancy nurse home visitation on the life course of youths: 19-year follow-up of a randomized trial”. Arch Pediatr Adolesc Med. 201- Jan; 164(1):9-15

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[1] King, A. (December, 2016). Coverage of maternal infant, and early childhood home visiting services. Retrieved on April 16, 2019 from https://nashp.org/coverage-of-maternal-infant-and-early-childhood-home-visiting-services/

[1] 11 Ibid

Resolution 19-06

RESOLUTION SUPPORTING IMMUNIZATIONS

WHEREAS, Immunizations are heralded as one of the 20th century's most cost-effective public health achievements. Immunizations protect both individuals and the larger population, especially those people who have immune system disorders and cannot be vaccinated; and

WHEREAS, School vaccination requirements have been a key factor in the prevention and control of vaccine-preventable diseases in the United States; and

WHEREAS, in order to prevent a disease from spreading, it is recommended that 95% of the population be immunized, thereby achieving herd immunity.

WHEREAS, Idaho is one of 18 US states that allows religious/other exemptions from vaccines, and the exemption rate for Idaho children enrolled in kindergarten was 7.7% during the 2018-19 school year;

WHEREAS, the majority of exemptions recorded in Idaho during the 2018-19 school year were for nonmedical reasons: 7.4%, marking a concerning increase from 6.4% the previous school year. In contrast, the US median, nonmedical exemption rate was 2%.

WHEREAS, exemption rates, specifically, nonmedical exemptions, are rising in Idaho and pose a serious public health threat to the state. With outbreaks of vaccine preventable diseases like measles appearing across the US, and in neighboring states, it is critical that we stand for the science-backed immunization standards;

WHEREAS, vaccines are a community's greatest line of defense to protect the most vulnerable among us, whether they are infants too young to get vaccinated or others who are immunocompromised, like those going through chemotherapy;

THEREFORE BE IT RESOLVED, that the Idaho Association of District Boards of Health support Childhood Immunizations, and will promote immunizations through public information.

Adopted by the Idaho Association of District Boards of Health
Adopted June 2019

(16-03 Updated June 2019)

RESOLUTION TO SUPPORT RAISING THE MINIMUM AGE OF LEGAL ACCESS AND USE OF TOBACCO/NICOTINE PRODUCTS IN IDAHO TO AGE 21

WHEREAS, Tobacco remains the leading cause of preventable disease and premature death in the U.S., and one of the largest drivers of health care costs[1], and

WHEREAS, Each year approximately 1,800 Idahoans die from tobacco use with 600 Idaho youth becoming new regular, daily smokers[2], and.

WHEREAS, 95% of current adult smokers began using tobacco before age 21, and the ages of 18 to 21 are a critical period when many experimental smokers transition to regular, daily use[3], and

WHEREAS, nearly all smokers start as kids or young adults, and these age groups are heavily targeted by the tobacco industry[3], and

WHEREAS, Adolescents are more likely to obtain cigarettes from social sources than through commercial transactions, and youth who reported receiving offers of cigarettes from friends were more likely to initiate smoking and progress to experimentation[3], and

WHEREAS, In Idaho, e-cigarettes are the most commonly used “tobacco” product among Idaho students as 14.3% of students used an electronic vapor product in the past 30 days and nearly half of all Idaho high school students have used an electronic vapor product at least once during their lifetime[4], and

WHEREAS, the American Academy of Pediatrics now strongly recommends the minimum age to purchase tobacco products, including e-cigarettes, should be increased to age 21 nationwide[5], and

WHEREAS, the U.S. Army Public Health Command says soldiers who smoke are less combat ready and take longer to heal and the U.S. Department of Defense is taking steps to ban all tobacco sales on military bases[6], and

WHEREAS, As of June 2019, fifteen states – California, Hawaii, Massachusetts, Maine, New Jersey, Oregon, Virginia, Utah, Washington, Texas, Illinois, Delaware, Arkansas, Vermont and Maryland – have raised the tobacco age to 21, along with at least 440 localities, including New York City, Chicago, San Antonio, Boston, Washington, DC, Cleveland, Minneapolis, and both Kansas Cities[3]

WHEREAS, Smoking-caused health costs in Idaho total more than $508 million per year, including more than $100.5 million in state and federal Medicaid expenditures, and raising the age of legal access to tobacco products to age 21 will likely decrease overall tobacco use rates, which in turn will likely lead to reduced future tobacco-related health care costs[3], and

Resolution 19-04 continued

WHEREAS, The tobacco industry aggressively markets and promotes its products to continue recruiting young adults as new consumers. Despite legal settlements and laws, the tobacco companies still spend $9.5 billion per year to market their deadly and addictive products, and they continue to entice and addict America's youth[7], and

WHEREAS, The Institute of Medicine concluded that raising the age of legal access to tobacco products to 21 years of age will likely prevent or delay initiation of tobacco use by adolescents and young adults and predicted that raising the age now to 21 nationwide would result in approximately 223,000 fewer premature deaths, 50,000 fewer deaths from lung cancer, and 4.2 million fewer years of life lost for those born between 2000 and 2019[8], and

THEREFORE, BE IT RESOLVED, that the Idaho Association of Boards of Health supports raising the minimum age of legal access and use of tobacco/nicotine products, including electronic vapor products, in Idaho to 21 years of age. District public health staff will actively engage in local and statewide efforts to support this public health policy.

