NACo 2011 Healthy Counties Forum

Creating Healthy Counties:
Investing in County Health in Tough Economic Times

Wednesday, Nov. 30-Friday, December 2, 2011

Sun Trust Building
1445 New York Ave. NW, 9th Floor, Washington, D.C.

Agenda

Wed. Nov. 30

5:30-7:00 p.m. Welcome Reception at Hamilton Crowne Plaza
1001 14th Street NW, Washington, D.C.

Thur. Dec. 1

7:30-8:30 a.m. Registration & Networking Breakfast

8:30-8:45 a.m. Welcome & Opening Remarks
Speakers:
- Maeghan Gilmore, NACo Program Director for Health, Human Services & Justice
- NACo President Lenny Eliason (Commissioner, Athens County, OH)
- NACo Healthy Counties Initiative Chair Larry Johnson (Commissioner, DeKalb County, GA)

8:45-9:45 a.m. Session I—National Investments in Prevention to Support County Public Health
This session will explore some of the recent federal-level investments in prevention and wellness that affect county public health infrastructure and activities
Speakers:
- Anand Parekh, M.D., M.P.H., Deputy Assistant Secretary for Health (Science and Medicine), U.S. Department of Health and Human Services
- Jonathan Fielding, M.D., M.P.H., M.B.A, Director, Los Angeles County Department of Public Health & County Health Officer

9:45-10:45 a.m. Session II—Tools to Identify Health Assets & Assess Local Health Needs
Presenters in this session will demonstrate tools and resources that counties can utilize to help inform health policy decisions and more effectively target local public health resources
Speakers:
- Bruce Bronzan, President, Trilogy Integrated Resources
- Richard Leadbeater, Global Manager, Esri

10:45-11:00 a.m. Break
11:00 a.m.-12:30 p.m.  Session III—County Policies & Initiatives to Build Healthier Communities & Workplaces
This session will highlight county examples of policies and initiatives that encourage residents and county employees to adopt healthier lifestyles, which can also support local economic development and potentially help lower health care costs.
Speakers:
- Councilwoman Helen Holton, Baltimore City, MD; Food policy council example
- James Rhodes, Planning Director, Pitt County, NC; Health considerations in county planning
- Kim Stroud, Employee Health Benefits Manager, Manatee County, FL; Your Choice Health and Wellness Initiatives for county employees

12:30-1:30 p.m.  Lunch

1:30-2:30 p.m.  Session IV—Public-Private Partnerships to Enhance County Health Initiatives
This session will explore how counties can engage with the private sector to expand the capacity of county health initiatives and the benefits of community partnership to advance county health promotion efforts.
Speakers:
- Steve Lodge, Director, Outreach & Special Projects, American Beverage Association
- Kay Owen, Project Director, HEALTHY Armstrong, Armstrong County, PA

2:30-2:45 p.m.  Break

2:45-4:15 p.m.  Session V—Coordinating Chronic Care Delivery through Technology & Innovation
Presenters in this session will talk about ways that counties can better coordinate safety net care delivery and communication amongst providers, including county hospitals and behavioral health care providers, to provide more efficient and cost-effective care for individuals with chronic diseases.
Speakers:
- Joseph Damore, Vice President, Integrated Engagement & Delivery, Premier, Inc.
- Marianne Burdison, Director, Product Development, Cenpatico
- Nick Macchione, Director, Health & Human Services Agency, San Diego County, CA

4:15-4:30 p.m.  Brief Recap
NACo 2011 Healthy Counties Forum

Creating Healthy Counties:
Investing in County Health in Tough Economic Times
Wednesday, Nov. 30-Friday, December 2, 2011
Sun Trust Building
1445 New York Ave. NW, 9th Floor, Washington, DC

Agenda

Fri. Dec. 2

7:30-8:30 a.m. Networking Breakfast

8:30-8:45 a.m. Welcome & Opening Remarks

8:45-10:00 a.m. Session VI—Building a Stronger Health Care Safety Net: Discussion on Community Health Needs Assessments
County officials and local health departments can be actively engaged in community health needs assessments, which the Affordable Care Act requires nonprofit hospitals to conduct to demonstrate they are taking on uncompensated care in their communities. Participants will have the opportunity to discuss how to ensure that the local health care safety net burden is shared.
Speakers:
• NACo 2nd Vice President Linda Langston (Supervisor, Linn County, IA)
• Theresa Pattara, Office of U.S. Senator Charles Grassley (R-IA)
• Paul Stange, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services
• Preston Quesenberry, Office of Chief Counsel, Internal Revenue Service

10:00-10:15 a.m. Break

10:15 a.m.-11:45 a.m. Session VII—Healthy Counties Action Planning: Making the Case for Investing in Health
This small group discussion session will allow participants to engage in practical instruction and brainstorm about how to move from community health assessment to community health action planning. Participants will have the opportunity to explore ways to demonstrate the positive return on local public health and prevention investments and how to maintain disease prevention and health promotion efforts within the context of constrained local budgets.
Speaker:
• Sue Polis, Outreach Manager, Trust for America’s Health

11:45 a.m.-12:00 p.m. Wrap-up & Closing Remarks
Healthy Counties Initiative

The National Association of Counties’ (NACo) Healthy Counties Initiative aims to enhance public/private partnerships in local health delivery, improve individual and community health, and assist counties to effectively implement federal health reform. NACo’s Healthy Counties Initiative engages county officials and private sector partners across the country to:

- Take a leadership role in implementing health reform at the county level;
- Enhance coverage, access to and coordination of health care for vulnerable populations in the community, including health services in hospitals, community health centers and county jails, while focusing on cost-containment strategies;
- Promote community public health, prevention and wellness programs, including increased physical activity and healthy eating;
- Participate in the national transition to health information technology and telemedicine; and
- Offer information, ideas and solutions for county government employee and retiree health benefits and programs.

NACo’s Healthy Counties Initiative directly complements NACo President Lenny Eliason’s (Athens County, OH) 2011–2012 presidential initiative. As NACo President, Commissioner Eliason is focusing on helping counties create and maintain healthy communities by providing counties with tools to promote healthy lifestyles and develop local policies and programs that support community health.

Photos in this brochure include images from Douglas, NE, Los Alamos, NM and Jackson, MO.
Current & Planned Activities

NACo’s Healthy Counties Initiative is guided by the Healthy Counties Advisory Board, which is comprised of county officials and staff who are health leaders at NACo and corporate partners. The public/private Healthy Counties Advisory Board assists NACo in identifying the priorities and activities of the Healthy Counties Initiative and provides input and expertise on program implementation. Current activities include:

- **Webpage** – A Healthy Counties Initiative webpage, www.naco.org/healthycountiesinitiative, has been developed on the NACo website, which includes a database of county health best practices and programs that will be enhanced and updated. The webpage will also feature the initiative’s publications, resources, webinar recordings and training opportunities.
- **Workshops** – NACo staff will work with the Healthy Counties Advisory Board to identify timely information and knowledgeable speakers to present at NACo conferences.
- **Webinar Series** – The Healthy Counties Initiative will conduct webinars highlighting health issues, concerns and opportunities for counties, such as health IT, food access, jail health services, public health prevention and wellness initiatives, employee health coverage and wellness initiatives, or others identified by the Healthy Counties Advisory Board.
- **Educational Forums** – NACo will conduct educational forums which will feature workshop sessions on topics of importance and priority to counties in creating and maintaining healthy communities.

For more about NACo’s Healthy Counties Initiative, visit www.naco.org/healthycountiesinitiative
2011 Healthy Counties Initiative
Corporate Sponsors

New Sponsors for 2012


**Speaker Bios**

**Bruce Bronzan**, President of Trilogy Integrated Resources, has a long and exceptional career in the health and social service arena. He founded and directed a substance abuse treatment program and served as a county supervisor for eight years. He was a member of the California State Legislature, and chairman of the Health Committee, for 10 years. Mr. Bronzan served as associate dean of the Medical School at the University of California San Francisco and was a senior vice president of the Birch and Davis Health Management Corp. He then became founder and president of Trilogy and the co-founder of Network of Care.org.

**Marianne Burdison, LCSW**, Director of Product Development at Cenpatico, is responsible for leadership and day-to-day oversight for all aspects of Product Development. Under the direction of the Vice President of Business Development and Marketing, she works closely with senior and cross-departmental leadership to ensure that product development opportunities are identified, and that product development activities are supportive of strategic growth initiatives and designed for viable implementation. Marianne was a three year member of Cenpatico’s clinical team prior to being chosen to lead the Business Development Department that launched in April 2008, and then shifting to specializing in product development in August 2010. She has a wealth of experience in holistic healthcare, addictions treatment, HIV treatment and many facets of behavioral healthcare delivery to underserved populations.

**Joseph F. Damore, F.A.C.H.E.**, Vice President of Premier Performance Partners, is responsible for assisting not for profit hospitals, physicians, and health systems in developing integrated health systems and in implementing accountable care organizations. He provides consultative assistance to both Premier Accountable Care Readiness and Implementation Collaborative members, and advises numerous health care organizations in areas such as strategic business planning, clinical integration, and quality and financial improvement. Mr. Damore has provided counsel and assistance to health care executives, physician leaders, and Board members in developing integrated health systems in more than a twenty states.

Prior to joining Premier, Mr. Damore served as CEO of Mission Health System from 2004 to early 2010 and the Sparrow Health System from 1990 to 2004. Prior to his tenure as a CEO he served as an executive with Mercy Health Services (Trinity Health), Western Reserve Care System, and Greenville (S.C.) Hospital System. He also was President of JFD Consulting, LLC, a firm focused on helping hospitals and health systems prepare for health care reform and in the development of integrated health systems and accountable care organizations. His entire thirty-five year career as a health care leader has focused on building and developing not for profit regional integrated health systems, including integrating comprehensive delivery systems and health plans. Throughout his career, he has received numerous awards for his successful leadership of integrated systems. In addition he helped founded and served as Executive Director of a new national coalition of hospital and health system (not for profit) sponsored health plans (HHP).

Mr. Damore holds a Bachelor of Arts degree from Thiel College in Greenville, Pennsylvania and a Masters degree in Health Administration from The Ohio State University. He is a Fellow of the American College of Healthcare Executives and most recently served as Board Chair of The Ohio State University Alumni Association, on the Board of Directors of the University of North Carolina-Asheville and currently serves on the board of the Alliance for the Advancement of nonprofit Health Care. In addition he served in 2010-11 as the Visiting Executive at the Graduate program in Health Management and Policy at The Ohio State University and has both lectured at several major universities (including the
University of Michigan, George Washington University and University of Pennsylvania Wharton School of Business) and provides speeches at state and national meetings on health reform, integrated care, and accountable care on a regular basis.

**Hon. Lenny Eliason** was elected to be NACo’s 2011-2012 President on July 19, 2011 at NACo’s 76th Annual Conference and Exposition in Multnomah County (Portland), Oregon. A member of NACo’s Board of Directors since 2005, Lenny is a member of NACo’s Labor and Employment Steering Committee and served as vice chair from 2006 to 2009. He is a member of the Membership Committee, Rural Action Caucus and served on Health Reform Advisory Group. In addition, he has served on the Financial Services Corporation Board of Directors and Finance Committee. Lenny was first elected as Athens County Commissioner in 1998. He serves on the County Commissioners Association of Ohio Board of Directors. He is a past board member of the County Risk Sharing Authority and is president of the Board of the County Employee Benefits Consortium of Ohio.

