

**A Population Health Approach to
Improving Nutrition and Physical Activity
for Obesity Prevention**

Workgroup #2
Final Report

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(This report has been produced by commission staff in consultation with a wide range of key stakeholders. It is intended to provide background information and policy options for one of the major potential topics of health care reform legislation. It does not necessarily represent either the positions or policy positions of the individuals, agencies or organizations who provided input to the paper. In particular, the Vermont Department of Health does not endorse any budget recommendations developed outside of the Executive Branch process for budget requests.)

Question: *How best to build and integrate the components of a comprehensive obesity prevention strategy to achieve breakthrough levels of improved effectiveness?*

Summary

This report prepared by Health Care Reform Commission staff provides a framework for discussion of strategies and recommendations to reduce the prevalence of chronic illness in Vermont, which has been a priority under health reform legislation and the Blueprint for Health. Act 191 (2006) sets forth the goal, in Health Care Reform Principle (6), that “Vermonters must be engaged, to the best of their ability, to pursue healthy lifestyles, to focus on preventive care and wellness efforts, and to make informed use of all health care services throughout their lives.” The *Blueprint for Health: Strategic Plan* (January 2007) also stresses the vital role of healthy living and primary prevention in reducing chronic illness.

This report focuses on poor diet and physical inactivity, contributing factors of obesity, because of their prominence as major risk factors for multiple chronic diseases, including diabetes, heart disease, stroke, high blood pressure, arthritis, respiratory diseases, and cancer. The paper calls for development of a comprehensive environmental and policy change strategy to make it easier for Vermont residents to choose healthy foods and be physically active. By necessity, this goal is realized through engaging a broad array of sectors, including state and local government, commercial institutions and advertisers, parents, communities, schools, work sites, and health care, and others.

In building a comprehensive obesity prevention program, Vermont must confront two major challenges in common with other states.

- Limited federal and state resources to build infrastructure and capacity
- Underdeveloped evidence base of the most effective mix of strategies.

In the face these challenges, Vermont must move ahead to develop consensus on a public policy strategy and enact legislation targeted at obesity prevention.

This paper offers two fundamental recommendations:

- (1) The legislature, administration, and interested parties need to engage in a high-level dialogue to sort out priorities for legislative action and determine where best to allocate fiscal resources. The last section of this paper discusses the various components of a comprehensive obesity prevention strategy. The section discusses options and offers recommendations to stimulate discussion, but it does not provide a clear set of answers.
- (2) The state should work with selected communities to combine components of a comprehensive strategy into a community-wide initiative. This would provide an opportunity develop, test, and evaluate the most effective ways to increase physical activity and healthy eating at the community level. Funding, technical assistance, and policy changes would be needed to support communities in taking on this complex endeavor. In addition to dedicated state funding, Vermont would need to secure continued federal funding (CDC obesity prevention grant) as well as private grants (e.g., Robert Wood Johnson Foundation).

Summary of Recommendations

1. State assistance to communities for environmental and policy change

- a. *Grants to pilot communities*: Retool existing state grant programs to support comprehensive (multi-sector) environmental and policy change in 4-8 pilot communities to promote nutrition and physical activity.
- b. *State leadership and support*: Increase staff capacity at VDH District Offices to support community planning, technical assistance, training, and evaluation. Use established VDH grant making process to promote community planning and accountability.
- c. *Public education (media) campaign*: Develop a set of complementary materials that each participating sector (e.g., school, work site, health care, etc.) can utilize, with well-researched and well-coordinated messaging.

2. “Built environments” in communities to support healthy choices

Key areas to review:

- a. Increase access to healthy foods in Vermont communities, including local foods.
- b. Create healthier communities through pedestrian, biking, and public transportation systems, etc.
- c. Build upon existing legislation that encourages Smart Growth principles in land use planning, growth centers, and downtown revitalization.

3. Healthy School Environments

- a. *School standards*: In collaboration with the schools community, strengthen:
 - i. program standards for nutrition education and physical education
 - ii. physical activity standards
 - iii. nutrition standards for “competitive foods” (i.e., foods sold outside federal meals programs such as a la carte and in vending machines).
- b. *Grants to schools*: Strengthen existing state grant programs to support environmental and policy change in schools.
- c. *Technical assistance and training*: Enhance resources available.

4. Healthy Work Environments

Options include:

- a. *Increased sharing of best practices*: Support public-private collaboration to develop and disseminate resource tools and enhance opportunities for interactive information exchange.
- b. *Small employer incentives and/or small employer assistance*.
- c. *Employee incentives*: Encourage use of economic and other incentives for employee participation in wellness programs.
- d. *Insurer innovation and leadership*: Enhance incentives for private health insurers to strengthen employee wellness and healthy lifestyle interventions.
- e. *State employee wellness program / health benefit program*: Strengthen the existing portfolio of exemplary practices for promoting wellness and healthy lifestyles.

5. Medical Home: Best-Practice Prevention of Overweight in Children

- a. *Provider training*: Promote clinical practice changes through toolkits and hands-on trainings based on best-practice guidelines for early identification, assessment, and treatment of overweight by the primary care practice team.
- b. *Stakeholder review of coverage and reimbursement policies for consistency with recommended best practices* for assessment, prevention and treatment of obesity – such as measurement of BMI, brief-intervention counseling, and referral to appropriate resources.
- c. *Integrate supportive services*: Use community pilot programs to forge closer links between “medical home” primary care practices and school health supports (such as school nurses and local school health coordinating committees) and public health supports that are available to patients and families (such as WIC clinics for children under six). Primary care practices serving as medical homes should also cultivate active referral relationships with other available resources in their communities such as non-medical counseling and behavioral interventions.
- d. *Increase the proportion of mothers who breastfeed their infants and toddlers*
 - i. Engage public and private insurers regarding the inclusion of lactation support in standard reimbursable prenatal care services.
 - ii. Review and support ongoing efforts in the state to ensure that health care settings, childcare facilities, and worksite environments are supportive of breastfeeding.

6. Encourage/Leverage the “Industry Response” to the Obesity Epidemic

- a. *Decrease marketing of low-nutrition foods to children*: Work with the Attorney General’s Office to develop a range of potential options to help shift marketing to children on television and in other contexts (e.g., movies, video games, and websites) to focus on more nutritious, lower-calorie foods.
- b. *Use mechanisms of state government to support industry awareness of the “business case” for promoting healthy food and beverage choices and physical activity*: Encourage business leaders to make their brands “publicly accountable” for making healthy options available to children and youth and their relatives. Areas to review include:
 - i. Promoting nutrition labeling at fast-food and other chain restaurants
 - ii. Encouraging leisure, entertainment, and recreation industries to develop products and opportunities that promote regular physical activity and reduce sedentary behaviors.

7. Surveillance of Trends and Risk Factors and Evaluation of Strategies

- a. Continue monitoring childhood, adolescent, and adult obesity rates in Vermont and contributing risk factors to provide information for planning and to evaluate progress towards goals.
- b. Explore the feasibility of using ICD-9 V codes to collect data about BMI, overweight, and obesity.
- c. Explore use of the Blueprint chronic care information system and the multi-payer data base to monitor weight status.

I. Introduction

A. Approach and Criteria

This report is strictly the work of commission staff. In drafting this document, commission staff consulted with many interested parties concerning current obesity prevention strategies in Vermont (see Appendix I for a list of individuals and organizations) and also examined efforts in other states. In addition, commission staff sought to ensure consistency of this report with the broad goals and objectives of the *Blueprint for Health: Strategic Plan* (January 2007).

All recommended options are meant to have significant impact (if sustained over the long term), support ongoing reform efforts, and elevate Vermont to the next level in terms of the goals outlined in Act 191. The criteria for the selection of recommendations are as follows:

- Likelihood of a long-term impact in reducing the prevalence of chronic disease across Vermont's population
 - Evidence of previous success from implementation (pilots, other states)
 - Ease of implementation
- Breadth of impact on Vermont residents
- Relationship with the existing health care reform foundation in Vermont
- Likely cost of the initiative
 - Direct cost to the state
 - Opportunities for leveraging through public/ private partnerships
- Breadth of support/opposition from stakeholders and interested parties
- Legal opportunities or potential barriers.

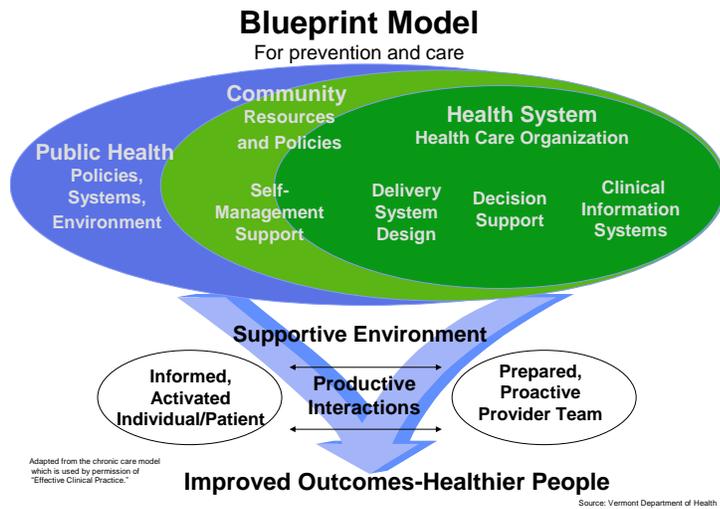
B. Guiding Principles

- 1. Strengthening Primary Prevention in the Blueprint for Health*
- 2. Focus on Improving Nutrition and Physical Activity for Obesity Prevention*
- 3. Environmental Change to Encourage Healthy Eating and Active Lifestyles*
- 4. Emphasis on Childhood Obesity*

1. Strengthening Primary Prevention in the Blueprint for Health

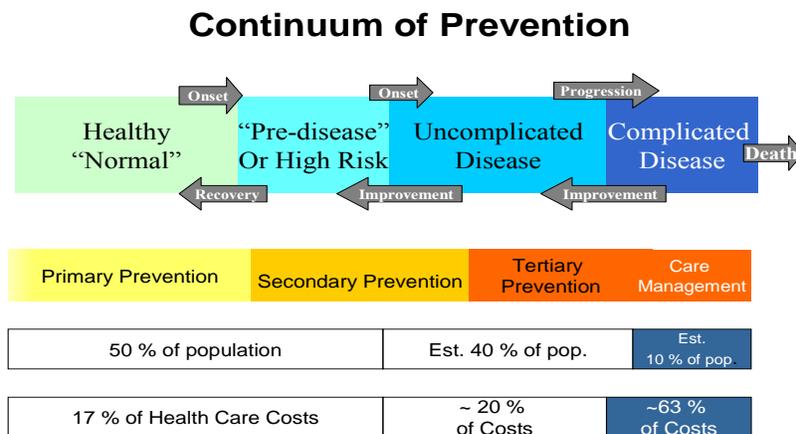
Strengthening primary prevention of chronic disease is an essential component of the Blueprint for Health, at least equal in importance to chronic care management. As reflected in Figure 1, the Blueprint for Health aims not only to reorient the health care system to improve quality of care for chronically ill persons, but also to use public health's environmental and policy change strategies to reduce the prevalence of chronic disease across Vermont's entire population.