Adopted by the Idaho Association of District Boards of Health
June 2019
Replaced 16-03

1. U.S. Department of Health and Human Services. The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General.(http://www.cdc.gov/tobacco/data_statistics/sgr/50th-anniversary/index.htm) Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014.
2. The Toll of Tobacco in Idaho. (2017). Retrieved from www.tobaccofreekids.org.
3. (2019). Increasing the Minimum Legal Sale Age for Tobacco Products to 21. Retrieved from www.tobaccofreekids.org.
4. Idaho State Department of Education, Idaho Youth Risk Behavior Survey. (2017). Retrieved from http://www.sde.idaho.gov/student-engagement/school-health/files/youth/2017-Youth-Risk-Behavior-Survey-Results.pdf.
5. American Academy of Pediatrics, Julius B. Richmond Center of Excellence. Tools and Information, Tobacco 21. Retrieved from http://www2.aap.org/richmondcenter/Tobacco21.html.
6. U.S. Army. Stand-To! Edition November 20, 2012. Retrieved from http://www.army.mil/standto/archive/issue.php?issue=2012-11-20.
7. Tobacco Industry Marketing. Retrieved from http://www.cdc.gov/tobacco/data_statistics/fact_sheets/tobacco_industry/marketing/index.htm.
8. Institute of Medicine. Public Health Implications of Raising the Minimum Age of Legal Access to Tobacco Products. Washington, D.C: The National Academies of Press, 2015. doi: 10.17226/18997.

Resolution 19-03
(17- 03 Updated June 2019)

RESOLUTION OPPOSING THE LEGALIZATION OF RECREATIONAL (NON-MEDICAL) MARIJUANA

WHEREAS, the Idaho Association of District Boards of Health is committed to the health and welfare of its citizens; and

WHEREAS, the Idaho Association of District Boards of Health strongly supports the success and positive future of the State's youth; and

WHEREAS, the sale, distribution, and possession of marijuana remains illegal under State and federal law; and

WHEREAS, studies from the U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA), Office of Applied Studies, establishes that marijuana, like cigarettes, is addictive[1]; and

WHEREAS, recent analysis from the National Institute on Drug Abuse reveals the potency of marijuana has reached the highest level since scientific analysis of the drug began, with tetrahydrocannabinol (THC) [the principal psychoactive constituent of the cannabis plant] amounts rising from 4 percent in 1980s to 15 percent in 2012[2]; and

WHEREAS, marijuana concentrates, with potencies of 90 percent THC and above, [3] are becoming more and more common in states that have legalized marijuana, sold on their own or as part of kid-friendly edible products like candy, lollipops, and gummy bears indistinguishable from non-pot-laced products; and

WHEREAS, the higher potency of today's marijuana may be contributing to the substantial increase in the number of teenagers and adults in treatment for marijuana dependence[4]; and

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[1] "Is marijuana addictive?" *National Institute on Drug Abuse (NIDA).* Web. 24 May 2016. Available at http://www.drugabuse.gov/publications/research-reports/marijuana/marijuana-addictive.
[2] "Marijuana: Facts Parents Need to Know," *National Institute on Drug Abuse (NIDA).* Web. 24 May 2016. Available at https://www.drugabuse.gov/publications/marijuana-facts-parents-need-to-know/want-to- know-more-some-faqs-about-marijuana.
[3] "Concentrates 101: What's on the market, from kief and CO2 oil to BHO." *The Cannabist.* Web. 24 May 2016. Available at http://www.thecannabist.co/2015/06/19/marijuana-concentrates-kief-bho-water-hash- co2-oil-wax-shatter/36386/.
[4] *See, e.g.*, van der Pol, et al. (2014), Cross-sectional and prospective relation of cannabis potency, dosing and smoking behaviour with cannabis dependence: an ecological study. Addiction, 109: 1101–1109.

WHEREAS, in the first two years of legalization in Colorado, arrests of Hispanic and African-American minors rose 29 percent and 58 percent, respectively[6]; and

WHEREAS, marijuana shops that sell kid-friendly pot products like candy, lollipops, and gummy bears near where children live, are a risk to public health and safety; and

WHEREAS, Colorado, one of the first states to legalize marijuana, now ranks first in the nation for marijuana use among 12 to 17 year-olds, according to SAMHSA[7]; and

WHEREAS, marijuana use by minors is strongly associated with other illicit drug use and abuse/dependence,[8] as well as dependence on tobacco[9]; and

WHEREAS, adults who use marijuana are five times more likely to develop an alcohol problem[10]; and

WHEREAS, scientific research establishes that marijuana use is harmful to the adolescent brain, affecting memory, thinking, pleasure, concentration, learning, sensory and time perception, and coordinated movement[11]; and

[6] Colorado Department of Public Safety. *Marijuana Legalization in Colorado, Early Findings: A Report Pursuant to Senate Bill 13-283.* N.p.: n.p., n.d. Mar. 2016. Web. 25 May 2016. Available at http://cdpsdocs.state.co.us/ors/docs/reports/2016-SB13-283-Rpt.pdf.