Lenny is Vice President of the Buckeye Hills Resource and Conservation Council. He serves on the Buckeye Hills Hocking Valley Regional Development Executive Committee and is a member of the board of the Appalachian Development Corporation. He is a past board member of the Hocking Athens Perry Community Action and a past board member of the Southeast Ohio Emergency Medical Services Board. Lenny earned a Master’s of Public Administration Degree from Ohio University in June of 2002. He is trained as a public sector dispute resolution mediator and also serves as a mediator for the Athens Area Mediation Service.

**Jonathan E. Fielding, MD, MPH, MBA**, is the Director of Los Angeles County Department of Public Health and the County Health Officer, responsible for all public health functions including surveillance and control of both communicable and non-communicable diseases, and health protection (including against bioterrorism) for the County’s 10+ million residents. He directs a staff of about 4,000 with an annual budget exceeding $800 million. He is also Vice Chair and Commissioner of the Los Angeles First 5 Commission, which grants over $100 million per year to improve the health and development of children 0-5 and their families.

Dr. Fielding chairs the US Community Preventive Services Task Force and was a founding member of the US Clinical Preventive Services Task Force. He received a presidential appointment to the Advisory Committee to the National Prevention, Health Promotion and Public Health Council. He also chairs the HHS Secretary’s Advisory Committee on the 2020 Health Objectives for the Nation. Dr. Fielding is a Professor in the Schools of Medicine and Public Health at UCLA. He has authored over 175 original articles, commentaries and editorials on a wide range of public health and health policy issues. He is Editor of Annual Review of Public Health and Chairman of Partnership for Prevention. He also serves on the Board of the American Legacy Foundation and is an elected member of the National Academy of Sciences Institute of Medicine. He received his medical and public health degrees from Harvard University, and an M.B.A. in Finance from the Wharton School of Business. He formerly served as Massachusetts Commissioner of Public Health and as Vice President of Johnson & Johnson. He is the recipient of a number of awards and honors, including the Sedgwick Memorial Medal from the American Public Health Association and The UCLA Medal, the highest honor bestowed by that University.

**Hon. Helen L. Holton** has served as a member of the Baltimore City Council since 1995. She represented the 5th District of Baltimore until December 2004 when she was sworn in as the first representative of the new 8th District. She currently serves as a member of the Urban Affairs and Aging Committee and the Health Committee. She is active with the Maryland Association of Counties (MACo), and the National Association of Counties (NACo). The Councilwoman is very active with NACo, she is an appointee of the national President as Chair of the Large Urban County Caucus (LUCC), elected as the 1st Vice President of the Northeast County Caucus and as Treasurer of the National Association of Black County Officials (NABCO), and the Councilwoman also serves on the Community and Economic Development Steering Committee.
The Councilwoman grew up in the Baltimore region and is a graduate of the University of Baltimore, the Johns Hopkins University, and St. Mary’s Seminary and University’s Ecumenical Institute of Theology. She began her college training at Morgan State University. She holds a Bachelor of Science (B.S.) degree in Accounting, a graduate certificate in Leadership Development, a Masters degree in Business Administration (MBA), a Masters of Arts (M.A.) in Theology, and a M.A. in Urban Ministry. Ms. Holton is also a Certified Public Accountant and holds designation as a Professional in Human Resources (PHR).

Councilwoman Holton has been recognized by the Daily Record as one of Maryland’s Top 100 Women of Maryland and was inducted into their Circle of Excellence for sustained achievement as a leading woman in Maryland in 2003. She has also been recognized by the Baltimore Business Journal as one of Baltimore’s 40 under 40 Business Professionals, by America’s Registry of Outstanding Professionals, and as a Distinguished Alumna of the Johns Hopkins University Leadership Development Program, along with other notable awards and honors.

Hon. Larry Johnson, M.P.H., was elected as the DeKalb 3rd District Commissioner in November 2002. Commissioner Johnson has served as Chairman of the Economic Development/Planning Committee for the Board of Commissioners; is the past Chair of the Board of Education/Board of Commissioners Intergovernmental Committee; former chair of the Budget Review Committee; former chair of the Economic Development/Planning Committee; and currently serves as the Chair of the MARTA Partnership Committee and is also the current Chair of the Economic Development Committee.

Commissioner Larry Johnson’s community involvement has included serving as a youth diversion counselor for the DeKalb Juvenile Court system and co-founding a Senior Citizens forum at Oakhurst Presbyterian Church. Commissioner Johnson is past President of The Board of Directors for the DeKalb Prevention Alliance and past Vice-Chair for the statewide Covering Kids Health Initiative. Commissioner Johnson worked as a Health Education Coordinator for the DeKalb County Board of Health where he collaborated with the South DeKalb Pedestrian Safety Coalition. He was also selected to serve as Chair of the county’s Early Learning/School Readiness Commission and to be nominated to serve on the Early Education Commission. Commissioner Johnson was also appointed to serve on the Joint Fulton/DeKalb MARTA Committee and the Joint Fulton/DeKalb County Grady Committee, committees which discuss methods by which the two governments could better coordinate their efforts to ensure the long-term vitality of Grady Hospital and MARTA.

Commissioner Johnson has received numerous national, state and local awards throughout his career, including an Outstanding Young Man of America award in 1998, the DeKalb NAACP Thurgood Marshall Social Justice Award in 2000, and the South DeKalb Neighborhood Coalition’s Pioneers Platinum Award and the United Negro College Fund Special Program’s Corporation Partnership Award in 2004. Also in 2004, Commissioner Johnson was recognized by the American City Business Journal as a 2004 Up & Comers Under 40 and Rising. Additionally, in 2005 he received the DeKalb NAACP Pat C. Jones Award and the Partnership for Community Action The Help Award and in 2006 he was awarded the Distinguished Leadership Award from the Glenwood Pedestrian Safety Initiative.

In 2006, Commissioner Johnson was re-elected to a second term and in January 2009 and 2010, Commissioner Larry Johnson was unanimously elected both times by the Board of Commissioners to the position of Presiding Officer. Professionally, Commissioner Larry Johnson served as the Manager for the Fulton County Health & Wellness, the Office of Healthy Behaviors. Currently he is the Vice-President, Community Relations for the Association of Black Cardiologists where he is in charge of development and implementation of community programs that focus on reducing cardiovascular disease in the African American community through education, research and advocacy.

Commissioner Johnson was appointed in 2005 to chair NACo’s Health Disparities Subcommittee of the Health Steering Committee, and served as chair of the Health Disparities Subcommittee from 2005-2008. In 2008, he was appointed as Vice Chair of the NACo Health Steering Committee. He is also the 2011-2012 chair of NACo’s Healthy Counties
Initiative Advisory Board. Commissioner Johnson graduated from the University of Illinois at Urbana-Champaign with a Bachelor in Community Health and later earned a Masters Degree in Public Health from the University of Northern Colorado.

Hon. Linda Langston was elected to be NACo’s 2011-2012 Second Vice President on July 19, 2011, at NACo’s 76th Annual Conference and Exposition in Portland, Oregon. Linda has been active in NACo since 2003. She is a member and past chair of NACo’s Health Steering Committee and was the inaugural chair of the Healthy Counties Initiative. She was a member of the Health Reform Working Group, which was responsible for ensuring that the interests of county government were reflected in national health reform. Linda is a member and past chair of NACo’s Arts and Culture Commission and is a member of the Women of NACo (WON) Leadership Network. She was an inaugural participant in the County Leadership Institute in 2004, and she also served on the Restore the Partnership Project.

Linda was first elected to the Linn County (Iowa) Board of Supervisors in 2002 and was reelected in 2006 and 2008. She is chair of the Corridor Metropolitan Planning Organization and is the incoming chair of the East Central Iowa Council of Governments. She is on the board of the Arc of East Central Iowa and the Housing Fund of Linn County and is an active member of the Cedar Rapids Downtown Rotary and the Cedar Rapids Area Chamber of Commerce.

Prior to being elected to the Board of Supervisors, Linda was a museum director and a psychotherapist in private practice, as well as a small business owner. Linda graduated from Knox College in Galesburg, Illinois with a degree in history and is a 2007 graduate of Harvard’s Kennedy School of Government for State and Local Officials.

Richard Leadbeater, Global Manager; Government Trade Association Industry at Esri, is responsible for coordinating all outreach, marketing and business development; identifying solution needs and serving as liaison to Esri’s clients in this sector. His focus is development of administrative tools and solutions addressing Census and Statistical Agencies with attention on GIS support of policy, elections, and administrative processes.

Steve Lodge is the Director of Outreach and Special Projects for the American Beverage Association. Steve is a graduate of Georgetown University and lives in Bethesda, Maryland. He is married to his former carpool partner from Georgetown and they have two lovely daughters. After eight years working on Capitol Hill, Steve entered the world of trade associations and has worked on government affairs for the National Association of Home Builders, the National Food Processors Association and the National Confectioners Association before joining ABA.

Nick Macchione, F.A.C.H.E., has over 25 years of experience in the planning, management, and delivery of health care and human services. In his current role as Director of San Diego’s County’s Health and Human Services Agency, Mr. Macchione oversees one of the nation’s largest government-run health and social services networks at the regional level, serving 3.2 million residents with direct services to an estimated 500,000 clients annually. With budget responsibility of over $2.0 billion annually, Mr. Macchione manages a diverse professional workforce of 5,200 employees and hundreds of volunteers. In addition, he manages a diverse portfolio of 500 for-profit and non-profit contracted agencies. He implements policy directives of an elected Board of Supervisors and manages the day-to-day operations of the Agency which provides a wide range of health and human services. These include: public health for the entire county, behavioral health for 70,000 clients, inpatient medical care for over 225 patients, an extensive Medicaid managed care network for 353,000 beneficiaries, employment assistance and other key public assistance programs for 85,000 individuals in CalWORKs and 225,000 in CalFresh, child welfare services for 6,000 children, adult protective services for hundreds of seniors and numerous early childhood development programs.

In addition, Mr. Macchione oversees the operation of the county’s 50-bed Psychiatric Hospital, 192-bed Edgemoor Hospital, 204 bed licensed group home and 184 bed licensed year round residential high school campus for foster youth. Prior to becoming the Agency’s Director in June 2008, Mr. Macchione served 10 years as the Agency’s Deputy Director
and one year as an executive with the former county department of public health. Mr. Macchione has also held numerous health care positions in the State of New Jersey. He served as Executive Director of a regional health planning agency addressing HIV/AIDS and other infectious diseases in a large and diverse five County metropolitan region; program coordinator for the City of Newark Department of Health and Human Services; and medical lab assistant for the Hackensack Medical Center.