Figure 1



Prevention of chronic illness takes place along a continuum of primary, secondary, and tertiary prevention levels, as illustrated in Figure 2.¹

Figure 2

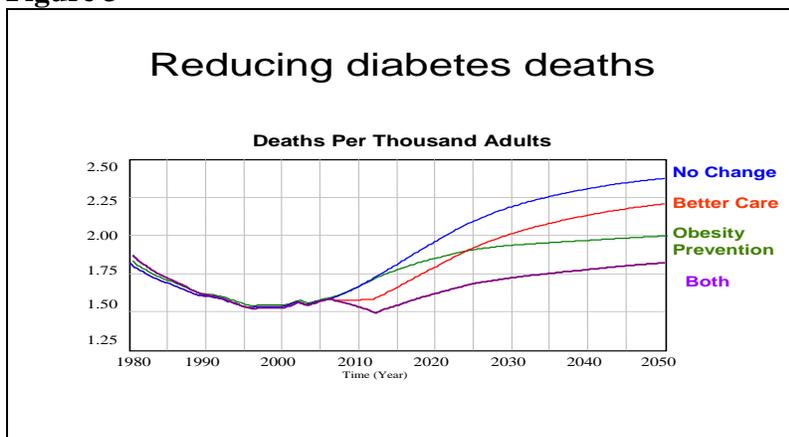


Recent health care reform legislation – Act 191 (2006) and Act 71 (2007) – has emphasized the effective management of chronic illness, through early identification and proactive care by providers and self-management by the individual (i.e., secondary and tertiary prevention). Reaching persons at early stages of chronic disease with effective management strategies offers the opportunity to slow disease progression and prevent complications of chronic illness, promising some immediate return on investment and long-term cost control. However, intervening further upstream to reduce the risk factors for chronic disease, such as physical inactivity and poor diet, reduces the likelihood of individuals developing a chronic illness in the

¹ U.S. Preventative Services Task Forces' Guide to Clinical Preventive Services (2d edition, 1996).

first place. The combined impact would substantially bend the curve in increasing health care costs and produce a higher long-term return on investment, as illustrated in Figure 3.²

Figure 3



2. Focus on Improving Nutrition and Physical Activity for Obesity Prevention

Tobacco, poor diet/inactivity (obesity), and substance abuse are the “top 3” preventable causes of chronic illness, making them leading candidates for public health prevention. Vermont has ongoing initiatives that target tobacco use and alcohol and drug consumption and has since 2004 been building a comprehensive obesity prevention initiative known as Fit and Healthy Vermonters. Commission staff singled out obesity³ resulting from poor diet and physical inactivity as a priority for legislative attention for two reasons. First, obesity will soon surpass cigarette smoking as the leading cause of preventable disease and death in the U.S. if current growth trends continue.⁴ At the national level, these trends are startling: obesity among U.S. adults and children has doubled since 1980, while obesity among adolescents has tripled.⁵ In Vermont, according to 2005 data,

- More than half (56%) of adult Vermonters were overweight or obese. The prevalence of obesity among adults increased by 58 percent from 1993 to 2003 (from 12% to 19%), so that now one in five adults is obese.
- Among school-age youth in grades 8-12, 11 percent are overweight (at or above the 95th percentile for BMI) and 15 percent are at risk for being overweight. Overweight adolescents have a 70 percent chance of becoming overweight or obese adults.

² Health reform legislation included two key primary prevention initiatives. Act 191 supported a broad immunization initiative and the FY 2007 budget bill supported community-based health promotion activities (CHAMPPS) aimed at common risk factors for chronic disease – e.g., poor nutrition, physical inactivity, tobacco use, and substance abuse.

³ Obesity in *adults* is defined as a body mass index (BMI) greater than 30. Obesity in *children and adolescents* (ages 2-18) is defined as a BMI at or above the age- and gender-specific 95th percentile. The CDC uses the term “overweight” rather than obesity to describe this group of children and adolescents.

⁴ U.S. Surgeon General, *The Surgeon General’s Call to Action to Prevent and Decrease Overweight and Obesity*, December 2001.

⁵ See Risa Lavizzo-Mourey, *President’s Message*, Robert Wood Johnson Foundation 2006 Annual Report (March 2007).

- Among low-income children age 2 to 5 years old, almost one-third (29%) were overweight or at risk of becoming overweight.⁶

Unless Vermont addresses the obesity epidemic head on, these trends will continue to escalate the suffering and premature death associated with obesity and related chronic illness.

Second, reducing obesity in childhood and curbing its development throughout the lifespan of Vermonters is critical to moderate the cost burden associated with multiple chronic diseases. The increase in obesity is compounding the rise in health care costs. According to one estimate, health care spending on obese Americans accounted for 27 percent of the growth in overall health care spending between 1987 and 2001, and health care costs incurred by obese patients are more than one-third higher than costs for those with normal weight largely because of a higher prevalence of common chronic conditions.⁷ By the Surgeon General's estimate in 2001, medical and lost productivity costs attributable to overweight and obesity amounted to about \$117 billion a year in 2001—fast approaching the \$140 billion economic toll stemming from smoking.⁸ In Vermont, annual medical expenses attributable to adult obesity were estimated in 2004 to be \$141 million, with \$40 million spent on the Medicaid population.⁹ Treating chronic disease complications associated with obesity consumes large portions of Vermont's overall health care budget, making obesity a priority condition to address if health care costs are to be brought under control.

3. *Environmental Change to Encourage Healthy Eating and Active Lifestyles*

Efforts to halt and reverse obesity trends in Vermont require an environmental change strategy to help change the system that makes Vermonters unhealthy, similar to the comprehensive approach used to combat tobacco use and substance abuse.¹⁰ As stated by the U.S. Surgeon General in the 2001 "Call to Action:"

Obviously, individual behavioral change lies at the core of all strategies to reduce overweight and obesity. Successful efforts, however, must focus not only on individual behavioral change, but also on group influences, institutional and community influences, and public policy. Actions to reduce overweight and obesity will fail without this multidimensional approach. Individual behavioral change can

⁶ Vermont Department of Health, *The Costs of Obesity*, April 2007. Although in a recent ranking Vermont had one of the lowest obesity rates among the 50 states (48th for adults and 42nd for children), the need to arrest current trends is no less pressing.

⁷ Thorpe et al, *Trends: the Impact of Obesity on Rising Medical Spending*, Health Affairs web exclusive, October 2004. See *An Unhealthy America: The Economic Burden of Chronic Disease*, Milken Institute, October 2007 (Lower obesity rates alone could avoid \$60 billion in treatment expenditures per year and produce productivity gains of \$254 billion).

⁸ The Facts about Overweight and Obesity, U.S. Surgeon General (2001), http://www.surgeongeneral.gov/topics/obesity/calltoaction/fact_glance.htm

⁹ Finkelstein, E.A., Fiebelkorn, I.C., Wang, G., *State-Level Estimates of Annual Medical Expenditures Attributable to Obesity*, Obesity Research, 12(1): 18-24 (2004)

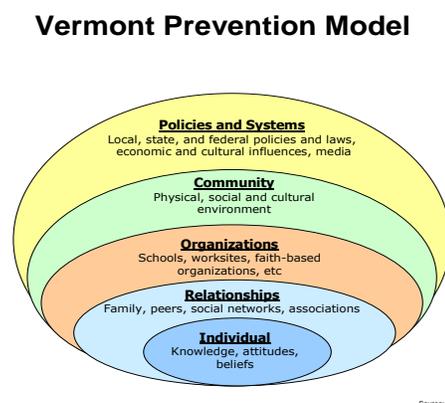
¹⁰ U.S. Department of Health and Human Services, *The Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity*, 2001; Institute of Medicine, *Preventing Childhood Obesity: Health in the Balance*, September 2004; Canadian Institute for Health Information, *Overweight and Obesity in Canada: A Population Health Perspective*, August 2004.

occur only in a supportive environment with accessible and affordable healthy food choices and opportunities for regular physical activity.¹¹

Vermonters are far more likely to make and sustain healthy choices if the physical, social, and cultural environments where they live, work, go to school, and play are conducive to nutrition and physical activity. In addition, state, local, and federal policies and the practices of organizations having powerful commercial and cultural influence must support healthy choices as the cultural norm. Individual-oriented messages (e.g., media campaigns and physician advice) are unlikely to succeed when policies and environments at the work site, in school, and other daily settings reinforce a sedentary lifestyle and unhealthy diet and “conspire against” healthy choices.¹² All of these influences must work together to support lifelong healthy eating and physical activity across the lifespan.

The interconnectedness of individual behavior change with broader environmental and policy changes at the community and systems levels is illustrated in the Vermont Prevention Model.¹³

Figure 4



Consistent with this prevention model, the success of state programs in tobacco use prevention is attributed to the comprehensive set of tools that have shifted environments and changed social norms – including state-wide and community coalitions, higher taxes on tobacco products, indoor smoking restrictions, media-based prevention campaigns, counter-marketing, school-based programs, and cessation therapies and services.¹⁴

The Vermont Department of Health has already laid the cornerstone for such a comprehensive environmental and policy approach for Vermont's obesity prevention initiative. In April 2006, *Preventing Obesity in Vermont: A Statewide Plan Engaging Individuals, Organizations, Communities, Government and Industry* was developed for the Fit and Healthy Vermonters

¹¹ U.S. Department of Health and Human Services, *The Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity*, 2001.

¹² See Institute of Medicine, "Promoting Health: Intervention Strategies from Social and Behavioral Research," 2000.

¹³ The Vermont prevention model is discussed at length in the *Blueprint for Health: Strategic Plan*, Appendix 3, pp. 60-63.

¹⁴ Institute of Medicine, *Ending the Tobacco Problem: A Blueprint for the Nation*, May 2007; Centers for Disease Control and Prevention, *Best Practices for Comprehensive Tobacco Control Programs*, 1999.

initiative.¹⁵ The plan outlined a broad collection of prevention strategies across state and local governments, community organizations, schools, employers and industry, health care providers, and the media.¹⁶ This workgroup report is intended to carry forward that planning work to the next level by helping define and prioritize a legislative agenda to make it happen.

4. *Emphasis on Childhood Obesity*

Prevention of *childhood* obesity has received particular emphasis among public health authorities at the federal and state levels. This is based both on the alarming trends for children and youth and the view that “to reverse the epidemic, we have to begin with the children.”¹⁷ In addition, children have less control over the environments in which they live and are less able to make informed decisions themselves.¹⁸ Finally, the focus on children and youth provides a natural rallying point to garner the public consensus and political will necessary to embark on the more controversial policy and environmental change measures that offer greater potential to turn around the obesity epidemic. These controversial measures include prodding food and beverage producers, fast food and restaurant chains, and the entertainment industry, among others, to take more direct responsibility for reducing childhood obesity.¹⁹

In 2004, the Institute of Medicine’s landmark report *Preventing Childhood Obesity: Health in the Balance* called on all sectors of society to make reducing childhood obesity a national priority.²⁰ In April 2007, the Robert Wood Johnson Foundation committed an unprecedented \$500 million over the next five years to support development of better strategies for reversing the childhood obesity epidemic. Many states have made childhood obesity a priority for state action.