[7] "National Survey on Drug Use and Health: Comparison of 2012-2013 and 2013-2014 Population Percentages (50 States and the District of Columbia)." 2013-2014 *National Survey on Drug Use and Health: Model-Based Prevalence Estimates (50 States and the District of Columbia).* SAMHSA, n.d. Web. 25 May 2016. Available at: http://www.samhsa.gov/data/sites/default/files/NSDUHsaeShortTermCHG2014/NSDUHsaeShortTermCHG2014.htm.

[8] Agrawal A, Neale MC, Prescott CA, Kendler KS. A twin study of early cannabis use and subsequent use and abuse/dependence of other illicit drugs. *Psychol Med.* 2004;34(7):1227-1237.

[9] Panlilio LV, Zanettini C, Barnes C, Solinas M, Goldberg SR. Prior exposure to THC increases the addictive effects of nicotine in rats. *Neuropsychopharmacol Off Publ Am Coll Neuropsychopharmacol.* 2013;38(7):1198-1208.

[10] Weinberger, Andrea H., Jonathan Platt, and Renee D. Goodwin. "Is Cannabis Use Associated With An Increased Risk Of Onset And Persistence Of Alcohol Use Disorders? A Three-Year Prospective Study Among Adults In The United States". *Drug and Alcohol Dependence* 161 (2016): 363-367. Web. 25 May 2016.

[11] *See, e.g.*, "DrugFacts: Marijuana." *DrugFacts*. *National Institute on Drug Abuse (NIDA),* Mar. 2016. Web. 24 May 2016. Available at https://www.drugabuse.gov/publications/drugfacts/marijuana; Medina et al. "Neuropsychological Functioning in Adolescent Marijuana Users: Subtle Deficits Detectable after a Month of Abstinence." *Journal of the International Neuropsychological Society : JINS*13.5 (2007): 807– 820. *PMC*. Web. 24 May 2016, available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2269704/.

WHEREAS, primary marijuana abuse accounted for 56 percent of all substance abuse treatment admissions for youth between 15-19 years of age, compared to 24 percent for alcohol, according to SAMHSA 2007 National Treatment Episode Data Set[12]; and

WHEREAS, the American Medical Association (AMA), the largest national physician organization in the country, pursuant to H-95.998 AMA Policy Statement on Cannabis, believes that (1) cannabis is a dangerous drug and as such is a public health concern; (2) sale of cannabis should not be legalized; (3) public health based strategies, rather than incarceration, should be utilized in the handling of individuals possessing cannabis for personal use; and (4) additional research should be encouraged[13]; and

WHEREAS, research by J. Jacobus and S. Bava on the functional consequences of marijuana use by adolescents establishes that marijuana use reduces inhibitions and can lead to risky behaviors, distorted perception, impaired coordination, and can cause difficulty with thinking, problem solving and difficulty with learning and memory[14]; and

WHEREAS, the threat to public safety caused by use of drugs, including marijuana, in terms of highway safety, criminal activity and domestic violence are well-documented; and

WHEREAS, according to the AAA Foundation for Traffic Safety, marijuana-related traffic fatalities in Washington state doubled from 2012, the year it legalized recreational (non-medical) marijuana, to 2014[15];

WHEREAS, according to the office of the Rocky Mountain High-Intensity Drug Trafficking Area, traffic fatalities in Colorado in which a driver tested positive for marijuana increased an average of 15 percent per year from 2009 (when medical marijuana became widely commercialized) to 2014[16];

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[12] "Treatment Episode Data Set (TEDS) 1997-2007." *Substance Abuse and Mental Health Services Administration, Office of Applied Studies.* August 2009. Web. 24 May 2016. Available at http://wwwdasis.samhsa.gov/teds07/TEDS2k7A508Web.pdf.

[13] "H-95.998 AMA Policy Statement on Cannabis." *American Medical Association.* Web. Available at http://www.ama-assn.org/ssl3/ecomm/PolicyFinderForm.pl?site=www.ama-assn.org&uri=/resources/html/PolicyFinder/policyfiles/HnE/H-95.998.HTM.

[14] Jacobus, J., S. Bava, M. Cohen-Zion, O. Mahmood, and S.f. Tapert. "Functional Consequences of Marijuana Use in Adolescents." *Pharmacology Biochemistry and Behavior* 92.4 (2009): 559-65. Available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2697065/.