Throughout his career, Mr. Macchione has received numerous national, state and local awards for implementing innovative, cost-effective reforms in delivery systems for health and human services. He is actively involved with numerous community initiatives and serves as Commissioner of the First 5 Commission of San Diego and board member for the San Diego Futures Foundation, Children’s Initiative and Vision San Diego. In addition, he participates on numerous national and statewide boards, commissions, and think tanks focused on improving health, safety and economic stability.

Mr. Macchione holds dual masters’ degrees from Columbia University and New York University in New York City where he specialized in health services management and health policy. He is a Fellow of the American College of Healthcare Executives, having previously served a three-year term as the elected Regent for San Diego and Imperial Counties. He is a Public Health Leadership Scholar Alumni with the federal Centers for Disease Control and Prevention and a Creating Healthier Communities Fellow Alumni with the American Hospital Association’s Health Forum. In addition, for the past 14 years he has been an active faculty member at San Diego State University (SDSU) in the Graduate School of Public Health. In 2007 he was inducted by the SDSU Graduate School of Public Health as an Honorary Member of Delta Omega of the Sigma chapter as well as appointed as the John J. Hanlon Executive Scholar.

Kay Owen is the Project Director for HEALTHY Armstrong, a youth obesity project in Armstrong County in southwestern Pennsylvania. In that position she directs the county-wide initiative to improve the health of the citizens. She is the Administrator for two federal U.S Department of Education Carol M. White Physical Education grants totaling $1.75 million. Prior to this position, Kay was the Executive Director of a county-wide private non-profit drug and alcohol treatment, intervention, and prevention program for 32 years. She has been a trainer for the Pennsylvania Department of Health and numerous other organizations in the state. Kay serves on the Board of Directors for the county hospital and the local public library. She is a graduate of Indiana University of Pennsylvania with both a bachelor’s and master’s degree.

Anand Parekh, M.D., M.P.H., is the Deputy Assistant Secretary for Health (Science and Medicine) at the U.S. Department of Health and Human Services (HHS). In this capacity, he provides oversight, direction and coordination of activities pertaining to (1) a range of emerging public health and science issues; (2) the continuum of medical research – including clinical science and health services research; and (3) issues requiring expert medical analysis and advice, particularly those concerning policy, planning, formulation, and presentation of public health issues affecting the Department. Dr. Parekh has worked on a variety of health issues, including quality of care improvement, chronic care management, disease prevention and health promotion, substance abuse prevention and control, HIV/AIDS, and seasonal influenza vaccine promotion. He also chairs the Department's Medical Claims Review Panel.

Prior to this role, Dr. Parekh served in the HHS Office of the Assistant Secretary for Preparedness and Response, supporting various initiatives related to bioterrorism and pandemic influenza preparedness. Specifically, Dr. Parekh provided leadership for the development of several modalities of medical countermeasures to be distributed in the event of an anthrax attack. He also contributed to various strategic planning efforts and the development and assessment of policy options related to the threat of an H5N1 influenza pandemic.

Dr. Parekh completed his undergraduate studies in political science, as well as his graduate school training in medicine
and public health, at the University of Michigan. He subsequently completed his residency training in the Osler Medical Training Program of the Department of Medicine at Johns Hopkins Hospital. In addition to engaging in health services research at Johns Hopkins, Dr. Parekh has completed separate stints as a research fellow at the Centers for Medicare and Medicaid Services and at the Institute of Medicine.

Dr. Parekh holds a Medical Staff position at Holy Cross Hospital in Silver Spring, Md., and practices at the Holy Cross Hospital Health Center, a low-income clinic for the uninsured. He is an Adjunct Assistant Professor in the Department of Medicine at Johns Hopkins Hospital. He also serves on the Board of Governors of the University of Michigan School of Public Health Alumni Society and is a member of the Presidential Scholars Alumni Society and the American College of Physicians.

Theresa Pattara serves as Tax Counsel to U.S. Senator Chuck Grassley, Ranking Member of the Senate Judiciary, and former Chairman and Ranking Member Senate Finance Committee. She is responsible for advising the Senator on tax and banking matters as well as Social Security issues. She has been with him since she joined his Finance Committee Staff in April 2008. Prior to joining Senate Finance, Theresa was a Project Manager and policy advisor with the Internal Revenue Service.

Theresa is a magna cum laude graduate of the University of Scranton where she earned her Bachelor’s of Science degree in Accounting and earned her Juris Doctorate degree from Georgetown University Law Center. Prior to joining the IRS, she was a licensed Certified Public Accountant in the Commonwealth of Pennsylvania and the District of Columbia and was a Senior Tax Associate with PricewaterhouseCoopers LLC in Philadelphia and Washington, DC.

Sue Pechilio Polis is responsible for the development and management of TFAH’s external affairs and advocacy outreach program in support of the organization’s public policy efforts. Prior to joining TFAH, Ms. Polis worked at AARP on health and financial security-related advocacy, outreach, campaign planning and implementation efforts most recently with the Initiative on the Future of Nursing: Campaign for Action in coordination with the Robert Wood Johnson Foundation. She was responsible for the development of overall campaign plans including issue strategy, policymaker engagement strategies, stakeholder management and state/regional organizing structure and execution.

Prior to joining AARP, Ms. Polis was the first National Director of Grassroots Advocacy for the American Heart Association. She was responsible for the development and implementation of a five-year strategic plan that led to significant growth of the organization’s advocate base in support of public policy objectives at the federal and state levels. Ms. Polis was Director of Marketing for Winning Connections, an electoral and grassroots consulting firm in Washington, DC. She worked with a wide range of clients on environmental, tobacco, and health-related issues. Prior to that, she was the Director of Political Programs with the Association for Advanced Life Underwriting. She was responsible for political fundraising programs and key contact recruitment and outreach. Ms. Polis began her career in New Jersey as a paralegal with the firm of Crummy, DelDeo, Dolan, Griffinger and Vecchione and is a graduate of Seton Hall University with a major in political science.

Preston Quesenberry is a Senior Technician Reviewer in the Exempt Organizations Branch. Mr. Quesenberry has expertise in a wide variety of exempt organizations matters, including the unrelated business income tax, private foundation excise taxes, and qualification for tax-exemption under a wide-variety of Code sections. He has been extensively involved in several guidance projects relating to the Patient Protection and Affordable Care Act, including Notice 2011-52 on community health needs assessments and Notice 2011-20 on accountable care organizations.

Mr. Quesenberry arrived at Chief Counsel in 2009. Prior to his government service, Mr. Quesenberry worked as an exempt organizations attorney at Caplin & Drysdale in Washington, D.C., as a tax attorney at Skadden, Arps, Slate,

**James F. Rhodes, AICP,** has served as the Planning Director for Pitt County, North Carolina since 1996 and has worked with the County’s Planning Department for over 23 years. His planning experience has ranged from the development of land use plans, hazard mitigation plans, transportation plans, recreation plans and, most recently, a 10-year plan to End Chronic Homelessness in Pitt County. He earned his Bachelor and Master of Arts degrees in Geography from East Carolina University with an undergraduate minor in Urban and Regional Planning. James serves on the East Carolina University Planning Advisory Board and is a past president of the ECU Planning Alumni Society. He has been a member of the American Institute of Certified Planners since 1993 and is a 2002 graduate of the County Administration Program through the University of North Carolina School of Government. Prior to his employment with Pitt County, James served as Technical Assistance Director for Region L Council of Governments and as a Demographic Researcher with the East Carolina University School of Medicine. A native of Eastern North Carolina, James is married and has three children. He is a volunteer coach for youth basketball, soccer and volleyball.

**Paul Stange** began his Centers for Disease Control and Prevention (CDC) career in 1972 working in the Los Angeles Department of Health Services. He is currently a senior policy advisor in the Office of Prevention through Healthcare in the CDC Office of the Associate Director for Policy. For the last 20 years of his CDC career he has focused on connecting CDC programs with other government and private organizations, with a special emphasis on health insurance. He is currently leading two projects with significant implications for state and local public health practice: 1) Through a cooperative agreement with the National Business Coalition on Health, CDC is working to strengthen the measurement of health insurance plan/provider delivery of preventive services and the links to community organizations to improve such service delivery. 2) CDC is leading the HHSC initiative to identify best practices in community health assessment and improvement plan development in support of new ACA requirements (and Treasury/IRS regulations) imposed on the 3000 tax-exempt hospitals to conduct a “community health needs assessment” and develop a related “implementation strategy” for addressing identified needs. He is a graduate of the University of California, Berkeley and the Emory University School of Public Health.

**Kim Stroud, M.A., LMHC,** is the Employee Health Benefits Manager for Manatee County Government. She joined the Health Plan in 2007 in the role of Director of Health and Lifestyle Management and developed and managed the combined EAP and Behavioral Health Program (LAMP), and oversaw the Disease Management and Wellness Programs for the Health Plan. In 2010, Kim assumed the role of the Benefit Manager for Manatee County Government. Manatee County operates a self-funded health plan designed to place accountability on employees through eligibility requirements related to preventative medical care.

Kim has her Masters degree in Human Development Counseling and she is a licensed Mental Health Counselor by The State of Florida. Kim has worked in Community Mental Health Programs and has managed Employee Assistance Programs (EAP) for various employers. Since 2007 she has been successful in incorporating her behavioral health training into areas related to health and productivity management and creative plan design for the self-funded insurance program. She and her team have integrated concepts of Stages of Change and the importance of emotional wellbeing into all of the Disease Management and Wellness Programs offered by the Health Plan in efforts to continue to build a Culture of Health in Manatee County. The integrated Health Plan and Wellness model that has proven return on investment at Manatee County has received national recognition by various groups including Pharmacy Benefit Management Institute, Institute for Health and Lifestyle Management and many others. Kim has a strong belief in integrated, individualized and prevention-based health and wellness care and the significant impact it has on an employee’s health and productivity and a subsequent positive impact it has on an employer’s overall costs.
NACo Resources to Support County Health Promotion Initiatives

NACo offers counties a number of ideas and strategies to help develop and enhance local efforts that can reduce the incidence of chronic diseases, improve overall community health and ultimately lessen the cost burden on county health care services. These and other resources are available on NACo’s Healthy Counties Initiative webpage:

www.naco.org/healthycountiesinitiative

NACo’s Healthy Counties Initiative aims to enhance public/private partnerships in local health delivery, improve individual and community health, and assist counties to effectively implement federal health reform. The initiative's activities build on NACo’s existing health promotion resources and include webinars, workshops and educational forums featuring topics related to helping counties build and maintain healthy communities.

NACo Healthy Counties Database

NACo’s Healthy Counties Database features model initiatives that counties nationwide have implemented to promote wellness. The database offers examples of county policies and programs that promote active living and healthy eating, and will be updated and expanded to include other types of county health promotion efforts.

NACo Issue Briefs

- **Food Access Solutions to Create Healthy Counties**
  This issue brief outlines strategies that county leaders can implement to increase residents’ access to healthy and affordable foods.

- **County Health and County Park and Recreation Department Partnerships to Create Active, Healthy Counties**
  This issue brief describes ways that county health departments and county park and recreation departments can collaborate and partner to develop and enhance health and wellness initiatives.