II. Building a Comprehensive Obesity Prevention Program

In building a comprehensive obesity prevention program, Vermont faces two major challenges in common with other states. The first, and most important, is the limited capacity and infrastructure due to insufficient federal and state resources. The second is the underdeveloped evidence base for the most effective mix of strategies to reduce community obesity levels. In the face these challenges, Vermont must move ahead to define a clear public policy strategy and enact legislation targeted at reversing obesity trends.

¹⁵ “Fit and Healthy Vermonters” is the name of Vermont’s obesity prevention initiative that includes the work of the Department of Health and external partners. It is a complementary component of the Blueprint for Health, focusing on obesity prevention while other Blueprint components focus on chronic disease care.

<http://healthvermont.gov/fitandhealthy.aspx#what>

¹⁶ *Preventing Obesity in Vermont: A Statewide Plan Engaging Individuals, Organizations, Communities, Government, and Industry* (April 2006), http://healthvermont.gov/family/fit/documents/Obesity_Plan.pdf

¹⁷ Risa Lavizzo-Mourey, *President’s Message*, Robert Wood Johnson Foundation 2006 Annual Report, March 2007.

¹⁸ Public Health Agency of Canada, *Childhood Obesity and the Role of Government in Canada*,

¹⁹ See, e.g., *Making the Food and Beverage Industry Take Responsibility for Reducing Childhood Obesity: A Market-based Approach to Public Health*, Legal Times, January 2005.

²⁰ Institute of Medicine, *Preventing Childhood Obesity: Health in the Balance*, September 2004.

A. Resources and Capacity

The first challenge is the lack of funding and related resources necessary to build infrastructure and multi-sector relationships to support a comprehensive obesity prevention approach.

1. Federal Funding

The amount of federal funding that Vermont receives for obesity prevention is relatively small.

- *Tobacco prevention and control efforts received \$6.2 million this year in federal and tobacco settlement funding.*
- *In contrast, the Vermont Department of Health (VDH) currently receives \$450,000 a year from a federal grant to support obesity prevention efforts.*

The Vermont Department of Health obtained a four-year commitment of federal funding for the prevention of obesity and related chronic diseases in 2004, through a capacity-building grant from the Center for Disease Control and Prevention (CDC). Vermont is one of 21 states funded at the capacity-building level; only seven states are funded at the implementation level (estimated to provide Vermont with an additional \$500,000-600,000).²¹ With the CDC grant, VDH has been able to engage in critical capacity-building activities – e.g., hire Obesity Prevention Program staff, develop Vermont-specific data and materials, review best and promising practices for obesity prevention, and engage in comprehensive planning. Vermont’s comprehensive planning document – *Preventing Obesity in Vermont: A Statewide Plan Engaging Individuals, Organizations, Communities, Government and Industry* – was completed in April 2006 for Fit and Healthy Vermonters with input from a large number of stakeholders from multiple sectors.

The Department of Health and other agencies and partners have made significant progress in advancing various elements of the statewide plan. Many of these accomplishments – in supporting communities, schools, work sites, and health care settings – are discussed in a later section (IV. Components of a Comprehensive Solution). However, the funding and staff resources available for this purpose have been limited by the amount of the CDC grant. There has been little direct state funding. As a result, these implementation efforts are relatively small, consistent with the resources available.

Early in 2008, Vermont will apply for another five-year competitive grant from the CDC. This time all 50 states will be competing, yet the overall appropriation for this grant program will remain at the level that currently supports only 28 states. At this time the amount of funding available for Vermont is not clear, and the state will not know until June 2008 whether it will secure continued funding at all, or whether any funding awarded will be at the capacity-building or implementation level. It is vitally important that Vermont receive a renewed five-year commitment of ongoing funds from the CDC, preferably at the implementation level of funding. In addition, Vermont will need funding from other non-state sources, such as through the Robert Wood Johnson Foundation’s national program to help states tackle childhood obesity.

²¹ See Trust for America’s Health, *F as in Fat: How Obesity Policies are Failing in America*, August 2007, p. 36.

2. State Funding

As discussed below in more detail (*IV.A.2. Direct Funding for Community Efforts*), state funding for prevention of obesity and related chronic diseases has been limited.

- The Community component of the Blueprint includes approximately \$240,000 in state funding for grants to communities for chronic disease prevention. In addition, staff positions in VDH District Offices are funded to assist the communities with planning and implementation.
- For FY 2007 and 2008, VDH has continued to direct about \$200,000 in state funding for Fit and Healthy Kids activities, which through legislation has been redirected to communities as a component of the CHAMPPS grants. Previously this funding had been used for statewide initiatives such as Girls on Track, Daylight Savings Challenges, and SPARK (Sports, Physical Activity, and Recreation for Kids).

In addition, VDH has provided leadership and partnered with other agencies to develop programs and leverage other agency resources (mostly federal funds) for Fit and Healthy Kids. Leading examples of these collaborative efforts include the following partners and projects:

- *Agency of Agriculture; Department of Education*: Developed the “Vermont Nutrition and Fitness Policy Guidelines” for schools in November 2005.²²
- *Agency of Agriculture, Food & Markets*: Implemented the “Farm to School Program” (Act 145, 2006) and increased dairy products in school vending machines.²³
- *Department of Forests, Parks and Recreation*: Launched “Leave No Child Inside” in July 2007, which focuses on state parks as places for families to be active.²⁴
- *Agency of Transportation*: Began “Safe Routes to School” program with federal funding in April 2006, providing funding and assistance with setting up walking or bicycling groups, teaching safe bicycling and walking skills, and sponsoring other events to encourage students to walk or bike to school.²⁵
- *Governor’s Council on Sports and Physical Fitness*: VDH’s public health specialist for physical activity has been a key contributor to the Council as opportunities are identified to leverage public-private resources.²⁶

B. Underdeveloped Evidence Base

A second challenge for Vermont and other states is that the evidence base for what works and doesn’t work in reducing obesity rates is in an early evolutionary stage due to insufficient experience in developing, testing, and integrating strategies.

In contrast to the situation with tobacco, the available evidence regarding effective interventions to prevent obesity and promote weight loss in clinical and community settings is incomplete. Programs, services, and guidelines needed to address obesity

²² http://education.vermont.gov/new/pdfdoc/pgm_nutrition/nutrition_policy_guidelines_05.pdf

²³ <http://www.vermontagriculture.com/Agriview/2007/1-12-2007Agriview.pdf>

²⁴ http://www.cnaturenet.org/01_news_center/pdfs/VA_Launch.pdf

²⁵ <http://www.aot.state.vt.us/VTransKicksOffSchoolCampaign.htm>

²⁶ <http://www.vermontfitness.org/index.html>

and weight loss are in an earlier stage of development than programs targeting the multiple levels of influence demonstrated to be effective in reducing tobacco use.²⁷

State experience and state resources are limited because the social consensus and related public action to prevent obesity are still only beginning.²⁸ Only in the last five years have the federal government and states elevated obesity prevention to a high public health priority, and state policies are uniformly reflective of the current phase of early experimentation and piecemeal effort.²⁹ A recent review of strategies to promote physical activity and nutrition to reduce obesity among children and youth found that states are “slowly moving in the right direction,” but these interventions “generally remain fragmented and small-scale.”³⁰ The knowledge base for evidence-based “best practice” programs and policies is limited, and it is not yet clear which interventions are most effective and what mixture of communication, counseling, and policy/environmental change will yield the best results.³¹

III. Recommended Strategies for State Action

A. Developing Legislative Priorities and Commitment

The present challenge for Vermont is to define a cohesive public policy strategy and develop legislation targeted at obesity prevention. The 2006 *Fit and Healthy Vermonters Obesity Prevention Plan* and the 2007 strategic plan for the Blueprint for Health outline essential objectives and strategies for obesity prevention, representing valuable resources for legislative review. However, those planning documents are not intended to establish priorities and make recommendations for legislative action. The legislature, the administration, and interested parties need to engage in a sustained high-level dialogue to sort out priorities for legislative policy making and determine where best to allocate limited fiscal resources. This discussion will benefit from continued consultation with national organizations such as the Council of State Governments (Healthy States Initiative³²), National Governors Association³³, the Robert Wood Johnson Foundation, the Alliance for a Healthier Generation, the Prevention Institute, and others.

The following section – IV. Components of a Comprehensive Solution – offers information and guidance to stimulate high-level consideration of priorities for legislative policy making and the availability of fiscal resources that can make those priorities happen.

²⁷ U.S. Preventive Services Task Force, *Integrating Evidence-Based Clinical and Community Strategies to Improve Health*, March 2007, <http://www.ahrq.gov/clinic/uspstf07/methods/tfmethods.htm>

²⁸ *Patterns of Childhood Obesity Prevention Legislation in the United States*, *Prev Chronic Dis*, July 2007.

²⁹ Trust for America’s Health, *Obesity-Related Legislation Action in States, Update*, August 2007; Health Policy Tracking Service, *A Report on State Action to Promote Nutrition, Increase Physical Activity, and Prevent Obesity*, October 2006, <http://www.rwjf.org/files/research/Balance122006.pdf>

³⁰ E.g., Institute of Medicine, *Progress in Preventing Childhood Obesity: How Do We Measure Up?* September 2006; *President’s Message*, Robert Wood Johnson Foundation 2006 Annual Report (March 2007).

³¹ Trust for America’s Health, *F as in Fat: How Obesity Policies are Failing in America*, August 2007, pp. 81-84.

³² See, e.g., CSG, *Trends in State Public Health Legislation January 1, 2007 – June 30, 2007*, August 2007.

³³ *NGA Awards 10 States \$100,000 Grants to Combat Childhood Obesity*, July 2007.

B. Pilot Programs to Develop and Test Multi-Component Community Initiatives

Consistent with the Blueprint for Health, the state should build on the Fit and Healthy Vermonters initiative and the existing CHAMPPS community grant program to implement a community prevention model to promote healthy lifestyles for all Vermonters. The model would rely on the leadership, public health planning expertise, and the statewide district office infrastructure of the Vermont Department of Health and enhance ongoing collaboration with other state agencies and community partners. Development of the model would begin with grants to selected communities to develop, test, and evaluate the most effective environmental and policy change strategies for promoting physical activity and healthy eating. **A breakthrough improvement is required in our existing strategies that support improved eating habits and greater physical activity if we are going to reverse the sustained trend of increased obesity.**

Beginning in 2009, the state would work with 4 to 8 communities to bring together the many components described in the next section into a cohesive and coordinated set of strategies similar to the community prevention model developed in tobacco prevention. Under this initiative, Vermont would expand existing community-based pilot programs to develop comprehensive environmental change strategies supported by the policy making apparatus of state and local government. Business and civic leaders, school officials and teachers, parents, leaders in health care and social service settings, local planning agencies, and others would come together to develop a set of strategies and interventions that extend across all sectors of the community. For example, to promote options for better nutrition, community coalitions would likely work with schools, commercial settings (such as supermarkets, restaurants, and fast food outlets), and farmer's markets to increase access to healthy food choices. To promote physical activity, the projects could increase access to walking/biking paths, exercise facilities, and playgrounds and recreational areas. Community efforts would be supported by a strong public awareness campaign, including communication toolkits with well-researched and coordinated messaging for all community settings including school, work sites, and health care. For example, the materials and messages that children and families receive in their schools concerning school nutrition, physical education, and physical activity would be reinforced by complementary materials and messages provided to children and families in their medical homes, with the same coordination of messaging for work places and other community settings. Incremental progress toward this holistic vision may be hinge on dynamic community leadership able to negotiate the challenges of working across community sectors, each with its own set of interest groups, to build and sustain such a comprehensive level of collaboration.