[15] "Prevalence of Marijuana Use Among Drivers in Fatal Crashes: Washington, 2010-2014." *AAA Foundation for Traffic Safety*. N.p., May 2016. Web. 23 May 2016. Available at https://www.aaafoundation.org/prevalence-marijuana-use-among-drivers-fatal-crashes-washington-2010- 2014.

[16] "The Legalization of Marijuana in Colorado: The Impact, vol. 3," *Rocky Mountain High-Intensity Drug Trafficking Area* (Sep. 2015) (citing data from National Highway Traffic Safety Administration, Fatality Analysis Reporting System (FARS), 2006-2013 and CDOT/RMHIDTA 2014). Available at http://www.rmhidta.org/html/2015%20final%20legalization%20of%20marijuana%20in%20colorado%20the%20impact.pdf.

WHEREAS, according to Quest Diagnostics, employers in the states of Colorado and Washington have rates of positive workplace marijuana tests well above the national average, and that rate is growing faster in both states than in the United States as a whole[17]; and

WHEREAS, the Idaho Association of District Boards of Health believes the effort to legalize marijuana is contrary to the interests of the public health, safety and welfare of its citizens, and desires to preserve the rights of citizens to live, work and play in communities where drug abuse is not accepted and citizens are not subjected to the adverse effects of drug abuse; and

NOW, THEREFORE, be it RESOLVED, that the Idaho Association of District Boards of Health opposes legalizing the production, sale, distribution and possession of recreational (non-medical) marijuana, hashish, marijuana concentrates, and products made from marijuana concentrates.

Adopted by the Idaho Association of District Boards of Health
June 2019
Updated Resolution 17-03

Resolution 19-05

RESOLUTION TO SUPPORT THE RECOGNITION OF SENIOR COGNITIVE HEALTH AS A PUBLIC HEALTH ISSUE.

WHEREAS, 5.8 million Americans are living with Alzheimer's. The number of older adults with Alzheimer's disease is expected to nearly triple over the next 40 years; and

WHEREAS, Every 65 seconds someone in the United States develops Alzheimer's; and

WHEREAS, Dementia is a general term for conditions that cause loss of memory severe enough that they may impact a person's ability to carry out daily activities. Alzheimer's Disease is a type of dementia that causes problems with memory, thinking, language, and behavior. It may begin with mild memory loss, and symptoms can slowly worsen over time; and

WHEREAS, Alzheimer's Disease is the 6th leading cause of death. Between 2000 and 2017 deaths from Alzheimer's disease increased 145% nationally, and 157% increase in Idaho; and

WHEREAS, Alzheimer's and related dementias have wide-ranging impacts not only on those with the disease, their families and caregivers, but also on communities and health-care systems; and

WHEREAS, Nationally, more than 16 million Americans provide unpaid care for people with Alzheimer's or other dementias. These caregivers provide an estimated 18.5 billion hours valued at nearly $234 billion dollars. In Idaho more than 85,000 caregivers provide an estimated $1.2 Billion Dollars in unpaid care.

WHEREAS, In 2019, Alzheimer's and other cognitive health issues will cost the nation $290 billion dollars. By 2050, these costs could rise as high as $1.1 trillion dollars.

THEREFORE BE IT RESOLVED, Public Health recognizes Senior Cognitive Health as a Public Health issue and encourages prevention efforts through health education programs and public policy.

Adopted by the Idaho Association of District Boards of Health
June 2019

Matthews, K. A., Xu, W., Gaglioti, A. H., Holt, J. B., Croft, J. B., Mack, D., & McGuire, L. C. (2018). Racial and ethnic estimates of Alzheimer's disease and related dementias in the United States (2015–2060) in adults aged≥ 65 years. Alzheimer's & Dementia. https://doi.org/10.1016/j.jalz.2018.06.3063External
Xu J, Kochanek KD, Sherry L, Murphy BS, Tejada-Vera B. Deaths: final data for 2007. National vital statistics reports; vol. 58, no. 19. Hyattsville, MD: National Center for Health Statistics. 2010.
Heron M. Deaths: leading causes for 2010. National vital statistics reports; vol. 62, no 6. Hyattsville, MD: National Center for Health Statistics. 2013.

Hurd MD, Martorell P, Delavande A, Mullen KJ, Langa KM. Monetary costs of dementia in the United States. NEJM. 2013;368(14):1326-34.

Tejada-Vera B. Mortality from Alzheimer's disease in the United States: data for 2000 and 2010. NCHS data brief, no 116. Hyattsville, MD: National Center for Health Statistics. 2013.
James BD. Leurgans SE, Hebert LE, et al. Contribution of Alzheimer disease to mortality in the United States. Neurology. 2014;82:1-6.