- **Planning and Land Use Solutions to Create Active, Healthy Counties**
  This issue brief outlines planning and land use strategies counties can implement to increase opportunities for residents to be physically active.

- **Transportation Solutions to Create Active, Healthy Counties**
  This issue brief features ways that counties can design transportation systems to encourage physical activity.

For more information about these resources or NACo’s Healthy Counties Initiative, please contact Anita Cardwell at 202-942-4267 or acardwell@naco.org
Healthier Americans for a Healthier Economy

INTRODUCTION

Preventing disease is one of the most common sense ways to improve health in America. But it is also a major factor for improving the economy.

More than half of all Americans currently live with one or more chronic illness, including heart disease, stroke, diabetes and cancer. High rates of these diseases, which in many cases are preventable, are among the biggest drivers of U.S. health care costs and they are harming worker productivity.

Employers around the country are searching for ways to support the health and wellness of their employees and their families while also struggling with high costs of benefits. For example, as Tom Mason, president of the Alliance for a Healthier Minnesota has said, “we’ve heard from employers around the state that their health care costs are unsustainable and they want to do something about it.”

Many employers are finding that workplace and community wellness programs offer a win-win way to make a real difference. They can make sense for the health of employees and their families and for the employer’s bottom line.

This report features six examples of places around the country where employers are working with communities to provide common sense ways to make healthier choices easier for employees and their families.

These stories examine how different states, cities and towns have recognized that a community’s health affects its ability to attract and retain employers, and how many businesses and organizations understand the value of workplace and community wellness programs for improving productivity and reducing health spending.

HEALTH AND ECONOMY CASE STUDIES

1. In Minnesota, SHIP Comes In, Saving Lives — and Money
2. Texas Recognizes the Costs of Excess Weight, and Tries to Do Something about It
3. Nashville’s New Tune: Investing In Health
4. Taking Steps to Tackle Obesity and Smoking in Indiana
5. San Diego: Building an Environment that Encourages Health
6. Hernando, Mississippi, Bucks a Statewide Trend
I. IN MINNESOTA, SHIP COMES IN, SAVING LIVES — AND MONEY

For years, Minnesota has been among the healthiest states in the country. It has low rates of tobacco use, obesity and chronic disease, and high rates of physical activity. But in recent years, Minnesota has slipped. In annual rankings of state health from the United Health Foundation and the American Public Health Association, Minnesota dropped from first in 2006 to sixth in 2010. And even though it remained near the top, the state still has millions of citizens with preventable diseases. More than 60 percent of Minnesota residents are either obese or overweight; 17 percent — almost a million people — use tobacco products. Obesity and tobacco use significantly increase the risk of chronic ailments such as heart disease, diabetes, cancer and asthma.

These conditions not only cause suffering; they are also expensive. Studies have shown that three-quarters of the money Americans spend on health care is devoted to dealing with largely preventable chronic diseases. In Minnesota alone, smoking kills more than 5,000 people a year, and leads to almost $3 billion in excess medical costs annually. According to a study published this year, obesity costs the state $2.8 billion a year; of that, $515 million came from Medicare, while $468 million came from Medicaid. In addition, experts say, high rates of preventable chronic disease can also harm the bottom line, increasing health care costs for businesses, and decreasing the possibility that new businesses will expand or relocate to a given area.

“Companies in Minnesota are now really thinking about how they can lower their health care costs,” said Sanne Magnan, MD, PhD, who from 2007 to 2010 was Minnesota’s health commissioner. “They are very interested in how to do that efficiently.”

The Goal: Improving Health on a Wide Scale

Four years ago, Minnesota started an ambitious attempt to reduce its burden of chronic disease by helping millions of residents lead healthier lives. Officials say the program, the Statewide Health Improvement Program, or SHIP, could save the state billions of dollars in healthcare expenses, and could help private business cut costs too.

“This is aimed at keeping people from getting these chronic diseases,” said Minnesota state representative Thomas Huntley, who was one of the law’s architects. “If they don’t smoke, and they watch what they eat and stay active, people are less likely to get heart disease or diabetes in the first place.”

SHIP was passed with the backing of then-governor Tim Pawlenty, and got bipartisan support in the legislature. “Everyone recognized that you had to invest in helping the population get healthier,” said Magnan. “That had wide appeal.”

The idea behind SHIP is simple. In recent years, public health researchers have found that people are more likely to change unhealthy behavior — give up smoking, increase physical activity, or eat more healthily — when such choices are easy. But right now, most Minnesotans, and most Americans, live in an environment dominated by fast food restaurants, high-calorie, low-nutrition snack food, television and the automobile, an environment that strongly encourages obesity and its attendant ailments.
**Aiming for Long-Term Change**

SHIP aims to turn this equation on its head. Through a variety of methods, the program is trying to modify the environment in which Minnesota residents live, so that it becomes much simpler to live in a healthy way. For instance, instead of funding a short-term program focused on weight loss, SHIP will help communities build new sidewalks and bike lanes, which will permanently increase the likelihood that all residents will walk and ride bicycles.

“We’re giving people more healthy food choices, more opportunities for physical activity, more opportunities to live in a smoke-free environment,” said epidemiologist Rachel Cohen, who is overseeing SHIP for the Minnesota Department of Health.

State officials say that over time, SHIP will save the state money. Julie Sonier, who until last year was Minnesota’s state health economist, estimated that if it receives funding through 2015, SHIP will help more than a quarter million Minnesotans stop smoking, and more than 460,000 residents lose enough weight to no longer be classified as obese or overweight. According to the estimates, these reductions will allow Minnesota to save almost $2 billion in health care costs annually.

“There is a lot of potential with this,” said Sonier. “If you’re going to contain health care costs, it’s important to stop the rise of preventable chronic disease. The idea is to generate savings by reducing the number of people who have these conditions.”

In addition, SHIP is helping small businesses across the state set up wellness programs, which can also save money. Studies suggest that for every dollar a company spends on these programs, it can save between three and six dollars in health care costs. Researchers have also found that employer wellness programs can cut costs related to sick leave, workers’ compensation and disability compensation by as much as 25 percent.

Beyond SHIP, the state’s private sector is increasingly aware that improving employee health can be a good investment. Last year, the non-profit group Alliance for a Healthier Minnesota polled 400 Minnesota manufacturers. “Health care costs were the top concern,” said Tom Mason, the group’s president. “It wasn’t even close. Even in the midst of the recession, health care was seen as the top issue.”

He said that for the first time, many of the companies are considering wellness programs as a way to lower costs. “This is a big trend,” said Mason. “My sense is that businesses are now really looking for ways to address spiraling health care costs.”

**State Funding, Local Autonomy**

But SHIP is much more comprehensive. The legislature provided the program with $47 million over two years, through 2011. Per capita, the cost ends up being $3.89 per person. “A Happy Meal costs more than that,” said Cara McNulty, a health policy expert who until earlier this year oversaw SHIP for the state health department.

The money is divided between 87 counties and nine tribal governments, with each region getting a base amount, as well as additional funding based on population. SHIP gives each region leeway to choose measures that will help local residents. Counties and tribal areas pick from a menu of 33 programs created by the state department of health, with input from the U.S. Centers for Disease Control and Prevention (CDC) and other experts.

“The idea is that individual counties and communities can do their own thing, with oversight from the state,” said Huntley.

The options include Complete Streets initiatives to build more sidewalks and bike lanes; efforts to improve the nutrition of school meals; “Walking School Bus” programs that encourage kids to walk to school; farm-to-school initiatives that supply local food to students; and cessation programs that make it easy for citizens to stop using tobacco. Each county or region must choose at least one tobacco program and one obesity program.

Each of the 98 zones has created a health council made up of local health, school and government officials, as well as business leaders. With help from experts at the state department of health, the councils set up and manage local SHIP efforts.
**Corner Stores and Complete Streets**

Some communities have focused on policy change. In Minneapolis, SHIP staff helped implement a law requiring convenience stores to carry a minimum quantity of healthy foods, including at least five varieties of fresh fruit or vegetables. The goal: to increase the availability of nutritious food in areas that lack full-service grocery stores. In these neighborhoods, which are known as “food deserts,” residents often end up doing much of their food shopping at corner stores. Also with the help of SHIP staff, the town of Eyota passed a Complete Streets law.15, 16

Other regions have emphasized increasing consumption of healthy food. In the northeast part of the state, a group of Ojibwe Native American communities created or expanded 13 community gardens and started 482 backyard gardens. Using vegetables they’ve grown in the gardens, several of these communities created farm-to-school programs. In addition, the group has started four new farmers’ markets.17

Many counties and tribal areas have targeted childhood obesity and teen and young adult smoking. Last year, a survey of Minnesota students found that just one in five sixth-graders ate the recommended five daily servings of fruits and vegetables.18 Studies have shown that childhood and adolescence are crucial windows for introducing healthy behavior: it is much easier to prevent obesity than it is to help those who are already obese lose weight. Similarly, it is easier to prevent tobacco addiction than it is to persuade smokers to quit.

St. Paul passed a law prohibiting candy cigarettes and lighters that look like toys. Dakota County, a rural area south of Minneapolis, used SHIP funding to set up a “Safe Routes to School” program: all of Dakota County’s 10 schools have developed routes that will allow more students to safely walk or bike to school. One school has its buses drop kids a half-mile from the campus, and students walk the rest of the way.19

In its first year, SHIP helped nearly 350 Minnesota child care centers improve nutritional value of the food they offer, and teach children about what to eat, and what to avoid. These centers take care of almost 8,000 young children. With help from SHIP, more than 300 child care centers set up exercise programs for their kids.20

In addition, SHIP has helped many schools set up farm-to-school programs. More than 130 Minnesota schools now have such efforts, enabling nearly 70,000 students to eat healthier food.21

**Helping Business Help Employees**

SHIP also works with local businesses to develop worker wellness programs. It offers advice, and sometimes gives grants to employers who want to start a program. Across the state, businesses have taken a range of steps. Some have reduced the amount of junk food in vending machines or improved the nutritional value of cafeteria food; others have built onsite gyms, paid for gym memberships, or otherwise encouraged workers to get more exercise. Some companies have offered incentives to employees who take smoking cessation classes, or who quit smoking, while others have prohibited smoking on company property.22

Huntley said that many counties have focused on helping small businesses set up employee programs. “Nationally, big companies are already into wellness programs, because they see that it saves them money,” said Huntley, the state representative. “But most small businesses don’t have the infrastructure to set up those kinds of programs. They need help.”

In Olmsted County, in the southern part of the state, Mark’t, a small marketing company, used SHIP funds to help pay for a dietician to help employees eat healthier. SHIP helped Eastwood Bank, a locally-owned institution just down the street, set up an employee fitness program. Hy-Vee, a regional grocery chain, used a SHIP grant to start smoking cessation classes at its Olmsted County store. So far, six workers have quit smoking. With help from SHIP, more than 300 child care centers set up exercise programs for their kids.20

This summer, the state legislature voted to extend SHIP through 2013. But it provided less money — $15 million — than it did for the first two years.24, 25 Magnan and others argue that SHIP needs continued support; they say that while it is already showing results, real changes will only show up after five or even 10 years. And they argue that because the program focuses on systemic change rather than quick results, the eventual improvements will be sustainable.