Public health specialists in the Department of Health District Offices would provide technical assistance to community partners (both public and private) using evidence-based public health tools such as community needs assessments based on epidemiological data, identification of best practice strategies, and evaluation of efforts to assure improved wellness outcomes. The District Health Offices would be responsible for leading this community health promotion work by bringing together community prevention teams that draw on the expertise of the Local Health Director, Substance Abuse Prevention Specialists, Chronic Disease Prevention Specialists, and community leadership. The regional public health specialists would provide a point of contact and coordination between community leaders and state agencies offering technical and policy assistance and needed resources. Evaluation of the community initiatives would be vital to track

progress and develop evidence of what works. Each of the components in this cohesive community initiative is discussed in more detail in the following section (IV. Components of a Comprehensive Solution).

To implement the comprehensive community component, a significant increase in funding is necessary. Funding for this enhanced community initiative could be provided through a combination of CDC funding (if the state grant is renewed in 2008), private grants (e.g., the Robert Wood Johnson grant program focusing on childhood obesity), and dedicated state funding. It is extremely important that Vermont position itself now to be competitive for the CDC grant (graduating from the “capacity-building” to the “implementation” level, if possible) and for other grant programs such as Robert Wood Johnson Foundation’s anticipated program to support state environmental and policy change. A visible commitment of dedicated state funding may be an important selection factor in winning out in the tight competition anticipated for these and other obesity prevention grants.

An important long-term objective in this community pilot initiative would be to shape an approach where community health promotion addressing nutrition and physical activity comes to be integrally connected with population health improvement programs targeting tobacco, substance abuse, and related risk factors for chronic disease. This synergistic orientation would take advantage of parallel resources that the state has developed in its assistance-and-support models for communities to reduce tobacco use and substance abuse. Although the content of prevention strategies in these areas can differ, the skills and expertise needed in coalition building, needs assessment, prioritization and implementation, and evaluation are cross-cutting. The “stretch” goal for community initiatives is to move away from the categorical, disease-specific orientation (described in the box below) toward a holistic sense of shared responsibility among a broad system of organizations working in partnership to create the conditions supportive of positive health outcomes for the community as a whole.

"Since the 1970s, health planners have understood that effective responses to the intertwined afflictions within communities (e.g., tobacco and substance addiction, obesity) require system-wide interventions. However, ingrained in financial structures, problem-solving frameworks, statistical models, and the criteria for professional prestige is the idea, inherited from medical science, that each affliction can be prevented individually by understanding its unique causes and developing targeted interventions. Consequently, most practitioners operate with resources focused on one disease or risk factor, leaving other problems to be addressed by parallel enterprises."³⁴

³⁴ See Syndemics Prevention Network, National Center for Chronic Disease Prevention and Health Promotion, <http://www.cdc.gov/syndemics/encyclopedia.htm>

IV. Components of a Comprehensive Solution

- A. Community Coalitions and State Support/Infrastructure*
- B. Community Environments Conducive to Healthy Living*
- C. Schools*
- D. Work Sites*
- E. Health Care Settings*
- F. Business and Industry*
- G. Public Policy*

A. Community Coalitions and State Support/Infrastructure

Recommendation: Establish stable funding to build state technical assistance capacity and provide funding support for broad-based community initiatives

Effective broad-based community initiatives for the primary prevention of poor health outcomes, including obesity and chronic disease, are dependent on leadership, technical assistance, and training from the State supported by stable funding. At present, the available state and federal resources are inadequate to meet the challenge.

1. State Technical Assistance and Oversight

The value of state infrastructure and technical assistance to support the development and ensure the quality of community-based initiatives has been demonstrated in the success of New Directions in tackling youth substance abuse. This infrastructure has been possible only because of the sustained financial investment of the federal substance abuse prevention grant. Currently, ten Substance Abuse Prevention Specialists operate locally throughout the state to develop coalitions and provide technical support in assessment, planning, implementation, and evaluation of substance abuse prevention activities. Similar technical assistance has been available to the statewide network of tobacco prevention coalitions in Vermont. Maternal child health coalitions in all districts rely on an interdisciplinary team to promote healthy outcomes for pregnant women and infants, and have emphasized breastfeeding as an obesity prevention strategy for the past decade.

State technical assistance and oversight ensure that communities follow a consistent coordinated approach (e.g., needs assessment, defined priorities, action plans) that can be tailored to the community while remaining accountable to statewide goals and evidence-based strategies. Based on the experience of tobacco and substance abuse prevention, the state has an all-important role in supporting community capacity building and quality improvement. As described in the *Blueprint Strategic Plan* (Objective 2), communities need to conduct needs assessments and develop action plans identifying priority strategies for policy and environmental changes and programmatic activities. Community initiatives are also encouraged to complement and integrate when possible with efforts to reduce tobacco use and substance abuse, two other leading risk factors for common chronic conditions.

The Department of Health has established a goal of having at least one full time equivalent (FTE) Chronic Disease Prevention Specialist in each of the 12 Department of Health District

Offices. Currently, there are three FTEs spread among five District Offices funded through the Blueprint for Health. The FY 2008 appropriation will allow the addition of one more FTE (for a total of four FTEs) to serve seven District Health Offices.

The role of the Chronic Disease Prevention Specialist is to work with communities in their district to implement policies, programs, and services for chronic disease prevention. This requires the development and mobilization of community partners and resources, with active collaboration across family, community, school, workplace, medical, and other domains. Because much of the infrastructure building is cross-cutting, the Specialist will work closely with the Substance Abuse Prevention Specialist to ensure coordinated community development. Coalitions will be guided through the assessment, planning, and development process and supported in implementation of their plans. Work will vary statewide based on community needs and resources, but the basic programs and services are comparable across District Health Offices. An essential role of the prevention specialist is to serve as the link between the VDH and the community to improve understanding of state policy and goals and to ensure that the Department is responsive to community needs.

A legislative commitment would be necessary to continue building this critical infrastructure and support the effective use of public health experts/consultants in broad-based community efforts.

2. Direct Funding for Community Efforts

Sustainable grant support for community efforts is also needed. Currently, very limited funding is available for community grants to support nutrition and physical activity, through Blueprint community funding, CHAMPPS, and Fit and Healthy Vermonters. Under CHAMPPS, the Department of Health has developed a standardized approach to inviting, reviewing, and funding proposals from communities, which is now being followed for all health promotion grants to communities.

- In FY 2008, the Blueprint for Health will provide small grants of about \$30,000 on average to each of the six Blueprint communities, with lesser amounts available in other communities, (\$240,000 in total) to support local infrastructure and implementation of local activities designed to address risk factors for chronic diseases.
- In June 2007, the CHAMPPS initiative awarded grants to communities for health and wellness efforts. Implementation grants of about \$100,000 each focusing on physical activity and nutrition were awarded to two communities (Rutland and Winooski), and a couple of the capacity-building communities that received \$60,000 each in grant funding may opt to focus on this area depending on their needs assessments.³⁵ It should be noted that CHAMPPS included no appropriation for staffing or administration that would support mentoring and technical assistance to funded communities, and half of the funding is from a federal substance abuse prevention grant that will expire in 2011. No additional appropriation was made for CHAMPPS in FY 2008, making future funding uncertain for currently funded communities and precluding expansion. CHAMPPS could be strengthened by moving it

³⁵ <http://healthvermont.gov/local/grants/documents/CHAMPPSGrantsFY08.pdf>

from the appropriations bill to state statute and linking it with the Blueprint community component.

- The Fit and Healthy Vermonters obesity prevention program has relied on the CDC capacity-building grant (federal funding) to award \$50,000 each to Swanton and Morrisville for the development of physical activity and nutrition initiatives targeting policy and environmental change. The community development and planning steps are modeled after the strategic prevention framework for substance abuse prevention. Through its community assessment, Swanton's Fit Family coalition identified parents' desire for places for safe recreation. The grant funding will allow them to complete a one-mile path connecting the town and school and conduct family-based nutrition and physical activities.

The perpetual “come and go” nature of prevention funding for communities often serves to discourage key partners from participating. The piecemeal approach that has evolved through disease-specific and grant-funding-driven efforts (usually federal) does not allow for consistent, sustainable approaches within a community or from community to community. Consequently, a long-term commitment by state and federal government to stable funding is needed for effective community-based obesity prevention.

B. Community Environments Conducive to Healthy Living (“Built Environment”)

Recommendation: Continue support for the development of physical environments in communities that promote or support healthy activity.

Aspects of the physical environment in which we live (often called the “built environment”) influence a person's health behaviors such as the level and amount of physical activity or consumption of fresh fruits and vegetables. Examples include the availability of safe accessible sidewalks, bicycle lanes, shared-use paths and trails, exercise facilities, and farmer's markets. Growth patterns in Vermont over the last several decades resemble those seen nationally. Businesses, retail centers, schools, and homes are located further away from established downtown areas and “growth centers.” Reliance on cars is increasingly a part of everyday life. Roads designed for rapidly moving automobiles make walking and bicycling to and from work or school more difficult and less safe.

1. Build upon existing legislation that encourages and supports development in “growth centers” through zoning and incentives/disincentives

Municipalities in Vermont have long been encouraged to include language in local town plans that support the principles of “smart growth.” This means developing communities with mixed-use zoning that supports easy walking or bicycling to homes, work, schools, stores, services and community centers. These areas also support and promote physical activity with sidewalks, bicycle facilities, paths and trails, parks and open spaces, and recreational facilities.

Growth centers legislation (Title 24, Part II Chapter 76 A, Sections 2790 and 2791) passed in 2006 had as a goal to further reinforce efforts to concentrate new development in mixed-use centers. Designated growth centers are eligible for a package of benefits including regulatory relief for new development and financing benefits for public infrastructure.

Vermont state agencies such as the Agency of Transportation and the Department of Housing and Community Affairs offer incentives to towns through grant programs that encourage and support building and redevelopment in designated downtowns, village centers, and designated growth centers. This helps to reinforce the vitality of Vermont's historic centers and planned growth centers by directing state funding for transportation infrastructure, housing, and economic development to those centers. Related state policies discourage growth and development in surrounding rural areas, helping to preserve productive farmland that can provide fresh food to nearby population centers.