Alzheimer's Association. Prevention and Risk of Alzheimer's and Dementia. Accessed July 16, 2015 from website: http://www.alz.org/research/science/alzheimers_prevention_and_risk.asp

Centers for Disease Control and Prevention, Division of Nutrition, Physical Activity, and Obesity. Physical Activity is Essential to Healthy Aging. Accessed September 1, 2015 from website: http://www.cdc.gov/physicalactivity/basics/older_adults/

Resolution 19-01

RESOLUTION TO SUPPORT AWARENESS, EDUCATION AND PREVENTION OF SUICIDE

WHEREAS, suicide is the 10th leading cause of death in the US[1]; and

WHEREAS, in 2017, 47,173 Americans died by suicide and an estimated 1,400,000 attempted suicide[1]; and

WHEREAS, in 2015, suicide and self-injury cost the US $69 billion[2]; and

WHEREAS, per 100,000 Idaho ranks 5th in the nation for deaths by suicide[2]; and

WHEREAS, more than 12 times as many people die by suicide in Idaho annually than by homicide making suicide the 2nd leading cause of death for ages 15-44[2]; and

WHEREAS, evidence indicates that suicide can be prevented by coverage of mental health conditions in health insurance policies and reduce provider shortages in underserved areas[4]; and

WHEREAS, educating the public on the primary methods and warning signs of suicide, promoting gatekeeper training, and providing access in local communities to treatment for people at risk of suicide are best practices[4]; and

WHEREAS, Idaho Public Health Districts are responsible to promote and protect the health of Idaho citizens; and

THEREFORE BE IT RESOLVED, that the Idaho Association of District Boards of Health support promoting strategies and the best available evidence recommendations in all 44 counties to create awareness and educate our population on suicide prevention.

THEREFORE, BE IT FURTHER RESOLVED, that Idaho Public Health Districts seek opportunities to collaborate with stakeholders to help communities improve their focus on prevention activities with the greatest potential to prevent suicide.

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1. Centers for Disease Control and Prevention: Data & Statistics Fatal Injury Report (2017)
2. Centers for Disease Control and Prevention: Data & Statistics Fatal Injury Report (2016)
3. American Foundation for Suicide Prevention (2019)
4. National Center for Injury Prevention and Control, Division of Violence Prevention, Preventing Suicide: A Technical Package of Policy, Programs and Practices (2017) https://www.cdc.gov/violenceprevention/pdf/suicide-technicalpackage.pdf

Resolution 15-03

RESOLUTION TO SUPPORT AN EXCISE TAX ON ELECTRONIC NICOTINE DELIVERY SYSTEMS

WHEREAS, it was in 1912 that smoking tobacco was linked to lung cancer, and it took more than 50 years for the US Surgeon General to declare smoking a health hazard and another 45 years before the Food and Drug Administration (FDA) was given the authority to regulate tobacco products.

WHEREAS, many electronic nicotine delivery system (ENDS), also marketed as electronic cigarettes, contain juices with nicotine, a highly addictive drug for which there are no safe levels.

WHEREAS, there is currently insufficient evidence to conclude that ENDS, or electronic cigarettes, help users quit smoking.[1]

WHEREAS, it is the flavored products that are driving the youth vaping epidemic. In fact, 84.7% of youth e-cigarette users use flavored products. E-cigarettes are sold in over 15,000 flavors, from mint and menthol to gummy bear and cotton candy.[2]

WHEREAS, in 2016, an estimated four in five (20.5 million) US youths, including 8.9 million middle school students and 11.5 million high school students, were exposed to e-cigarette advertisements from at least one source; a 13% increase from 2014. Exposure in retail stores increased 24% in 2016 compared to 2014 and was the primary factor responsible for the increases in exposure from any source during 2014-2016. Nearly seven in 10 youths (17.7 million) were exposed to e-cigarette advertising in retail stores in 2016; approximately two in five were exposed to e-cigarette on the Internet (10.6 million) or television (9.7 million), and nearly one in four (6.2 million) were exposed in newspapers and magazines.[3]

WHEREAS, electronic cigarettes are the most commonly used tobacco product among US middle and high school students. From 2017 to 2019, e-cigarette use among high school students more than doubled to 27.5%, leading the US Surgeon General and other public health authorities to declare the problem an epidemic. In 2020, 3.6 million US kids – including 19.6% of high school students – were current e-cigarette users. From 2019 to 2020, disposable e-cigarette use has increased significantly among youth who currently used e-cigarettes in middle school (from 3.0% to 15.2%) and high school (from 2.4% to 26.5%). [2,3,4]

WHEREAS, in January 2020 the FDA prioritized enforcement against the sale of most candy or fruit flavors in "closed pod" refillable e-cigarettes, such as the popular JUUL brand, but disposable flavored e-cigarettes, such as the newer brand Puff Bar were exempted.[5]