“With a problem as big as this,” Magnan said, “we need to have patience. We’ll see health improvements, and savings, but it will take time.”
TARGET: AIMING HIGH TO IMPROVE EMPLOYEE HEALTH — AND CUT HEALTH CARE COSTS

With 355,000 employees, Target, which operates 1,755 stores in 49 states, has the population of a large city. The company provides health insurance to nearly a quarter of a million people. This cost is rising rapidly, as it is throughout the private sector.

In an attempt to control that expense — and to help its employees and their families improve their health — the Minneapolis-based company is rolling out an ambitious wellness program. The effort is modeled in part on SHIP, Minnesota’s statewide prevention program.

The company hired one of the architects of SHIP, Cara McNulty, to develop and oversee its initiative. Both programs share the same basic goals: increasing physical activity, improving eating habits and reducing tobacco use.

In a bid to change its culture, Target has designated 2,000 workers across the country as “Wellness Champions,” who encourage colleagues to get more exercise and eat right. The company gives information on healthy living to the Champions, who share it with other workers and encourage them to change their behavior. And the company has increased the number of healthy foods available in store vending machines.

Target is considering a range of other steps. Among them:

- Subsidizing healthy food in company cafeterias and encouraging workers to offer healthier snacks and drinks during meetings.
- Giving employees free or subsidized access to gyms, either on site or nearby.
- Providing individualized cessation programs to help some of the 35,000 or so Target workers who smoke.
- Offering discounts on insurance to employees and family members who take steps to improve their health.
- Sending sick workers for treatment in regions of the country that have a particular expertise in a given illness. The goal: to improve quality of care and reduce unnecessary treatment.

The company is also discussing ways to attack childhood obesity among workers’ children, as well as in the communities where it operates.

McNulty said that the program could yield multiple benefits: not only lowering health care costs and improving health, but also improving employee productivity.
Texas has a reputation as a pro-business state. It has a long history of embracing and encouraging entrepreneurs, from wildcat oil prospectors to cutting-edge energy companies, and it regularly tops state rankings for its educated workforce, low taxes and relative lack of regulation.

But in one key way, businesses in Texas are at a disadvantage. A report published earlier this year by the state comptroller found that obesity cost Texas businesses an extra $9.5 billion in 2009: more than $4 billion for health care, $5 billion for lost productivity and absenteeism and $321 million for disability. The analysis estimated that if current trends continue, the cost could more than triple by 2030.

“Those are shocking numbers,” said Susan Combs, the state comptroller.

Obesity is a serious problem for Texas. Nearly 30 percent of the state’s residents — more than eight million people — are obese, while another 37 percent are overweight. Over the past 20 years, these rates have increased dramatically; in 1990, just over 12 percent of residents were obese. Overall, Texas is the 12th most obese state in the country, according to a report released earlier this year by the Trust for America’s Health.

Of course, Texas is not the only state where obesity hinders economic development. But for almost a decade, Combs has focused on the economic costs of the obesity crisis. As a result, more information exists about Texas’ situation than for most states. First as agriculture commissioner and then as comptroller, she has worked to alert Texans to the health and economic risks of obesity.

In addition, Combs has focused on raising awareness in the private sector. “This is a huge issue for the financial security of our state,” she said. “We know we have to get business involved. I don’t know any other way to do it.”

Combs is not the only one worried about obesity’s effect on the state’s economy. “If obesity continues to rise, we will have a workforce that will not be as attractive as it could be to companies thinking of expanding or moving to Texas,” said Eduardo Sanchez, a former state health commissioner who is now the Chief Medical Officer for Blue Cross Blue Shield of Texas, as well as a member of the TFAH board of directors.

“Obese workers tend to have lower productivity because they have chronic disease, and they tend to lose time to disability. These are things that companies think about.”

The situation could get much worse. A 2009 report by the state demographer estimated that if current trends continue, 15 million Texas adults will be obese by 2040 — three times as many as now.

“Future levels of obesity will be intolerable unless we make some changes,” said demographer Karl Eschbach, who wrote the report. “If you look at this from a financial point of view, it’s scary.” Eschbach, who is now a professor at the University of Texas at Galveston, pointed especially to the growing cost of type 2 diabetes, a disease closely linked to obesity.
Based on the possible projections, “you’re looking at the state of Texas going from 10 percent of adults with diabetes to 25 percent with diabetes,” he said. “Diabetes is a very expensive disease.”

As more in both the public and private sector have recognized the financial and medical costs of obesity, the state has become a leader in the fight to improve health. The state government, as well as some cities, counties and businesses, has taken steps to help residents, students and workers increase their physical activity and eat more wisely. “Texas has been on the cutting edge in fighting obesity,” said Carrie Kroll, chairwoman of the Partnership for a Healthy Texas, a coalition of more than 20 health and medical organizations trying to reduce the state’s obesity rates.

Toward Healthier Communities: San Antonio

Many Texas cities and towns are working to help residents improve nutrition and increase activity. Last year, San Antonio embarked on an ambitious anti-obesity program, paid for by a $15.6 million federal grant.39

The program is funding the creation of three new farmers’ markets around the city, and has started an effort to encourage people to choose healthy food when eating out. Health department dieticians have analyzed the menus of more than 100 local restaurants and identified the healthiest items, which receive stickers that say “¡Por Vida!” Some local fast food restaurants have even joined the program: for instance, at McDonalds, oatmeal and yogurt received the health department’s approval.40

In addition, San Antonio has bought 150 bikes, which can be used for a few hours at a time by any city resident who registers online and pays a $10 yearly fee. So far, the bikes, which are stored at 14 kiosks around the city, are averaging 100 checkouts a day. And the city is crafting Complete Streets regulations, which would require any new projects to include consideration of walkers and bicyclists.41

The program has installed playgrounds and exercise equipment in 26 parks around the city, as well as outside several city libraries. To encourage activity, the parks department is offering free exercise classes in various parks: yoga, tai chi, as well as more intensive “boot camp” sessions. Since last year, more than 4,000 people have taken the classes.42

The initiative has also focused on childhood obesity, which is a major problem for San Antonio: nearly one in three of the city’s public school students have an unhealthy weight.43

Combs and others emphasize that childhood obesity is also an economic problem. “The cost of childhood obesity is not as well appreciated by policymakers, and by the private sector, as it ought to be,” said Sanchez.

A national study published last year found that for one large corporation, average health insurance costs for an obese child were more than $1,200 higher than for a healthy-weight child. For a child with type 2 diabetes, costs were more than $9,000 higher annually.44 And of course, obese children are more likely to become obese adults, who spend an average of more than $1,400 extra on health care annually compared to healthy-weight adults.45

To help its children lose weight and stay healthy, San Antonio is installing salad bars in 100 schools, and it has bought exercise equipment for 365 schools, which together serve 275,000 students. The material includes hundreds of balance balls, hula hoops and jump ropes, as well as thousands of orange plastic cones for relay races and obstacle courses.46

Some evidence indicates that in San Antonio (as in most places), those with lower incomes tend to have higher obesity rates.47 To help deal with this, the health department will give away 1,000 bikes to lower-income residents. The bikes are free, but recipients must first show their commitment by taking classes on bike safety and bike maintenance. The city has also built five walking trails in public housing projects around the city.48

To publicize all of this work, San Antonio will soon roll out an integrated media campaign, whose slogan is “Find Your Balance.” It will include TV, radio and print ads, a website and social media.49

San Antonio is not the only place in the state trying to lose weight. Over the past decade, El Paso has undertaken several anti-obesity efforts, much of it funded by the Paso Del Norte Foundation, a local non-profit group.50, 51 The group is funding a community walking program, cooking classes and food labeling in supermarkets and restaurants, so shoppers and diners can more easily identify healthy and unhealthy foods.
Employers: Helping Workers Get Healthy, Lowering Insurance Costs

Across the state, businesses are also realizing how obesity can significantly increase health care costs and reduce productivity. Some are attacking the problem by setting up wellness programs that help workers better control their weight. “Corporations are starting to realize that this is costing them a lot of money,” said University of Texas epidemiologist Steve Kelder, who has studied the state’s obesity problem for more than a decade.

For instance, the regional supermarket chain H E B, which is based in San Antonio, has also developed a successful wellness program.52 “We wanted to reduce health care costs and get people to take more responsibility for their health,” said Kate Rogers, who oversees the company’s program. More than 700 workers serve as “wellness champions,” encouraging colleagues to join and answering their questions. Over the past eight years, the program has helped H E B keep health care cost increases at less than half of the national average.53, 54

Last year, the company inaugurated its “Slimdown Showdown”: 15 employees, one from each region, competed to see who could lose the most weight. The winner received $10,000. Rogers said the contest helped energize other employees who want to improve their health. In addition, each of the 15 regions sponsors at least one 5k community race.55

HEB is also encouraging kids to be more active. It will award 12 schools $15,000 each to improve their health and nutrition education programs. The contest is open to any school in Texas within 60 miles of an H E B store.56, 57

Some towns and cities in the state are also trying to cut costs through wellness programs. Hurst, a suburb of Fort Worth, developed a comprehensive wellness program for employees, retirees and their families.58 Started six years ago, it encourages participation with bonuses, gifts and extra vacation time. For the last two years, the program has had a weight loss contest, and more than a third of all city workers have taken part. Due largely to the wellness program, the city’s health insurance premiums have risen little over the past five years, much less than would be expected. And between 2007 and 2009, absenteeism among Hurst workers fell by nearly 40 percent.59

The city also offers a less extensive web-based wellness program to all of its 36,000 residents. That program, Healthy Hurst, helps participants with exercise plans, nutrition information, food logs and a program to track progress.60

Health in Schools: Investing in the State’s Future

Across the state, childhood obesity is a major problem: one in five Texas children is obese, higher than the national average.61

Over the past decade, the state government has made several moves to reduce the problem. In 2001, it required all elementary schools to provide 135 minutes of physical education per week.62 A large percentage of schools, especially elementary schools, have adopted these guidelines.63

Two years ago, the legislature passed regulations requiring schools to devote at least half of every PE class to physical activity.64 Previously many schools used PE as study hall or supervised free time.

In 2003, the state department of agriculture limited access to unhealthy competitive foods — products sold at on campus that are not part of the school meal program.65 Texas was one of the first states to regulate competitive foods.66

Many state elementary and middle schools have also adopted the Coordinated Approach To Child Health (CATCH), a program to help students control weight and improve health.67 CATCH includes a range of features, such as classroom education about nutrition and physical activity, training for teachers and expert advice for cafeteria workers on how to make school food healthier. The program was developed two decades ago by researchers at four universities, including the University of Texas Health Science Center at Houston. Studies have shown that CATCH can reduce the fat content of school lunches, increase physical activity during PE classes and improve students’ eating and exercise habits.68

An independent study of CATCH in the El Paso school district found a seven percent decrease in obesity rates among fourth graders.69 “There were dramatic reductions in rates of obesity and overweight,” said Kelder, one of the study’s authors. “This is a good example of what a community can do.”