Both the *Fit and Healthy Vermonters Obesity Prevention Plan* and *Blueprint Strategic Plan* have a shared objective that “by 2010, all cities and towns with a population of 2000 or more will have a community-based physical activity program.” Communities are required to include policy and environmental components in the development and implementation of these programs. In addition, the Fit and Healthy Vermonters state plan includes the objective “by 2010, 75 percent of the 251 municipalities in Vermont will include ways to increase availability and accessibility of opportunities for physical activity and healthy eating in comprehensive plans, zoning and subdivision ordinances and other transportation planning and design projects.” To accomplish this objective, the Department of Health is partnering with agencies such as the Department of Housing and Community Affairs and the Department of Transportation to develop technical assistance, trainings, and resources as well as encouraging coalitions on a local level to work with town planners, select boards and regional planning commissions.

Finally, Vermont has a strong Safe Routes to Schools program to educate, encourage, and construct facilities for children to routinely bicycle and walk to school. Currently, over 30 schools are funded for “non-infrastructure” activities, such as education, encouragement, building awareness, and enforcement. The Agency of Transportation is the lead agency for the program, with partners including the Department of Health, Department of Education, and private non-profit organizations, such as the American Heart Association.

Barriers to “smart growth” include cost and other challenges associated with infrastructure capacity, such as sidewalks, paths, and (in particular) sewage capacity. Not only do many small towns in Vermont lack sufficient physical infrastructure to accommodate new growth in centers, but volunteer-run towns often lack the management capacity to deal effectively with public infrastructure. Public fear and reaction against real and perceived problems associated with new development, especially new housing, and the subsequent resistance to updating local bylaws to permit higher densities and mixed uses needed for smart growth, allows sprawling patterns of development to continue.

2. Other Ideas

Other ideas needs further development include:

- Improve access to healthy foods in rural and low-income communities by attracting supermarkets through regulatory and financial incentives, promoting farmers markets and community gardens, and improving transportation options to supermarkets.

- Continue to build planning capacity by pulling together non-traditional partners in areas such as health and health care, transportation, environment, and education.

C. Schools

Recommendations

1. *Reduce the sale and consumption of less nutritious foods available in Vermont schools.*
2. *Increase the number of Vermont students who routinely participate in quality physical education and physical activity.*
3. *Support and expand grant programs to support innovation in schools.*

Schools are a logical setting for interventions aimed at preventing and controlling childhood obesity through the promotion of both healthful eating and physical activity. Nationally, the leading school policy initiatives across states include the following objectives:

- Establishing nutritional standards for foods and beverages sold in schools
- Restricting access to and sales of foods and beverages high in fat and added sugar and low in nutrients
- Setting physical education and physical activity requirements
- Educating children about nutrition and active living
- Monitoring and reporting students' body mass index (BMI).³⁶

Many states have adopted school-based programs in the interest of helping children and adolescents control their weight. However, there is not yet conclusive evidence concerning their effectiveness, underscoring the evolving state of the field.³⁷

Federal law (2004) requires every school district that participates in the federal school meals programs to have a wellness policy that sets goals for nutrition education and physical activity and provides nutrition guidelines for all foods available at schools.³⁸ Pursuant to Act 161 (2003), Vermont established the November 2005 *Vermont Nutrition and Fitness Policy Guidelines* to provide schools with the most recent information on best practices for school nutrition and physical fitness, based on the recommendations of nationally recognized authorities.³⁹

At the July 2007 public policy forum on obesity prevention sponsored by the Department of Health and the American Heart Association, advocacy groups expressed concern that implementation across schools of the guideline recommendations has been inconsistent and in some cases incomplete. Advocacy organizations are pushing for stronger state direction in establishing school nutrition and physical education standards.

Past legislative efforts to set statewide school nutrition and physical education requirements have raised concerns among local officials and school administrators about legislative mandates that

³⁶ Health Policy Tracking Service, *A Report on State Action to Promote Nutrition, Increase Physical Activity and Prevent Obesity*, Issue 2 July 2006 and Issue 3 October 2006.

³⁷ U.S. Task Force on Community Preventive Services, *Guide to Community Preventive Services*, 2005 (update pending).

³⁸ Section 204 of the federal Child Nutrition and Women, Infants, and Children Reauthorization Act of 2004 (PL 108-265).

³⁹ Available at http://education.vermont.gov/new/pdfdoc/pgm_nutrition/nutrition_policy_guidelines_05.pdf

impose additional curricula requirements or cut off additional sources of revenue. While state government clearly has an interest in facilitating healthy school environments, the potential costs of new mandates and ease of adoption tend to be the sticking point with the schools community.

1. Reduce the sale and consumption of less nutritious foods

Policy developments at the national level since 2005 as well as ongoing policy discussions within Vermont point to opportunities for strengthening the nutrition standards and improving implementation across schools.

For example, many schools rely on revenue from vending machines and school stores to supplement activities for young people, and even equipment for physical education programs. In 2006, the national Alliance for a Healthier Generation (AFHG), a joint venture of the American Heart Association (AHA) and the William J. Clinton Foundation, developed “science-based and age-appropriate guidelines” to promote nutrient-rich foods, fat-free and low-fat dairy products in school vending machines and a la carte lines and to place limits on calories, fat, saturated fat, trans fat, sugar and sodium. The Alliance has obtained agreements from both snack food and beverage industries to create a line of products to be sold in schools that are based on these guidelines (similar to Act 161 guidelines).⁴⁰ The intent of these efforts is to enable schools more easily to implement nutritious choices without the loss of income that foods sold on school grounds generate for school programs. The Alliance cites growing evidence that youth will continue to purchase the more healthful options, preserving opportunities for schools to generate revenue. In some states, state and local public health agencies are presenting workshops to help schools and support organizations adopt healthier ways to support school programs.⁴¹

In the fall of 2007, the Vermont Department of Health in collaboration with the Department of Education and the Action for Healthy Kids coalition developed the Healthy Schools Resource to help schools and school wellness teams implement best practices based on their wellness policy.

It is anticipated that legislation for the 2008 session (Sen. Lyons is sponsor) would establish consistent statewide standards for foods sold on school grounds, possibly moving from the level of “recommended best practices” to “required standards.” This prospective legislation provides a vehicle for weighing legislative options in this area.

2. Increase participation in quality physical education and physical activity.

Expanding opportunities for students to develop knowledge and skills that are essential to health and fitness is also an area for consideration. Options that have been suggested include:

- Raising minimum physical education requirements in Vermont’s School Quality Standards, which currently state:
 - Elementary and middle schools (K-8) offer students physical education “at least twice weekly, or the equivalent thereof”

⁴⁰ See Alliance for a Healthier Generation, <http://healthiergeneration.org/>

⁴¹ See, e.g., the Coordinated School Health Program in Washington State, funded by a CDC grant. <http://depts.washington.edu/waschool/>

- The minimum graduation requirement for high school students for physical education is “one and one-half years of physical education.”
- Enhancing efforts to promote best practices for expanding physical education and physical activity, with a focus on minimizing any additional burden on a school’s fiscal and human resources. The Department of Education has compiled best practices and is sharing them with schools, so the question is what more can be done to achieve greater impact.
- Exploring ways to increase physical activity for students in addition to formal physical education programs, by examining successful models and sharing ideas.

Here again, this is an area where development of a specific legislative proposal would benefit from further discussion with a variety of interested parties.

3. Continue Grant Programs to Support Innovation

Current grant programs include:

- The School Wellness grant program (Act 161, 2004) provides a total of \$30,000 for school communities to implement wellness programs. 2007-08 grants will fund projects at the high school level to increase student time spent in moderate to vigorous physical activity during physical education and develop student self-knowledge, personal goal setting, and fitness planning skills. Pilot high schools will receive equipment and training to achieve these goals.
- The Farm to School Program (Act 145, 2006) provides \$125,000 (06-07) for grants up to \$15,000 to help Vermont schools develop relationships with local farmers and producers. Key goals are to encourage schools and school districts to serve food to students that is as fresh and nutritious as possible; maximize the use of fresh, locally grown, produced and processed foods; and educate students about healthy eating habits through hands-on nutrition education. While successful on an individual school basis, the Farm to School grant program would have greater impact if Vermont farmers gained improved access to processing and distribution systems that help deliver local foods to schools. This is another area that deserves further discussion with the Agency of Agriculture, Food & Markets and other interested parties.

D. Work Sites

Along with schools, worksite wellness programs and employee health management programs are central to the environmental shift required for improving healthy eating and physical activity in families to prevent childhood obesity. Work sites provide a natural setting for promoting healthy behaviors because of the amount of time that workers spend at their work sites and the number of people potentially reached through these programs. The organizational culture and environment are powerful influences on behavior that can be put to good use in helping employees and their loved ones adopt healthier lifestyles. The state should continue to engage employers in finding creative ways for employees to be more physically active at work and have healthier food choices.

Rapidly rising health care premiums and evidence of the “hidden costs” of poor health status, including absenteeism and reduced productivity, have led many large and medium-sized employers to see a business case for keeping employees healthy. Nationally, there is well-

documented evidence to support investment in these programs, with a 2003 meta-analysis finding an average 28% reduction in absenteeism, 26% reduction in health care costs, and a 30% reduction in workers compensation and disability claims.⁴² Overall savings-to-cost ratio estimates range from \$3.50-to-\$1 and \$6.00-to-\$1.^{43,44} However, the dominance of small businesses in Vermont as well as the community rating of most insurance premiums make it unlikely that most Vermont businesses will be able to achieve that rate of return.

In Vermont, worksite wellness programs have been an integral part of comprehensive obesity prevention planning. The *Fit and Healthy Vermonters Obesity Prevention Plan* outlines a target that by 2010 all work sites with more than 25 employees will have policies in place that promote health behaviors and will offer physical activity or nutrition programs to their employees. The *Blueprint Strategic Plan* includes a similar goal in Objective 4. This year, the Fit and Healthy Vermonters program convened a worksite wellness workgroup with representation from the Vermont Employers Health Alliance, hospital wellness centers, Blue Cross and Blue Shield of Vermont, MVP Healthcare, and State of Vermont Employees' Wellness Program. The workgroup has developed a technical assistance guide that will disseminate the best practices from Vermont businesses to other organizations interested in developing these programs. This resource builds off of the annual employer awards given annually by the Governor's Council on Physical Fitness and Sports, and will soon be available on the web.

The Governor's Council awards program shows that many small and large businesses in Vermont are already implementing innovative programs to improve the health of their employees.⁴⁵ Despite barriers to adoption and implementation, high retention rates and competition for qualified employees give Vermont employers strong incentives to support these programs. Taking full advantage of these circumstances would perhaps be the most powerful environmental change strategy for obesity prevention among Vermont's adults and their children.

Options to support making wellness the cultural norm at Vermont work sites include the following:

1. *Support development and dissemination of best practices*

Modest funding could be provided to VDH to sponsor in partnership with employer and other organizations an annual conference to promote outreach and dissemination concerning best practices in worksite wellness. Building on VDH's current technical assistance work under Fit and Healthy Vermonters, the state should restore support for an annual conference to bring together business leaders from around the state to learn from each other's experiences and hear from industry experts. The conference would help disseminate the technical resource guide that outlines best practices in comprehensive worksite wellness programs – including nutrition, physical activity, tobacco cessation, stress reduction, and promotion of breastfeeding for mothers

⁴² Chapman LS. Meta-evaluation of worksite health promotion economic return studies. *The Art of Health Promotion*. 2003;6(6):1-16.