WHEREAS, a September 2020 study found that the top 10 videos featuring Puff Bars on the social media app Tik Tok received between 2.8 and 42.4 million views. Among high school current e-cigarette users, 26.1% reported that their usual brand was Puff Bar, followed by Vuse (10.8%), SMOK (9.6%), JUUL (5.7%), and Suorin (2.3%). Among middle school current users, 30.3% reported that their usual brand was Puff Bar, and 12.5% reported JUUL. A 2018 study also found that exposure to e-cigarette advertisements on social media among young adults was strongly associated with positive expectations of e-cigarette use and directly correlated with

current use.[2,5]

WHEREAS, while electronic cigarettes are likely to be less toxic than conventional cigarettes, their use poses threats to adolescents and fetuses of pregnant mothers using these devices.[6]

WHEREAS, compared to young people who have never vaped, youth who have ever used e-cigarettes are seven times more likely to become cigarette smokers one year later.[7]

WHEREAS, the FDA conducted an analysis on samples of electronic cigarettes and components from two leading brands, which showed that the product contained detectable levels of known carcinogens and toxic chemicals to which users could potentially be exposed. The FDA's findings also suggested that quality control processes used to manufacture these products are inconsistent or non-existent.[8]

WHEREAS, according to FDA the electronic cigarette cartridges that were labeled as containing no nicotine had low levels of nicotine present in all cartridges tested, except one.[8]

WHEREAS, the American Association of Poison Control Centers reports that, as of February 28, 2022 poison control centers have managed 831exposure cases about e-cigarette devices and liquid nicotine only two months into 2022. In 2020, there had been 3,830 calls involving exposures to electronic cigarette devices and liquid nicotine.[9]

WHEREAS, North Carolina, the number one tobacco producing state, taxes liquid nicotine at 5 cents per milliliter, which is one of the lowest state taxes. Idaho does not currently have a vape and e-cigarette tax.[10,11]

WHEREAS, an increase in taxes on cigarettes and other tobacco products leads to significant reductions in cigarette smoking and other tobacco use. For every 10 percent increase in cigarette prices, the overall cigarette consumption is reduced by 3-5%. Increasing the price of cigarettes is very effective for specifically reducing smoking rates among high-risk populations such as youth, young adults, and individuals of low socioeconomic status. Health economists have estimated that raising the cost of cigarettes to ten dollars a pack nationwide would result in 4.8 million fewer smokers between the ages of 12-25.[11,12,13]

THEREFORE BE IT RESOLVED, that the Idaho Association of Local Boards of Health support establishing an excise tax on ENDS including the delivery devices and liquid solutions used in the devices and use of any such funds be designated for tobacco cessation and prevention.

Adopted by the Idaho Association of District Boards of Health
June 4, 2015; Updated March 17, 2022

Resolution 15-03 (continued)

[1]Centers for Disease Control. (2020, January). Adult Smoking Cessation – The Use of E-cigarettes. Retrieved from https://www.cdc.gov/tobacco/data_statistics/sgr/2020-smoking-cessation/fact-sheets/adult-smoking-cessation-e-cigarettes-use/index.html

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Resolution ##-##

RESOLUTION TO REMOVE THE FOOD ESTABLISHMENT LICENSE FEE IN IDAHO CODE

WHEREAS, protecting the public from the hazards of food borne illness and disease is a primary function of Idaho's Public Health Districts; and

WHEREAS, the Centers for Disease Control and Prevention estimates that one in six Americans, or 48 million people, get sick from foodborne illnesses every year. Approximately 229,000 of these are hospitalized and 3,000 die[1]; and

WHEREAS, foodborne illness poses a $77.7 billion economic burden in the United States annually[2], and

WHEREAS, it is well recognized that foodborne outbreaks can be devastating to a food establishment business; and

WHEREAS, the Public Health Districts are committed to providing an appropriate balance between code enforcement and education; and

WHEREAS, the food protection system in Idaho presently meets state standards, but fails to meet the national standards for inspection frequency for establishments deemed to be high risk for foodborne illness; and

WHEREAS, the Public Health Districts are required by the Idaho Food Code to perform at least one food safety inspection per year for each licensed food establishment; and

WHEREAS, general state appropriation funding is no longer provided to the Public Health Districts to subsidize food establishment inspection fees for private businesses, placing the full burden on the county tax payers;

THEREFORE BE IT RESOLVED that the Idaho Association of District Boards of Health supports removing food establishment license fees in Idaho Code and allowing the local boards of health to establish a fee based on the actual cost to deliver the food safety inspection program.

Adopted by the Idaho Association of District Boards of Health
June 9, 2016; readopted June 9, 2017

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Resolution XX-XX

RESOLUTION TO SUPPORT RAISING THE MINIMUM AGE OF LEGAL ACCESS AND USE OF *MITRAGYNA SPECIOSA* (KRATOM) PRODUCTS IN IDAHO TO AGE 21.