CATCH has been implemented in schools across the country, but it has been used most widely in Texas.70 Kelder, who is one of the program’s original developers, estimates that half of the state’s elementary schools have received CATCH training, as have 30 to 40 percent of middle schools.71
Research suggests that CATCH is a good investment. A 2007 study found that the program was the most cost-effective way to prevent obesity among youth. According to the study, the program costs $900 for every healthy year it adds to an obese child’s life. This is far below the cut-off point of $30,000 a year that the study used to determine cost-effectiveness.  

In 2007, Texas instituted a comprehensive evaluation of students’ physical fitness levels. Known as the Fitnessgram, the analysis consists of six tests, which measure body composition, aerobic capacity, strength, endurance and flexibility. During the 2009-2010 school year, the state tested nearly three million students. Only 31 percent of third-grade boys and 37 percent of third-grade girls could pass all of the tests. For older students, the results got progressively worse. For seventh-graders, 28 percent of girls and 21 percent of boys passed every test. Less than ten percent of high school seniors of either gender passed.  

But the situation may be improving. In 2007, at Combs’ urging, the legislature created Texas Fitness Now, which provides state middle schools with grants to improve physical and nutrition education programs. So far the state education agency has given $27 million to more than 2,100 schools. Most schools have used the grants to train teachers and buy physical education equipment. An evaluation of the program found that participating schools significantly improved the percentage of students who passed their Fitnessgram tests. Researchers have correlated the Fitnessgram results with other data from school districts, and found links between physical fitness and improved academic performance, school attendance and good behavior.  

Combs has more plans for the Fitnessgram data. Her office is now integrating the results with information about communities’ obesity rates along with the number of parks and grocery stores. She plans to share the results with communities so that officials, parents and others will have a better sense of how these environmental factors may affect health and weight.  

Combs and other experts realize that Texas faces years of hard work. The obesity crisis has many causes, and reversing it will not be easy. The state faces significant obstacles, including potential state and local budget cuts. “This is a 20- to 30-year process,” said Kelder, the University of Texas epidemiologist. “We can’t expect dramatic results quickly.”

---

**USAA TAKES WELLNESS TO THE NEXT LEVEL**

Peter Wald is willing to try almost anything to help his company’s workers get healthy. As the director of USAA’s wellness program, he has instituted discounted salads, bonuses for going to the gym, even mileage signs in long hallways.

His work seems to be paying off. Since starting the program in 2002, the San Antonio-based financial services company has reined in health costs. And 85 percent of the company’s 22,000 workers have joined. The company’s program has three goals: to improve health, lower company health costs and improve productivity. Reducing and controlling obesity is a key focus. USAA researchers found that obesity is behind a significant amount of the company’s health care spending. “Health care is always a big chunk of your labor costs,” Wald said. “With obesity, health care costs have the potential to really go up.”

USAA offers employees a variety of inducements to get healthy:  

- Employees pay $300 a year to use company fitness centers, which are in almost every company building. But workers who go once a week for a year get 25 percent off; those who go twice a week get half off; those who go three or more times a week get 75 percent off.
- USAA has built running and walking trails and paths at many of its campuses, and painted mileage markers in company hallways to encourage indoor walking. In company cafeterias, healthy food is at eye level, while food that’s bad for you is lower down — the opposite approach taken by many supermarkets. Healthy items have a prominent green tag.
- In 2008, the program added weight loss and other health incentives; employees who meet requirements can earn up to $550 a year. USAA also offers lower health insurance premiums for improving health; single workers can save up to $300, while those with dependents can save as much as $950.
- In company cafeterias, pricing encourages workers to buy healthy food, water costs $1.25, while soda is $1.50; a turkey burger costs slightly less than a beef burger; and a veggie burger costs less than a turkey burger. “We keep track of consumption,” Wald said. “It works.”

The incentives have contributed to increased weight loss, improved health measurements and decreased costs. In 2009, the company’s average employee BMI fell for the first time in five years. Over the past five years, its health insurance costs rose just two percent a year, far below the national average.

In recent years, USAA’s annual health care costs have increased by just two percent a year, a quarter of the national average. On top of that, the average employee BMI has gone down slightly for two years in a row.

“It’s much cheaper to keep people healthy than it is to take care of them when they’re sick,” said Wald. “The way for us to control costs is to keep people healthy. We’re doing a full court press.”
Nashville is known as the home of country music. But these days, the industry that really makes the city move is health care. More than 20 large health care companies are based there, including the Hospital Corporation of America (HCA), one of the country’s largest hospital chains. Health care revenues account for more than $29 billion a year, a fifth of the city’s total economy.

But when it comes to its own health, Nashville is a beat behind. Nearly 28 percent of its adults are obese, and another 36 percent are overweight.

This disconnect has alarmed city officials, health advocates and business leaders — not only because obesity and its related ills are consigning tens of thousands of the city’s citizens to unnecessary illness or disability. They also realize that poor health is expensive, and can harm economic development, both in the short and long term.

“If your company has a lot of people with chronic disease, you’re spending a lot of money,” said William Paul, the city’s health commissioner. “If you can prevent those diseases from happening, you can save a significant amount.”

To improve Nashville’s long-term prognosis, the city government, along with businesses and non-profit groups, have undertaken an ambitious effort to increase residents’ physical activity and improve their eating habits. Combining money from the city budget with more than $7 million in federal funds, Nashville is adding sidewalks and bike lanes, making healthy food more widely available and encouraging citizens to get more active.

While the central goal is improving Nashville’s health, saving money is also crucial, said Alisa Hauhalter, a nurse with the health department who is project director for the program. “Everything we do takes economic impact into account,” she said. “It’s the old adage, an ounce of prevention is worth a pound of cure.”

Encouraging Exercise and Better Nutrition

City officials are focusing on changing systemic policies rather than just introducing specific, time-limited programs. For instance, instead of starting an exercise program that will end when funding runs out, the city passed a Complete Streets law, which encourages street improvement projects to include sidewalks and bike lanes. The goal is to change the overall environment in which people live, work and play, making it easier to exercise and eat healthy foods.

This year, Nashville also allocated $30 million for parks and greenways, a 30 percent increase from the year before. Nashville is planning to build 25 miles of new walking trails, and has allotted $3 million for 19 miles of new bike paths and $12.5 million to build or improve 19 miles of sidewalks.

In addition, the city helped set up 80 urban vegetable gardens around the city, to encourage both exercise — gardening burns calories — and healthy eating. Many of the gardens pair teens with senior citizens as a way to create social bonds that might not occur otherwise.

The health department also bought 126 bikes, which will be stored around the city on racks near bike paths and greenways. The bikes can be used by any city resident for a few hours at a time, at no cost. To ensure that the bikes are not stolen, those who want to use them must first register online. In addition, the parks department is improving signs and markings along many city trails and bike paths.

This summer, to make sure that residents know about this work, and to encourage them to change how they live, the city rolled out “Nashvitality,” a media campaign with radio and TV ads, as well as a web site.

In addition, the health department is working to improve food in neighborhoods that have little access to healthy food. In these areas, many residents end up shopping at convenience stores, which typically sell few nutritious products. In partnership with Community Food Advocates, another local non-profit, Nashville is helping 29 of these stores improve what they offer. The city provides coolers to each store and offers advice on how to choose, stock and market fresh fruits and vegetables, as well as other items such as whole wheat bread.

“Before, all you could buy in these stores was chips, candy and beer,” said David Campbell, one of the project’s coordinators at the city health department. “There was hardly any fresh fruit or vegetables.”
Nashville’s mayor, Karl Dean, has taken a leading role in improving the city’s health. Earlier this year, he started “Walk 100 Miles with the Mayor,” a program that challenged residents to walk that distance over the course of several months. This spring and summer, he took part in 28 public walks around the city, all between two and 10 miles. So far, more than 4,000 residents have signed up; together, they have walked more than 100,000 miles.

“This is a difficult problem, but obesity comes down to issues we can control — what we eat and how much we exercise,” Dean said. He takes the message personally: he lifts weights almost every other day, and does cardiovascular exercise several times a week.

Businesses on Board

Nashville is also focusing on the workplace. Health department officials, along with the Chamber of Commerce, are talking to 10 of the city’s largest companies and institutions, including Vanderbilt University and HCA, which together employ tens of thousands of residents, about how to encourage physical activity and smarter eating. Among the options being discussed: increasing nutritious options in vending machines; requiring water and healthy food at meetings; subsidizing gym memberships and mass transit passes; allowing employees to exercise during work time; and installing bike racks on company grounds.

Vanderbilt has already developed an extensive wellness program for the 43,000 participants in its health plan (25,000 employees and 18,000 family members). Seven years ago, the institution created “Go For The Gold,” a program that pays people up to $360 a year if they provide information about their health and lifestyle and receive instruction in how to get healthier. Almost 90 percent of those in the school’s health plan participated in at least part of the program. In 2008, the program received the prestigious C. Everett Koop National Health Award.

The university is also revamping its cafeterias, subsidizing some nutritious foods and prominently displaying healthier choices. In one building, they replaced a McDonalds with an Au Bon Pain.

Vanderbilt has also developed a pilot program designed to help those most at risk. It started 30 employees, all recently diagnosed with diabetes, on an intensive exercise and nutrition program. All participants improved their cholesterol and blood sugar measurements, and nearly a quarter were able to stop taking all their medications. “We’ve seen dramatic changes,” said Dexter Shurney, MD, who helps direct Vanderbilt’s wellness program. “We’re pretty excited about this.”

He is now working to expand the program. “The question,” he said, “is how to scale this up for 43,000 people. But if we can get more of our population to do these intensive lifestyle programs, we can see substantial savings.”

HCA is also trying to cut costs by improving workers’ health. This year, the company, which insures 148,000 employees and 72,000 dependents around the country, began offering a $250 health care spending credit to those who complete an online health survey and assessment. So far 65 percent of workers have taken part. About 15,000 were found to have increased risk of a chronic disease; they were advised to see a doctor and to visit a company website with disease information.

The company is also testing a pilot program for people with pre-diabetes or diabetes. Once a month, about 350 workers receive individual coaching from a certified diabetes educator on how to reduce risks through exercise, healthy eating and medication. HCA researchers found that compared to a control group, those who were coached had a nearly 50 percent drop in emergency room visits, and a five percent drop in overall health care costs. None of the pre-diabetics who were coached became fully diabetic, and 57 percent stopped being pre-diabetic altogether.

Yonnie Chesley, who is in charge of HCA’s wellness efforts, said the pilot program will soon expand to 1,000 people. If that proves successful, the initiative will go company-wide next year; overall, the company has about 17,000 pre-diabetic or diabetic employees.
Improving Children’s Lives — and Saving Money

The city is also investing in ways to improve the health of the city’s future workforce, with efforts aimed at children and schools.

Improving the health of Nashville’s children will do more than reduce costs in decades to come; it will also help cut current costs. Childhood obesity is expensive: a recent study calculated that in the United States, each obese child costs the health care system nearly $300 a year more than a healthy weight child. The researchers calculated that reducing the rate of childhood obesity by just one percentage point would save at least $1.4 billion annually.