⁴³ Chapman, 2003.

⁴⁴ Aldana SG. Financial impact of health promotion programs: a comprehensive review of the literature. *Am J Health Promotion*. 2001;15(5):296-320.

⁴⁵ Governor's Council on Physical Fitness and Sports, Awards, <http://www.vermontfitness.org/awards.html>

returning to work. It would also increase information sharing on how best to implement new or expanded programs in diverse workplace settings. The conference should be targeted to both executives and human resources personnel and should provide a set of tools to navigate the increasing number of options in commercial wellness programs as well as share the experiences of other Vermont businesses. Additionally, funding for additional outreach for the resource, including a DVD, should be explored.

2. Increase use of economic incentives to induce employee participation

Act 191 authorized private health insurers to provide premium discounts or rebates or modify otherwise applicable co-payments or deductibles in return for adherence to health promotion and wellness programs that promote physical activity, healthful diet, or weight loss.⁴⁶ This economic incentive mechanism available to encourage employee commitment to healthy living has yet to be implemented by any of the private insurers in Vermont. Evidently, this delay in implementation is largely a reflection of the competing priorities for the insurers (including Catamount Health) rather than lack of interest. The *Blueprint Strategic Plan* (Objective 4) calls for a task force of business representatives to promote use of employer incentives such as premium discounts, payment or reimbursement for lifestyle or weight loss classes, and time off for physical activity. Carrying out this objective could inform the legislature regarding the most effective way to advance implementation of employee incentives for participation in wellness programs, including the use of regulatory mechanisms to require use of premium discounts or waived cost sharing.

Self-insured employer programs may provide important lessons. In October 2007, IBM announced that it would launch a wellness program designed to encourage employees to help their children lead healthier lives. The company plans to offer the Children's Health Rebate program as part of its annual benefits enrollment, paying \$150 cash rewards to employees whose children complete a 12-week online program promoting sound nutrition and active lifestyles. The goal is to reward good nutrition and physical activity for the entire family, which is key to helping children develop healthy habits for a lifetime.⁴⁷

3. Provide economic incentives to Vermont employers to design and implement comprehensive worksite wellness programs

Vermont employers, especially small employers, face significant financial burdens in pursuing comprehensive worksite wellness programs. Comprehensive programs include at least five key elements: 1) health education, 2) links to related employee services, 3) supportive physical and social environments for health improvement, 4) integration of health promotion into the organizations' culture, and 5) employee screenings with adequate treatment and follow-up.⁴⁸ Recent studies among large employers show that companies that are most effective at containing costs are those that pursue wellness programs that are "more extensive" and "address the

⁴⁶ See also Final Rules, *Nondiscrimination and Wellness Programs in Health Coverage in the Group Market*, 71 Fed. Reg. 75014 (December 13, 2006).

⁴⁷ <http://www-03.ibm.com/press/us/en/pressrelease/22496.wss>

⁴⁸ Goetzel RZ, Shechter D, Ozminkowski RJ, Marmet PF, Tabrizi MJ, and Roemer EC, "Promising Practices in Employer Health and Productivity Management Efforts: Findings from a Benchmarking Study," *JOEM*, Vol. 49, No. 2, Feb. 2007, p. 112.

underlying causes of health care cost increases.”⁴⁹ The need for programs to be evidence-based and well-resourced over the long-term is a barrier to many smaller businesses. Incentives to assist Vermont businesses in the development and implementation of workplace wellness programs could take at least three forms:

- *Ongoing tax incentives for worksite wellness programs:* Vermont could offer tax credits or incentives to companies that implement workplace wellness programs. This would support ongoing investments in wellness initiatives and encourage companies to pursue more comprehensive programs. However, tax credits will likely require a larger investment of state resources and sustained incentives may be unnecessary if an established program provides a reasonable return on investment.
- *Small grants (with matched funds) to defray the start-up costs:* A small grant program has the advantage of living within a defined appropriation, but may have more limited impact.
- *Help small businesses purchase worksite wellness programs for less cost:* Vermont could also help small and mid-sized employers in forming a coalition or collective group to purchase worksite wellness products, with potential benefit from economies of scale. This type of pooling is already being conducted on a small scale in Vermont. One example is the agreement between PKC Incorporated, which builds an on-line health and wellness tool for consumers, and Business Resource Service, which purchases the product for all of its employer customers.

Input is needed from the employer community as to the best means to support worksite wellness programs, while evaluating the costs and benefits. Perhaps this input could come from a workgroup formed before hearings are held during the legislative session.

- *Use of incentives or regulatory mechanisms to promote inclusion of worksite wellness programs in private health insurance packages*

National worksite survey results indicate that health insurance or managed care providers are the leading source of health risk appraisals, health screenings, lifestyle behavior change programs, and disease management programs offered by employers of all sizes.⁵⁰ Although commercial insurers offer worksite wellness programs to those employers who elect to use them, these programs are not a part of the standard package of services. This is an area that merits further exploration.

4. Develop new innovative approaches for very small employers

It is not clear how useful the options listed above would be for very small employers (e.g., with fewer than 20 employees), whose employees make up more than a quarter of Vermont’s private sector workforce.⁵¹ Given the link between health insurance and health promotion programming, it is important to note that only about half of employers with fewer than 10 employees and about three-quarters of employers with 10 to 19 employees offer some type of health insurance.⁵² Furthermore, even with businesses that offer employee health insurance, longstanding experience shows that smaller worksites are less likely to offer any type of health promotion program, offer

⁴⁹ Goetzel RZ et al, 2007. From Towers Perrin 2007 Health Care Cost Survey, press release dated October 9, 2006.

⁵⁰ *Results of the 2004 National Worksite Health Promotion Survey*, Am J Public Health, 2006.

⁵¹ See *Annual Average Enrollment by Size of Establishment (Number of Employees)*, Vermont Department of Labor, 2005, <http://www.vtlmi.info/cew2005.pdf#countyxsize>

⁵² See *2005 Fringe Benefit Survey of Private Industry Employers*, Vermont Department of Labor, 2005, <http://www.vtlmi.info/fringebene.pdf>

fewer environmental programs or supports, and report fewer health-oriented policies.⁵³ In order to reach very small employers, the following ideas were offered as mutually supporting strategies:

- For over six years, all hospitals in Vermont have had on-site tobacco cessation services that include classes, one-to-one counseling, and more. With a small amount of incremental funding, these counselors and/or their colleagues could become resources for small employers interested in connecting their employees with health and wellness supports.
- Vermont 2-1-1 could be used as a resource for employers/employees to access information about diet, nutrition, and physical activity. 2-1-1 already has much of this information, and it would take only a modest effort to enhance this information and to keep it up-to-date.
- The Vermont Chamber of Commerce, Lake Champlain Regional Chamber of Commerce, Green Mountain Care, insurers, and United Ways could distribute posters, paycheck stuffers, employer homepage inserts, and the like that employers could post, distribute, or employ to encourage their employees to access health and wellness information via Vermont 2-1-1.
- Modest rewards could be available for employers who post and/or distribute this information. A postage paid return postcard that employers can use to affirm they've posted or distributed information might result in a \$25 incentive, entry into a raffle, or the like.⁵⁴

These ideas are floated to stimulate further thought and discussion concerning how to expand wellness practices within this especially hard-to-reach segment of Vermont's working population. As suggested by the proposals, this may be an area where comprehensive, multi-sector community-based health promotion initiatives may be particularly well-suited to create solutions.

5. Support Vermont's state employees' health benefit program as a model program

The Vermont state employees' wellness and health benefits program should serve as a model for best practices in supporting healthy choices in physical activity and nutrition. As Vermont's largest employer, the state serves a population of over 9,000 active employees. The state began integrating a wellness and prevention model with its health care benefit over two decades ago. To date, the State Employees' Wellness Program has relied on a range of health promotion strategies to increase physical activity and healthy eating, including:

- Nurse educator screening programs offering health assessments and one-on-one counseling
- Fitness challenges and events (e.g., pedometer program)
- Healthy work environment initiatives.

Independent of the Wellness Program, the health benefits program offers chronic care management for employees with established weight problems through the CIGNA Well Aware Weight Complications program. CIGNA also offers member discounts to Weight Watchers and an on-line weight loss program with the option of interactive counseling at a reduced rate.

⁵³ *Small Businesses, Worksite Wellness, and Public Health: A Time for Action*, NC Med J, November/December 2006.

⁵⁴ Email communication with Penrose Jackson (Community Health Improvement) and Lori Smith (Employer Health Management) of Fletcher Allen Health Care.

The State Employees' Wellness Program recently merged with the Workforce Planning & Development Division to become the Workforce Development & Wellness Division. This unit is now reviewing data and best practices to develop a strategic plan for implementing effective ways to promote the health and well-being of all state employees, including in the areas of physical activity and nutrition. The Division is also developing a partnership project with other state programs – such as the Employee Assistance Program, Worker's Comp, Risk Assessment (e.g., ergonomic assessment), CIGNA and CIGNA Behavioral Health – to look at ways in which they can all be more proactive and strategic in promoting health and wellness and preventing illness or injury in the state employee population as a whole. The legislative hearing process in 2008 will provide opportunity to learn more about the progress of these new developments.

E. Health Care Settings

Recommendation: Engage health care providers and payers (employers and insurers) in collaborative review and development of strategies and interventions to ensure that best-practice obesity prevention is part of routine primary care.

Primary care settings are an important leverage point for obesity prevention because health care professionals have frequent, albeit time-limited, opportunities to encourage children, youth, and adults to engage in healthful lifestyles. The alarming rise in the prevalence of obesity makes it incumbent on front-line health care professionals and on health care purchasers and insurers to make best-practice obesity prevention part of routine preventive care.⁵⁵ It also requires developing more effective interventions to promote healthy behaviors among overweight individuals and accelerating practice improvement through guidelines and implementation toolkits that disseminate successful practices.

1. Distribute AHEC and VCHIP Healthy Weight toolkits to primary care practices and offer training and education

The *Fit and Healthy Vermonters Obesity Prevention Plan* sets forth the goal that primary care providers and related health practitioners routinely measure and record Body Mass Index (BMI) and provide counseling and/or referral for patients. Current efforts are underway to support that goal for both children and adults.

Children

It is highly important that primary care practitioners develop an active monitoring system of weight status for children. By identifying at-risk and overweight children and adolescents at an early stage and measuring body mass index (BMI) during every health supervision (or wellness) visit, clinicians impress on families that health physical activity and nutrition are as important as routine immunizations or screening tests in protecting children's health. Practitioners also need to educate patients about the risks associated with overweight and obesity and work with the willing patient and family on goal setting and action planning toward improved nutrition and increased physical activity.⁵⁶ Despite the critical importance of BMI screening, a 2007 RAND

⁵⁵ See Institute of Medicine, *Preventing Childhood Obesity: Health in the Balance*, September 2004.