WHEREAS, the Idaho Association of District Boards of Health is committed to the health and welfare of its citizens; and

WHEREAS, the Idaho Association of District Boards of Health strongly supports the success and positive future of the State's youth; and

WHEREAS, the U.S. Food and Drug Administration is warning consumers not to use *Mitragyna speciosa*, commonly known as kratom, a plant which grows naturally in Thailand, Malaysia, Indonesia, and Papua New Guinea. The FDA is concerned that kratom, which affects the same brain receptors as morphine, appears to have properties that expose users to the risks of addiction, abuse, and dependence[1] and

WHEREAS, the leaves of kratom are consumed either by chewing, or by drying and smoking, putting into capsules, tablets or extract, or by boiling into a tea[1], and

WHEREAS, at low doses, kratom produces stimulant effects with users reporting increased alertness, physical energy, and talkativeness. At high doses, users experience sedative effects. Side effects include nausea, itching, sweating, dry mouth, constipation, increased urination, tachycardia, vomiting, drowsiness, and loss of appetite[2] Users of kratom have also experienced anorexia, weight loss, insomnia, hepatotoxicity, seizure, and hallucinations[1]. Kratom can lead to addiction[3]; and

WHEREAS, estimates from the American Kratom Association suggest 3 to 5 million individuals in the U.S. may be using kratom. According to the DEA, several cases of psychosis resulting from use of kratom have been reported, where individuals addicted to kratom exhibited psychotic symptoms, including hallucinations, delusion, and confusion[2], and

WHEREAS, the FDA has issued reports about deaths associated with kratom[1], and in 2019 a CDC report found that kratom was detected in 152 overdose deaths between July 2016-December 2017[2]. Kratom was identified as the cause of death in 91 of the 152 kratom-positive deaths but was the only identified substance in just seven of these cases[2]. Data suggests that kratom use is associated with a complex population of polydrug users and especially with opioid use disorder, and that a deeper investigation into the toxicity of kratom is needed, especially focusing on drug–herb interactions[2]. Though supporters of keeping the drug legal for research purposes note that the death certificates often mention the possible involvement of other drugs[1], and

WHEREAS, the FDA is actively evaluating all available scientific information to better understand kratom's safety profile, including the use of kratom combined with other drugs[1], and

WHEREAS, while FDA evaluates the available safety information about the effects of kratom, the agency encourages health care professionals and consumers to report any adverse reactions to the FDA's MedWatch program[1], and

WHEREAS, there are currently no FDA-approved uses for kratom, and the DEA has labeled kratom as a Drug and Chemical of Concern[2], and

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WHEREAS, kratom is now considered a Schedule 1 drug in Alabama, (the same classification as heroin and ecstasy), and Wisconsin, Vermont, Tennessee, Indiana, Rhode Island and Arkansas [1], D.C.; Alton, IL; Jerseyville, IL; San Diego, CA; Sarasota, FL; and Union County, MS [2] have also banned the botanical supplement with additional states considering the same course[1]. Internationally, kratom is illegal in Australia, Denmark, Finland, Ireland, Latvia, Lithuania, Malaysia, Myanmar, Poland, Romania, Sweden and Thailand[2], and

WHEREAS, in Idaho it is currently legal to buy and sell kratom. It can be purchased in smoke shops, boutique botanical stores, and online vendors. Nationwide, the number of kratom exposures reported to Poison Control Centers (PCCs) increased 52-fold between 2011-2017. Data from PCCs found that Idaho had the highest kratom exposure rate in the U.S[2], and

THEREFORE, BE IT RESOLVED, that Idaho Association of District Boards of Health supports raising the minimum age of legal access and use of kratom products in Idaho to 21 years of age. District public health staff will actively engage in local and statewide efforts to support this public health policy.

[1] Association of Food and Drug Officials Board (AFDO). (2018, June 4). *2018 Resolution 1: Kratom*. Association of Food and Drug Officials. Retrieved March 9, 2022, from https://www.afdo.org/resolutions/2018-resolution-1-kratom/
[2] Kratom in Idaho Fact Sheet. (2020). Idaho Office of Drug Policy. https://odp.idaho.gov/wp-content/uploads/sites/114/2020/12/Kratom-in-Idaho_Fact-Sheet.pdf
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Resolution XX-XX

RESOLUTION TO SUPPORT VAPING PREVENTION IN SCHOOLS

WHEREAS, e-cigarettes and youth vaping remain a public health crisis. In 2020 more than 3.6 million U.S. youth used e-cigarettes in the past 30 days. 1 in 5 high school students and almost 1 in 10 middle school students who use e-cigarettes are using them every day.[1]

WHEREAS, according to the 2019 Idaho Youth Risk Behavior Survey almost half (48%) of high school students have used an e-cigarette at least once and 21.5% of Idaho students used e-cigarettes on one or more of the past 30 days. Academic achievement was significantly associated with the percentage of students who use e-cigarettes. 35% of students who mostly had grades of D's and F's used e-cigarettes and 41% of students who mostly had grades of C's, compared to 12% of students using e-cigarettes who had grades of mostly A's.[2]