And because obese adults tend to use even more health care resources, helping obese children lose weight before they grow up will eventually save even more money. “Helping them learn healthy habits will really help down the road,” said Haushalter, the city’s obesity program director. “It’s a long-term economic solution.”

Last year, the Nashville school district lowered sugar levels in flavored milk, a reduction of 22 calories per carton. Because of the change, Nashville’s 77,000 public school students will ingest 50,000 fewer pounds of sugar a year. In conjunction with a local non-profit, the district is also working to improve the nutrition of products sold in school vending machines.

More than 40 schools have set up vegetable gardens, which are tended primarily by students. This summer, 20 of the district’s cafeteria managers, who together are responsible for food at more than 140 schools, received training on improving nutrition. Many of these schools are adding salad bars, and most are increasing the number of dishes that are prepared from scratch or with fresh fruits and vegetables.

Other changes are on the way too. “Nashville is like most places,” said Campbell. “The food you eat in a school is generally not very healthy — tater tots, hot dogs, french fries. We want to move to salads, fresh fruit and vegetables.”

In addition, the city is targeting children who aren’t yet old enough for school. The health department is working with eight Head Start programs, which together have nearly 2,000 students, to incorporate physical activity into learning and teach children about good nutrition.

Paul, the health commissioner, is confident that the combination of Nashvitality and private sector efforts will yield results. “If we can have even a small effect on health care costs,” he said, “it’s going to be a big payoff, for a relatively small investment.”

Haushalter agrees, but preaches patience. “We are in an epidemic that has occurred over several decades,” she said. “We have to be very diligent. This will take many years to change.”
4. TAKING STEPS TO TACKLE OBESITY AND SMOKING IN INDIANA

Indiana faces serious health challenges. Almost two-thirds of the state’s population is either overweight or obese.\textsuperscript{108} Nearly 10 percent of the state’s 6.4 million people have diabetes, double the rate 20 years ago.\textsuperscript{106} More than a quarter get little or no exercise and just one in five eats enough fruits and vegetables.\textsuperscript{107} And, more than a quarter of the state’s adults smoke, the second-highest rate in the country.\textsuperscript{108}

Obesity, tobacco, and unhealthy lifestyle choices all contribute to higher rates of chronic illness, including heart disease, hypertension, diabetes and cancer.\textsuperscript{109} The result: hundreds of thousands of Hoosiers don’t live as long as they should, experience a lower quality of life, and spend billions extra on health care.

According to a study published earlier this year, obesity alone costs the state more than $3.5 billion a year in health care and lost productivity.\textsuperscript{110} “We are spending an enormous amount on obesity-related disease,” said Marcie Memmer, director of the Indiana State Department of Health’s Division of Nutrition and Physical Activity.

The private sector also recognizes that the state’s health holds back economic development. “When you look at the drawbacks to Indiana, health is at the top of the list,” said Chuck Gillespie, director of the Wellness Council of Indiana, a private group affiliated with the state chamber of commerce, which helps companies set up or improve wellness programs. “I’m concerned that companies may think twice about relocating here.”

Over the past six years, the state’s public and private sectors, led by Governor Mitch Daniels, have worked hard to increase physical activity, improve smoking cessation and decrease tobacco use. In 2005, the state rolled out INShape Indiana, an effort to help residents get healthier; in 2007, with the governor’s support, the state legislature passed a significant tax on cigarettes; and earlier this year, the state released an ambitious ten-year plan to reduce obesity and boost residents’ overall health.\textsuperscript{111, 112, 113}

“Adopting a healthy lifestyle is good for you and good for Indiana,” the governor has said. “Too many Hoosiers are losing years because they do not embrace healthy habits. And, health care costs in Indiana are among the highest in the country. Our rising cost of health insurance coverage, combined with lost productivity due to illness, has made Indiana a less desirable place to do business.”\textsuperscript{114}

Daniels himself is a fitness buff: almost every day, he runs, swims, works out in the gym, or golfs (he usually walks all 18 holes).\textsuperscript{115} His wife Cherri walks 10 miles nearly every day.\textsuperscript{116}

**Information to Help Hoosiers Help Themselves**

The core of INShape Indiana is a website, which serves as a clearinghouse of information for Hoosiers who want to lose weight, quit smoking or otherwise improve their health.

The site includes advice and recommendations on a range of health-related topics. It features information on how to incorporate walking into daily life (walk at work, use a pedometer, wear shoes with proper support), as well as maps of appealing walks all over the state. It also gives advice on how to reach CDC’s recommended 150 minutes of exercise per week (do small amounts of exercise several times a day).

The site is divided into three sections: “Eat Better,” “Move More” and “Avoid Tobacco.” Each section offers information on how to be healthier, as well as practical hints about how to reach your specific goals. For example, the section on diet counsels residents to do most of their shopping in the perimeters of the grocery store, which generally includes fresh and frozen fruits and vegetables, dairy, eggs, meat, chicken and seafood. (The central aisles of most supermarkets tend to have more processed foods, such as potato chips, cookies and sodas.) The section also has a list of more than 100 healthy recipes, including vegetable pasta with tomatoes and green beans with roasted red peppers.

In addition, the site has a link to a list of every farmers’ market in the state, and a downloadable nutrition log to help users keep track of what they eat.

In the tobacco section, residents can find out how to join a cessation program, and how, if they still smoke, to minimize exposure of family and friends to second-hand smoke. In the Community Corner section, the site lists health-related resources — trails, gardens, nutrition education centers, YMCAs, and so on — in each of the state’s 92 counties.

For inspiration and guidance, the site also offers stories from people who have improved their health in one way or another. Among those featured is Allison Fore, of Indianapolis, Indiana. In 2009, after hearing the governor’s wife speak about INShape Indiana at the state fair, Fore, who is 49, began visiting the site regularly and going on some
of the walks listed there. Over the past two years, she has lost more than 40 pounds. This spring, she completed a 13-mile race, her longest so far. She visits the site about twice a week for events and tips. “I like reading the stories about other people,” she said. “So many of us share the same problems. It gives you a sense of community.”

Businesses and community groups around the state have also leaned on INShape Indiana for weight loss guidance. The Northwest Indiana Community Action Corporation adapted INShape’s “10 in 10 Challenge” — an approach that encourages people to lose 10 pounds over 10 weeks — for use with senior citizens. Participants learned how to exercise at home and eat smaller portions; some lowered their cholesterol and reduced their consumption of sugar.

Earlier this year, the site went through an extensive redesign to make it easier to use. In addition, INShape Indiana has increased its use of social media, and now regularly posts health information to Twitter and Facebook.

Over the past six years, INShape Indiana has also rolled out several marketing campaigns to spread the word about its web site and the importance of being healthy. A survey last year found that almost 60 percent of state residents were aware of the program. Since 2005, 86,000 state residents have asked to receive INShape Indiana’s regular emails. More than 50,000 are currently signed up.

In 2007, INShape Indiana started the “10 in 10 Challenge,” encouraging people to lose 10 pounds in 10 weeks. The campaign included an extensive media campaign, and more than 40,000 people signed up. That same year, INShape Indiana won an “Innovation in Prevention” award from the U.S. Department of Health and Human Services.

INShape Indiana also works in the non-virtual world. It helps the Indiana Department of Natural Resources promote its improved network of trails. Along with the state Chamber of Commerce and the Wellness Council of Indiana, INShape Indiana puts on an annual conference on private sector wellness programs.

Gillespie, director of the Wellness Council of Indiana, said the state’s program encourages businesses to do more for workers’ health. “When the governor lives it, breathes it and supports it,” he said, “it makes it very hard for corporate leaders to ignore it.”

He said Indiana businesses are starting to understand the importance of encouraging employees to be healthy. His group has 70 members; he expects that to double or triple over the next two years. “CEOs are saying ‘What can we do to lower health care costs?’” Gillespie said. “The conversation is starting to move toward prevention.”

The state has also focused on reducing tobacco use. In 2006, Daniels eliminated smoking at the state government complex. In 2007, the state raised the tax on a pack of cigarettes by 44.5 cents — a move supported by Daniels. “The biggest impact of a higher price is on dissuading young people or nonsmokers from taking it up in the first place,” the governor has said.

According to the state health department, in the year after the increase went into effect, consumption of tobacco products dropped by almost 20 percent, a decrease of 81 million packs.

Earlier this year, a bill to ban workplace smoking was defeated in the state senate. A study by the American Cancer Society found that the ban would have saved the state $84 million in health care costs.

An Ambitious Plan to Improve Health

Following up on the progress of the INShape Indiana efforts, in January 2011, the state health department announced a comprehensive 10-year plan to reduce obesity, as well as increase physical activity and access to healthy food. “We’ve been encouraging Hoosiers to eat better and move more since launching INShape Indiana nearly six years ago,” Gov. Daniels has said. “Since then, I’ve heard many individual success stories, but we can’t truly solve this issue without affecting change on a much broader scale. We’re taking the next step with this plan.”

The plan calls for systemic changes at both the state and local level, and offers a list of goals, including:

- Reduce the state’s obesity rate from 30 percent to 25 percent by 2020;
- Create a system to measure students’ body mass index in at least three different grades by 2013;
- By 2020, increase the state’s trail mileage by one-fifth; and
- By 2020, decrease the number of adults who drink one or more cans of sugar-sweetened beverage a day, from 69 percent to 59 percent.

The state has already started several obesity-related projects. The health department is training public health workers from around the state to better
advocate for policies that can reduce obesity — for example, laws that require new road construction to include sidewalks, trails and bike lanes. The department has started a pilot program, working with more than 30 small businesses to create work environments that encourage healthy eating and physical activity. State health workers evaluate the companies and offer ideas: adding a refrigerator in the break room so employees can bring lunch, adding healthy snacks and water to vending machines or installing bike racks and showers to make it easier for employees to bike to work.

The department is now developing a free online toolkit so that other Indiana businesses can make the same changes.

And, to improve the health of Indiana students, the department is undertaking a similar project with 25 state school districts. Memmer said the department will eventually create another online toolkit aimed at schools.

“I feel optimistic,” said Memmer. “This plan provides a roadmap for what we need to do. We now have a very aggressive population-based public health approach to obesity.”

5. SAN DIEGO: BUILDING AN ENVIRONMENT THAT ENCOURAGES HEALTH

San Diego County has a reputation as a sand-and-sun sort of place, peopled by slim surfers catching waves and trim Navy sailors walking the beach. But the county is much more diverse than that. It encompasses more than 4,000 square miles, stretching from the Pacific to the fertile avocado and strawberry farms further inland. It has a population of more than three million, spread over 18 cities, suburbs and unincorporated rural areas.

And, like the rest of the country, San Diego County has its share of fast food restaurants, televisions, Xboxes and cars — and its share of excess weight. More than 21 percent of the area’s population is obese and another 37 percent are overweight.

Increasingly, public officials in the county, as well as business leaders, are realizing that this problem is more than a health issue. County supervisor Ron Roberts has been concerned about the issue for a decade. He worries that chronic illnesses such as diabetes will slow economic development. “Looking ahead to our future workforce, these people’s performance will be severely hampered,” he said. “You end up paying for that. It is almost like a monster movie. There’s something lurking out there.”