⁵⁶ See *Prevention and Treatment of Overweight in Children and Adolescents*, *Am Fam Physician* 69:2591-8 (2004).

study found that nationally only 31 percent of children ages 3 to 6 and only 15 percent of adolescents were weighed and measured during regular check-ups.⁵⁷

A measurement-based collaborative initiative for youth led by VCHIP has move Vermont down the path toward best-practice obesity prevention. For several years, VCHIP – in partnership with the Department of Health, MVP Healthcare, Blue Cross and Blue Shield of Vermont, OVHA, and BISHCA – has been working with primary care practices on four different topics related to health promotion for youth ages 8-18. One of these topic areas is physical activity and nutrition. The whole practice, both medical and office staff, discusses best practices and office-based systems change to support optimal intervention for children and families. Under a contract with the Department of Health, VCHIP has developed a toolkit for child and adolescent primary care that is available via the Department of Health’s website effective October 2007.⁵⁸ V-CHIP is also developing a new module to address the increasing numbers of children in the 0-5 age group who are severely overweight.

Adults

Evidence-based guidelines recommend that clinicians screen all adult patients for obesity and offer intensive counseling and behavioral interventions to promote sustained weight loss for obese adults.⁵⁹ The VDH, in collaboration with the Vermont Area Health Education Centers (AHEC) Network and the University of Vermont College of Medicine, developed the *Promoting Healthier Weight in Adult Primary Care* toolkit. The toolkit supports the promotion of healthier weight with patients, including recommendations for the prevention, identification, assessment and management of overweight and obese adult patients in primary care.

The kit contains tools to facilitate conversation about weight and health. Using the *Weight and Health Profile & Prescription* (a 2-part NCR form with a copy for the patient and one for the health record), the practitioner and patient review weight, BMI, and associated health risks, as well as the patient’s readiness for change. The kit also includes a brief primer on motivational interviewing techniques to help clinicians understand and enhance patient motivation. In August 2007, the completed product was mailed to all primary care practitioners (physicians and mid-levels) in Vermont (approximately 700 copies). In addition to this mailing, AHEC plans to offer training in motivational interviewing, office systems, and resources via the Internet at www.vtahec.org.

⁵⁷ *The Quality of Ambulatory Care Delivered to Children in the United States*, N E Jour Med, Sept 2007, pp. 644-649, <http://www.rand.org/news/press/2007/10/10/index1.html>

⁵⁸ The children’s toolkit is consistent with the newly released *Expert Committee Recommendations on the Assessment, Prevention and Treatment of Child and Adolescent Overweight and Obesity* issued in June 2007 by the Childhood Obesity Action Network, a national organization supported by the Centers for Disease Control (CDC) and the Robert Wood Johnson Foundation with more than 600 health care professionals, quality improvement leaders, childhood obesity experts, and child health advocates. <http://www.nichq.org/NR/rdonlyres/7CF2C1F3-4DA3-4A00-AE15-4E35967F3571/5316/COANImplementationGuide62607FINAL.pdf>

⁵⁹ See *Diagnosis and Treatment of Obesity in Adults: An Applied Evidence-Based Review*, J Am Board Fam Practice 17:359-369 (2004) (recommendations addressing obesity in adults, including the National Heart, Lung, and Blood Institute, the World Health Organization, the Canadian Task Force on Preventive Health Care, and the US Preventive Services Task Force).

2. Evaluate and improve reimbursement for clinical prevention of obesity

As recommended in the 2006 *Fit and Healthy Vermonters Obesity Prevention Plan*, a second strategy for enhancing obesity prevention in primary care is to ensure that public and private insurance coverage and payment policies in Vermont support recommended clinical practice for the assessment, prevention, and treatment of child and adolescent overweight and obesity. Many primary care physicians already perform BMI screening and nutrition and physical activity counseling as part of preventive services or “check up” office visits. If a problem or concern about healthy weight is identified, primary care practitioners often recommend follow-up for these patients over the next period of time with more in-depth prevention assessment and counseling. If in addition to their obesity, the patient has already developed high blood pressure or diabetes, payment for these follow-up visits is covered by their insurance (including Medicaid). On the other hand, if the child or adult is overweight or obese but has not developed a complication, these visits are not covered by insurance. Many patients are not able to pay for these visits on their own, so they do not come back. This is a missed opportunity for early intervention, especially in the case of children and adolescents. Reimbursement for visits with the diagnosis of obesity or overweight by health insurers would rectify this problem.

Increasing awareness of the rising economic and social costs of obesity provides incentives to insurers and employers to promote obesity prevention measures in clinical settings. The Blueprint for Health has made clinical prevention services a high priority. The Blueprint provides a forum for OVHA, the state employees’ health benefit program, and Catamount Health plans, in concert with primary care providers, to discuss needed changes in payment strategies for obesity prevention services.

3. Promote development of moderate-cost lifestyle interventions to reduce individuals’ risk from overweight and obesity

Clinician counseling is an integral part of the environmental change and population-based health promotion efforts described in this paper. The “physician message” has been shown to be an important factor in many adults’ decisions to quit smoking and change substance abuse behavior. Yet, primary care clinicians generally have limited time and in most cases their office systems and staff are not effectively designed to provide the long-term behavioral support needed to motivate patients to take steps toward diet and exercise change.

Current evidence shows that high-intensity counseling—about diet, exercise, or both—together with behavioral interventions aimed at skill development, motivation, and support strategies produces modest, sustained weight loss in adults who are obese.⁶⁰ A high-intensity intervention is defined as one that offers more than one person-to-person (individual or group) session per month for at least the first three months of the intervention. This type of intensive individual-based counseling may be difficult to provide in a primary care setting and raises cost-effectiveness and magnitude-of-impact considerations.⁶¹

⁶⁰ E.g., U.S. Preventive Services Task Force, *Integrating Evidence-Based Clinical and Community Strategies to Improve Health*, March 2007.

⁶¹ National Commission on Prevention Priorities, *Priorities Among Effective Clinical Preventive Services*, *Am J Prev Med*;31(1):52–61 (2006).

Similar to programs that help adults quit smoking, moderate-cost interventions need to be available for clinicians to refer individuals to for support in reaching nutrition, physical activity, and weight goals. Some options include:

- The Medicaid chronic care management program and chronic care initiatives in Blueprint communities might provide support for overweight or obese individuals to attend Weight Watchers or other programs shown to be effective in helping adults control overweight and obesity opportunities for piloting programs. In January 2007, West Virginia began a pilot offering obese Medicaid recipients 16 weeks of free Weight Watchers courses. Tennessee has a similar program.⁶²
- Insurers could be encouraged through the regulatory process to support multi-component worksite programs that incorporate effective nutrition and physical activity interventions.
- Insurers could also be encouraged to offer chronic care management programs for persons who are already seriously overweight, or enable members to attend community or Blueprint self-management programs at reduced or no cost.

4. Increase the Proportion of Mothers Who Breastfeed Their Infants and Toddlers

Breastfeeding with its many benefits for mothers and babies has been found to play a foundational role in preventing childhood overweight and related chronic diseases. There is a large and growing body of literature on the importance of breastfeeding on reducing childhood obesity.⁶³ Breastfeeding promotion is a mandated program area for states participating in the CDC grant program for the prevention of obesity and related chronic diseases. Strategies to promote breastfeeding outlined by the CDC include:

- Clear hospital policies more supportive of breastfeeding result in increased breastfeeding at hospital discharge.
- Community-based peer counseling programs increase breastfeeding rates among low-income women.
- Well-designed workplace programs increase breastfeeding rates and reduce health care costs for businesses.⁶⁴

Recommendations

- Engage public and private insurers regarding the inclusion of lactation support in standard reimbursable prenatal care services.
- Review and support ongoing efforts in the state to ensure that health care settings, childcare facilities, and worksite environments are supportive of breastfeeding.

F. Business and Industry

Vermont should use the mechanisms of state government to support industry awareness of the “business case” for promoting healthy choices and to encourage “brand accountability” where

⁶² Trust for America’s Health, *F as in Fat: How Obesity Policies are Failing in America*, August 2007, p. 37.

⁶³ Centers for Disease Control and Prevention, *Breastfeeding and Obesity Prevention*, <http://www.cdc.gov/breastfeeding/promotion/index.htm>

⁶⁴ *The CDC Guide to Breastfeeding Interventions*, Centers for Disease Control and Prevention, 2004. See *Breastfeeding: The First Defense Against Obesity*, California WIC Association, March 2006.

industry takes on responsibility to be part of the solution to the epidemic of obesity. As stated this year by the Robert Wood Johnson Foundation's Risa Lavizzo-Mourey, M.D., M.B.A.:

If in fact industry leaders make their brands publicly accountable, with specific actions and timetables, the return on their investment to society will be huge. As in any business plan, it is the implementation of a vision that is the ultimate measure of success. The steps taken today will help ensure a healthy workforce and lower health care costs for businesses, taxpayers, and individuals far into the future.⁶⁵

Industry has an indispensable role to play in reversing childhood obesity trends. The food, beverage, restaurant, leisure, entertainment, and recreation industries can all be instrumental in creating environmental and policy changes that influence social norms, and the state should use the powers at its disposal to encourage industry leaders to make obesity prevention in children and youth a high priority. Consumer demand is an important driver of industry decisions, and American children and youth represent dynamic and lucrative markets for foods having little nutritional value. However, significant profit incentives now exist for industry to develop and promote products and information that will encourage healthy eating and regular physical activity.⁶⁶ Brand accountability for healthy products is understood to be an effective marketing tool to create brand loyalty among parents concerned about their children's health.

1. Sale of Beverages and Snacks on School Grounds

The voluntary efforts of national corporations to develop foods and beverages that have fewer calories or are fortified with nutrients for sale on school grounds provide a leading example of industry's ability to respond fruitfully to the obesity challenge. In 2006, the Alliance for a Healthier Generation worked with Cadbury Schweppes, Coca-Cola, PepsiCo, and the American Beverage Association to establish model School Beverage Guidelines to limit portion sizes and reduce the number of calories available to children during the school day. The Alliance also brokered voluntary guidelines giving children healthier options for snacks and side items sold in schools, which gained the endorsement of the Snack Food Association and commitments from the Campbell Soup Company, Dannon, Kraft Foods, Mars, PepsiCo, Bachman Company, and several other national snack food companies.

2. Television Food Advertising to Children

Another example of industry response to public concern occurred in July 2007 when 11 of the nation's largest food and beverage companies announced they had established new standards for the marketing of high fat, high sugar foods to children under the age of 12. The announcement came just ahead of a forum, "Weighing In: A Check-Up on Marketing, Self-Regulation, and Childhood Obesity," held by the Federal Trade Commission and Department of Health and Human Services. A study published in the September 2007 issue of *Pediatrics* found that, in the 170 top-rated TV programs for children, 98 percent of all food advertisements viewed by

⁶⁵ See *President's Message*, Robert Wood Johnson Foundation 2006 Annual Report (March 2007).