WHEREAS, nicotine is highly addictive and youth use of e-cigarettes can harm adolescent brain development, cause respiratory problems, decrease impulse control, and lead to mental health illnesses such as depression, anxiety, and substance use disorder. Most e-cigarettes contain nicotine and can contain other harmful toxins.[1,3]

WHEREAS, youth are vulnerable to using e-cigarettes because of the appeal of flavors, social influencers, peer pressure, misinformed marketing, and misperception of the actual harm of e-cigarettes. Youth are constantly being exposed to both messaging around the flavors and positive aspects of e-cigarettes, both from social media and official advertising from the tobacco industry itself.[3]

WHEREAS, the CDC recommends the State of Idaho annually spend $15.6 million on tobacco prevention and in fiscal year 2022 Idaho spent $3.6 million, just 23.4% of the CDC recommended spending. While the estimated annual amount spent on tobacco marketing in Idaho by the tobacco industry is $45.6 million.[4]

WHEREAS, a 2005 study concluded that if every state had spent the minimum amount recommended by the CDC for tobacco prevention, youth smoking rates nationally would have been between three and 14 percent lower during the study period, from 1991 to 2000. Further, if every state funded tobacco prevention at CDC minimum levels, states would prevent nearly two million kids alive today from becoming smokers, save more than 600,000 of them from premature, smoking-caused deaths, and save $23.4 billion in long-term, smoking-related health care costs.[5]

WHEREAS, in 2006 Florida voters approved increasing their funds in statewide tobacco prevention and cessation by implementing and funding the statewide program Tobacco Free Florida in 2007. From 2006 to 2020 high school smoking rates declined by 85% from 15.5% to 2.3%. Middle school smoking rates declined from 6.6% in 2006 to 1.1% in 2020.[5]

WHEREAS, out of youth and young adults aged 15-24 who use e-cigarettes, 63% of those who use JUUL did not know that the product always contains nicotine. 44% of youth believe their

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peers approve of nicotine vaping and around 80% of youth do not perceive the use of e-cigarettes as being harmful.[6,7,8]

WHEREAS, given the high rates of use and known health consequences of using e-cigarettes, it is critical now more than ever that youth are educated about e-cigarettes so that they can make informed decisions regarding their health, and that efforts to prevent and reduce adolescent use of e-cigarettes are developed, implemented, disseminated, and evaluated.[3]

WHEREAS, effective components of such school-based tobacco prevention programs include interactive curricula, activities around refusal skills, and content addressing targeted marketing and health effects, which if applied collectively in prevention curriculum may lead to decreases in youth intentions to use and actual use.[3]

WHEREAS, research shows that the CATCH My Breath curriculum resulted in reductions in nicotine vaping use (both lifetime and within the past 30 days), increases in nicotine vaping knowledge, increases in positive perceptions of a vape-free lifestyle, and reductions in overall tobacco use. CATCH My Breath is an evidence-based, school-based program developed to prevent nicotine vaping and tobacco use among students in 5th through 12th grade.[7]

THEREFORE BE IT RESOLVED, that the Idaho Association of Local Boards of Health support continued funding to prevent vaping among youth and young adults.

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Resolution XX-XX

RESOLUTION TO SUPPORT INNOVATIVE FUNDING STREAMS TO SUPPORT AWARENESS, EDUCATION AND PREVENTION OF SUICIDE

WHEREAS, suicide is the 12th leading cause of death in the US[1]; and

WHEREAS, in 2020, 45,979 Americans died by suicide and an estimated 1,150,000 attempted suicide[1]; and

WHEREAS, in 2019, suicide and self-injury cost the US $782 million[1]; and

WHEREAS, in 2020, per 100,000, Idaho ranks 5th in the nation for deaths by suicide[1]; and

WHEREAS, in 2021, the Idaho Suicide Prevention Hotline received over 16,000 contacts[2]; and

WHEREAS, in 2020, The National Suicide Prevention Hotline Designation Act was signed into law, creating 988 as the national dialing code[3]; and

WHEREAS, Idaho Department of Health and Welfare has been building Idaho's crisis continuum of care for over two years with the Division of Behavioral Health taking the lead on the 988 Suicide Hotline implementation[4]; and

WHEREAS, Idaho Public Health Districts are responsible to promote and protect the health of Idaho citizens; and

WHEREAS, funding for Idaho Public Health District suicide prevention efforts are not enough to meet the regional prevention needs; and

THEREFORE, BE IT RESOLVED, that the Idaho Association of District Boards of Health supports sustainable funding streams (e.g., telecommunication fees, general state fund appropriations, or other funding sources) to maintain and strengthen the crisis continuum of care, implementation of the 988 Suicide Hotline, and other suicide prevention resources and services in all 44 counties.

[1] Centers for Disease Control and Prevention: Number of Injuries and Associated Costs (2019)
[2] Idaho Suicide Prevention 2021 Annual Report (2021)
[3] Idaho Department of Health and Welfare: 988 National Behavioral Health Crisis Line (2021)