⁶⁶ See *Obesity: Re-Shaping the Food Industry*, JP Morgan Chase, Global Equity Research, January 2006 ("Any form of marketing of foods to children, especially energy-dense and nutrient-poor products, should be considered very carefully because this may ultimately damage the brand.")

http://www.unepfi.org/fileadmin/documents/materiality2/obesity_jpmorgan_2006.pdf

children ages 2 to 11, and 90 percent for adolescents ages 12 to 17, were for products high in sugar, fat or sodium.⁶⁷ It has been estimated that more than \$30 billion is spent annually on advertising for high-fat/sugar/salt foods, with over \$12 billion directed at children, and that the average child in U.S. watches three hours of TV per day and views some 10,000 food ads per year. Growing concern with “the stark realities of television food advertising to children” is increasing public pressure on food companies to change their advertising practices. The Attorney General’s Office could help the state develop a range of potential options, including working with national partners, to help shift marketing to children on television and in other contexts (e.g., movies, video games, and websites) to focus on more nutritious, lower-calorie foods.

3. Nutrition Labeling at Fast-Food and Other Chain Restaurants

The push to encourage fast food and full service restaurants to expand healthier meal, food, and beverage options (including children's meals) and provide calorie content and general nutrition information at the point of purchase is another approach gaining momentum. Typically these measures would require fast-food and large chain restaurants to list calories, saturated and trans fat, and sodium content on printed menus, and list only calories for menu boards since space is limited. The idea is to extend the successful nutrition labeling requirement on packaged foods to include offerings at fast-food and other large chain restaurants. The National League of Cities is a major proponent of such posting efforts, and several cities have passed such measures. California is the first state legislature to pass a bill to require restaurant chains with 15 or more locations to print nutritional information on their menus and menu boards, but the legislation was vetoed in October 2007 by Governor Schwarzenegger. In June 2007, the American Medical Association passed a policy resolution supporting federal, state, and local efforts to require fast-food and other chain restaurants with 10 or more locations nationally to provide easy-to-see nutrition information for all standard menu items for customers to see and use as a part of their purchasing and eating decisions.

Efforts are ongoing at the national and state levels to encourage or spur on industry to follow other actions recommended by the Institute of Medicine and other public health authorities, such as:

- Food and beverage industries should develop product and packaging innovations that address total calorie content, energy density, nutrient density, and standard serving sizes to help consumers make healthful choices.
- Leisure, entertainment, and recreation industries should develop products and opportunities that promote regular physical activity and reduce sedentary behaviors.

⁶⁷*New Study Confirms Vast Majority of Ads Seen by Kids Promote Foods High in Sugar, Fat or Sodium*, Robert Wood Johnson Foundation, Sept. 2007.

<http://www.rwjf.org/newsroom/newsreleasesdetail.jsp?productid=21922>

G. Public Policy

1. Develop Highly Effective Community-Wide Media Campaigns

Current efforts in Vermont relative to obesity prevention are small and fragmented due to the lack of resources and capacity. The *Blueprint Strategic Plan* (Objective 12) calls for population-based policy and environmental approaches for improving health and preventing chronic disease. Included in this objective are media campaigns promoting healthy behavior choices and what it means to be an effective self-manager. A well-designed and well-funded public media campaign would focus not just on influencing the behavior choices of individuals, but more importantly on influencing environments and changing social and cultural norms. The campaign would provide a connecting thread for environmental change efforts across all sectors of community, school, work site, and health care. This type of campaign would be expensive and would require the commitment of new resources. A more practical option may pilot public education materials and communication tools for community pilots, with well-researched and well-coordinated messaging for use by each participating sector of the community, such as schools, work sites, health care settings, and supermarkets.

2. Support for National Efforts to Prevent Obesity

Because states can only do so much on their own, Vermont and other states need to add their voice and support national efforts to prevent obesity. Some examples include:

- Organizations such as the Trust for America's Health are calling on the federal government to develop and implement a more coordinated, strategic National Strategy to Combat Obesity. The overview of key federal agencies' involvement in obesity policy provided in its 2007 report illustrates the importance of leadership at the federal level.⁶⁸
- As previously noted, the Federal Trade Commission has focused on marketing of "junk food" to children resulting in a number of companies pursuing self-regulation efforts over the past year.⁶⁹ Those national efforts can be supported by the state, or similar efforts might be carried out at the state level.

3. Impose a Soda Tax or Snack Tax

Food taxes are but one means of intervening economically to change the nutrition landscape. Currently, 17 states and the District of Columbia have laws that tax foods of low nutritional value.⁷⁰ These taxes are very controversial. There is strong evidence from the tobacco control movement that when taxes are high enough they provide a significant deterrent to tobacco use. However, it is problematic to use taxes to encourage individuals and families to substitute healthy foods for junk foods.⁷¹ In Vermont, consideration might be given to a small tax on soda or snack foods that would provide a dedicated funding source to support community programs and fund a public media campaign.

⁶⁸ Trust for America's Health, *How Obesity Policies are Failing in America*, at pp.42-43.

⁶⁹ *Ibid.*; *Perspectives on Marketing, Self-Regulation, & Childhood Obesity*, Federal Trade Commission, Department of Health & Human Services, April 2006.

⁷⁰ Trust for America's Health, at p. 35.

⁷¹ Rudd Center for Food Policy and Obesity, <http://www.yaleruddcenter.org/default.aspx?id=101>

4. Review the Coordinating Structure for Obesity Prevention

The Vermont Department of Health faces an enormous challenge in working collectively across departments and drawing in players from across many sectors. At this early stage of planning and capacity-building, obesity prevention efforts in Vermont have exhibited a high level of coordination. A few major examples of the collaborative projects initiated during this short time frame are the development of the *Fit and Healthy Vermonters Obesity Prevention Plan*, the school wellness policy guidelines, the Safe Routes to School program, the Eat for Health nutrition campaign, the Healthier Weight provider practice toolkit, and the Farm to School grant program. These accomplishments have required successful coordination among multiple public agencies, not only public health, but also health care delivery, education, agriculture, transportation, and others. Many stakeholders across these diverse fields have participated in these efforts.

Obesity prevention currently has a small program staff utilizing existing advisory groups to review program priorities and coordinate efforts, including the Fit and Healthy Vermonters Advisory Committee, the Community Workgroup of the Blueprint, and the CHAMPPS advisory group. It is recommended that the current coordinating structure for obesity prevention efforts should be evaluated in consultation with the administration before changes are recommended. The administration has worked with the legislature in developing the current coordinating structure for the Blueprint for Health, which involves a relatively small number of high-level staff at the Agency of Administration and the Department of Health, with advisory functions constituted in the Blueprint Executive Committee and advisory workgroups. Similarly, the existing advisory council structure for Fit and Healthy Vermonters should be strengthened and should maintain close links with the Blueprint for Health.

At the current level of funding, elevating or strengthening the coordinating structure may yield limited benefits because existing staff capacity and resources can support only a relatively modest set of accomplishments. The current priority should be to obtain an enhanced level of grant funding from the CDC and funding support from the national obesity prevention initiative to be launched by Robert Wood Johnson Foundation, as well as to dedicate some level of state funding, since those resources would enable a more robust set of options for advisory review.

5. Improve Health Surveillance/Data Collection

Surveillance is critical to the success of any obesity prevention and management approach, as it helps decision makers understand the health of the population and measure progress toward reaching policy objectives. Surveillance of childhood, adolescent, and adult obesity rates in Vermont and contributing factors adds valuable information for planning and evaluation purposes. Current surveillance measures for obesity prevention are available to measure youth and adult prevalence of obesity. Although Vermont does not have measured data for youth ages 5 and older, and has only self-reported measures for youth in grades 8-12, there are statistical samples from national surveys indicating the trend in prevalence. The 2006 Obesity and Health status report provides an overview of the burden of obesity in Vermont.⁷²

⁷² Available at <http://healthvermont.gov/research/chronic/documents/ObesityHealth2006.pdf>

The available data demonstrates the need for action and serves as a surveillance measure. Utilizing existing data, the Department of Health continues to monitor the prevalence of overweight and obesity along with behavioral risk factors including physical activity and sedentary time, fruit and vegetable consumption and breastfeeding rates. In addition, process measures are in place to evaluate progress towards outcomes outlined in the state prevention plan.

Recommendations

- Continue coordination of surveillance and evaluation to measure progress towards goals
- Explore use of the Blueprint chronic care information system and the multi-payer data base to monitor weight status
- Explore the feasibility of using ICD-9 V codes to collect data about BMI, overweight, and obesity.

APPENDIX 1: List of Organizations/Individuals Consulted

Vermont Department of Health

Sharon Moffat, Commissioner

Barbara DiMaggio, Deputy Commissioner (Alcohol and Drug Abuse Programs)

Christine Finley, Deputy Commissioner (Health)

Karen Garbarino, Interim Director - Health Promotion and Disease Prevention

Susan Coburn, Nutrition and Physical Activity Chief

Ellen Thompson, Public Health Planning Chief

Kelly Dougherty

Suzanne Kelly

Vermont Department of Human Resources

Workforce Development and Wellness: Tracy Gallo (Director), Maura O'Brien

Employee Benefits: Kathy Callaghan (Director)

Vermont Department of Education

Student Support Team & Safe and Healthy Schools: Shevonne Travers (Asst. Director)

Physical Education: Lindsay Simpson

Child Nutrition Programs: Josephine Busha (State Director)

School Health Coordinating Council: includes representatives from the VT Department of Health and VT Department of Education and the Directors of the VT Principals Association, the VT Superintendents Association, and the VT School Board Association.

Governor's Council on Sports and Physical Fitness

Janet Franz

Vermont AHEC and V-CHIP

Paula Duncan, Laurie Horowitz

American Heart Association, Vermont Chapter

Nicole Lukas

Obesity Prevention Public Policy Group

Over 85 individuals met on July 10, 2007 at a state-wide public policy forum convened by the Vermont Department of Health and the American Heart Association. The forum focused on developing an advocacy agenda for moving obesity prevention forward in Vermont. An Advocacy Advisory Committee has scheduled ongoing meetings.

CIGNA

Gerhild Bjornson, Associate Medical Director, CIGNA

MVP Healthcare

Joyce Gallimore, John Hollar

Blue Cross and Blue Shield of Vermont

Kevin Goddard, Leigh Tofferi

Office of Vermont Health Access (OVHA)

Joshua Slen (Director), Kristin Sprague

Dartmouth Medical School

Sharon McDonnell, Community and Family Medicine

UVM College of Medicine

Brian Flynn, Office of Health Promotion Research

Vermont Medical Society

Madeleine Mongan, Steve LaRose

Vermont Association of Hospitals and Health Systems

Bea Grause, Jill Olsen

Fletcher Allen Health Care

Meg O'Donnell, Penrose Jackson and Lori Smith (Community Health Improvement)

Vermont Employers Health Alliance

Craig Fuller

Vermont Business Roundtable

Lisa Ventriss

Green Mountain Power

Beth Peters

MacLean, Meehan & Rice, LLC

Andrew McLean, Susan Gretkowski

Downs Rachlin Martin PLLC

Lucie Garand

Carol Vassar, MD