Research backs up Roberts’ concern. A study released two years ago by the California Center for Public Health Advocacy calculated that obesity and physical inactivity cost San Diego County more than $3 billion a year in health care expenses and lost productivity.

“Obesity is a massive drain on our country’s economic productivity,” said Dr. Harold Goldstein, executive director of the group. “We need to recognize that it is not only a huge health risk, but a huge fiscal risk too.”

California state officials have also recognized the issue. “The economic cost to California of adults who are obese, overweight and physically inactive is equivalent to more than a third of the state’s total budget,” California State Controller John Chiang has said. “Think of the programs we could protect, the children we could educate and the families we could help if we could recapture those dollars by investing in prevention.”
An Ambitious Effort to Make Healthy Living Easier

Over the past five years, San Diego County has begun a major effort to reduce and prevent obesity. Last year, the county began a $16 million project to develop policies that encourage exercise and better eating. The project, known as “Healthy Works,” is part of the county’s 10-year strategic plan for improving residents overall health and reducing rates of chronic disease. The plan lays out a broad strategy to reduce cardiovascular disease, cancer, type 2 diabetes and respiratory conditions. Because excess weight contributes to many of these problems, the plan emphasizes the need to reduce obesity.

Healthy Works, which is overseen by the county health department, focuses on making long-term environmental and policy changes to encourage physical activity and healthy eating. For example, county health officials are working with the regional planning agency on its 40-year transportation plan to ensure that the plan includes bike trails, walking paths and other means that promote physical activity.

As part of the initiative, the health department has focused on increasing the number of community produce gardens. These gardens increase fruit and vegetable consumption, and also help the gardeners burn calories. The department has also created five regional garden training centers to teach garden managers, school staff and volunteers about the best ways to set up a garden and grow produce. In addition, the department is working with the county government to remove barriers that have blocked people from starting gardens. For example, until recently, groups that wanted to start a garden were required to pay a $40,000 startup fee.

In addition, Healthy Works is trying to make local fruits and vegetables more accessible to members of the community. San Diego has more than 6,000 farms, more than any other county in the country. They grow a variety of fruits and vegetables, including broccoli, avocados, strawberries and oranges. But very little of this produce goes directly to San Diego stores or tables. Instead, it is trucked to processing centers 120 miles north in Los Angeles. (Some then travels south again, and ends up in San Diego stores – but it is more expensive and not as fresh.)

To increase the local availability of this produce, Healthy Works is examining several alternatives: creating a processing center in the county; starting farmers’ markets to sell produce bought directly from county farmers; and linking county farmers to schools and other institutions that want fresh, lower-cost produce.

Healthy Works is also setting up a system that allows residents who receive food stamps to redeem them at some of the county’s 50 farmers’ markets. Those who enroll receive $20 in matching funds, allowing them to buy more fresh produce.

And, to counteract the effects of billion-dollar marketing campaigns for unhealthy foods and sedentary activities such as video games, the county is rolling out its own TV, radio and web campaign, encouraging residents to be more active and to eat more fresh local produce.

Other groups are joining in too. The San Diego Childhood Obesity Initiative, a non-profit collaboration of several local organizations, is re-vamping four corner stores by providing them with coolers and refrigeration units so they can store and sell fresh fruits and vegetables. In exchange, the stores, which are in neighborhoods that have little access to fresh fruit and vegetables, must promise to continue selling produce after they receive the equipment.
The Private Sector Responds

Area companies are also realizing that improving workers’ health can reduce costs.

In 2003, the San Diego County Regional Airport Authority, which oversees the San Diego International airport, launched a wellness program for its 360 employees. The Authority built an onsite 24-hour gym (airport employees work three shifts), and added incentives, such as gift certificates and extra days off, for workers who exercise. “People say it’s changed their lives,” said Marci Fredericksen, who directs the Authority’s wellness program. “You can see people shedding pounds.”

From 2008 to 2009, the percentage of employees with a normal BMI increased by five percent. By 2010, 10 percent of workers had reduced their BMI. The Authority calculates that the program likely saved $1 million in health insurance costs between 2009 and this year.

Software maker Intuit has also developed a vigorous wellness program. The company has about 1,400 employees in the San Diego area (its headquarters are in Mountain View, California, near San Jose).

Part of the motivation is economic, says Intuit’s Sarah Lecuna, who helps run the program. “We’re looking to lower health care costs,” she said. “If we take preventive measures up front, we hope to see cost reductions in the future.”

The program, which is available to all of Intuit’s 7,200 American workers, offers a range of approaches to encourage healthy living. The company offers a free screening program that checks cholesterol levels, blood pressure, triglycerides and blood sugar. Employees who take part receive a $650 reduction in their health insurance premiums; 93 percent of all Intuit workers take part. The screening is also open to spouses and domestic partners.

Lecuna sees this group as a crucial part of the wellness program. “If you don’t have a support system at home, this doesn’t go very far,” she said. “It’s got to be a lifestyle change.”

In addition, workers who pledge to stay tobacco-free for the year receive another $650 discount on premiums. In addition, Intuit provides employees with free pedometers. Depending on the number of steps they take, participants are eligible for up to $300 in cash and prizes. Intuit cafeterias offer a range of healthy choices at significant discounts, and the company also offers free exercise classes, in San Diego and at several other locations.

Lecuna said that because the screening program has been so successful, Intuit’s health insurance costs have gone up slightly, because so many people see doctors after getting screened. However, she expects that over the long term, the program will lower health costs. “Down the road,” she said, “we expect we won’t be paying as many huge claims, because people are taking better care of themselves.”

Targeting Childhood Obesity

The county is also focusing on childhood obesity, which is a costly problem. According to research published this year in Academic Pediatrics, the average obese child costs the health care system nearly $300 a year more than a healthy-weight child. Reducing the childhood obesity rate by just a single percentage point would save at least $1.4 billion a year. In addition, obese children have a significantly higher risk of growing up to be obese, and obese adults spend, on average, $1,400 more per year on health care than healthy-weight adults.

As part of Healthy Works, the county is awarding $50,000 grants to five county schools to develop Safe Routes to School programs, which encourage children to walk or bike to school. Research shows that few contemporary students expend calories getting to and from school. In 2001, one in ten students walked or biked to school; by comparison, in 1969, the rate was four times higher. The county is also giving out several smaller grants to educate parents, students and teachers on walking and bicycle safety.

The school district is also changing its approach to food. It published new guidelines that encourage administrators, teachers and parents to have healthy food at school events and meetings. And it is expanding its breakfast program, offering it to more students and making the food healthier. Previously, only 25 to 30 percent of eligible students ate breakfast at school and only three percent of eligible students participated in the summer breakfast program.

Roberts, the county supervisor, is optimistic about his community’s prospects. “We’re moving in an aggressive way,” he said. “I think it’s going to bring positive results. We still have a long way to go. But we’re going in the right direction.”
6. HERNANDO: A SMALL MISSISSIPPI TOWN BUCKS A STATEWIDE TREND

Between 2000 and 2010, average health insurance premiums for the private sector more than doubled. Across the country, thousands of companies, and tens of millions of employees, face higher health costs every year.

Hernando, Mississippi, is an exception. This year, the town of 14,000 has lowered its health insurance costs by 15 percent — without reducing benefits. The savings come to $130,000.

“For us, that’s a lot of money,” said Hernando Mayor Chip Johnson.

Over the past five years, Hernando has developed a comprehensive wellness program for its 115 workers. Employees receive free screenings for hypertension, diabetes, and other chronic ailments. They can get free help to quit using tobacco. They are encouraged to exercise regularly. Johnson thinks the wellness program likely played a large role in the rate reduction.

That’s not all. Hernando employees signed a pledge agreeing not to smoke at all during work hours, even on breaks. In exchange, the city’s insurance company lowered rates by another $21,000. Johnson said the pledge is simply good business. “I saved our taxpayers $21,000,” he said. “I can’t picture taxpayers wanting to pay that kind of money so our employees can smoke at work.”

Johnson said that so far, three employees have stopped using tobacco as a result of the policy.

A Model For Active Living

The city is doing more than lowering its premiums. Over the past five years, Hernando has become a model for how a city can encourage residents and workers to improve their health — and improve economic prospects at the same time.

Leading this effort has been Mayor Johnson, an energetic Republican who owns a carpet cleaning business. Before becoming mayor, he wasn’t particularly interested in prevention or public health. But six years ago, just after being elected for the first time, he was asked to serve on a regional health group trying to reduce obesity. Soon after, he attended a conference on obesity in the South.

As he listened to speaker after speaker describe the medical, social and economic damage wrought by the region’s weight problem, Johnson realized that obesity, and the chronic diseases linked to it, were major obstacles to the state’s health and prosperity. “That’s where I had my ‘aha’ moment,” he said.

Mississippi is among the least healthy states in the country. It has the highest obesity rate in the country; more than a third of its adults are obese, as are more than 20 percent of its children. It has the highest rates of hypertension, and of physical inactivity among adults. Almost 12 percent of the state’s adults have diabetes, the third highest rate in the country.

In 2008, the state spent more than a billion dollars on obesity-related health care. By 2018, those costs could quadruple, according to a recent report. “That would bankrupt the state. We need to deal with this. It’s a dollars and cents issue,” Johnson said. “Our state’s health is holding us back economically.”

“People don’t think of the economic impact of obesity and other chronic diseases,” said Mississippi State University researcher Judith Phillips, who has examined the economic and medical costs of obesity in the state. “But it’s a serious issue.”

In some ways, Hernando is not a typical Mississippi town. Over the past 20 years, it has increasingly become a bedroom community of Memphis, 20 miles to the north. As a result, Hernando has a relatively affluent, professional population, and, as a result, has more social and economic resources to support the creation of bike paths and playgrounds.

Even so, Hernando remains a thoroughly Southern place, and even if its obesity rates aren’t as high as some other Mississippi communities, it still has its fair share of fast food, Southern cooking, and sedentary living. The town doesn’t keep its own statistics on obesity, but it is part of DeSoto County, where a third of adults are obese.
Exercise Without Planning

Johnson and other city officials have focused much of their work on making it easier for residents to be active within the context of everyday routines. Although the mayor himself often gets up at 4 a.m. to exercise, he realizes that this approach doesn’t work for everyone. Many experts argue that if people are to burn adequate calories, they must get activity by walking or biking to and from work, or around their neighborhoods.

Hernando began by introducing a design standard requiring sidewalks for all new, and some existing, commercial and residential developments. Research has shown that sidewalks can increase walking by giving pedestrians safe, clearly-marked space to stroll. The city repaired crumbling downtown sidewalks, and the design standard resulted in miles of new sidewalks in suburban developments that previously had none.

With encouragement from Johnson, the city also passed a Complete Streets law, which requires new road construction to include consideration of pedestrians and bicyclists. And the city is building almost a mile of sidewalks connecting a lower-income neighborhood to a nearby elementary school, so students can walk to the school more easily.

Since 2008, Hernando has striped bike lanes on several main streets and added new walking trails in existing parks. “The city has done a lot,” said Bo McAnich, a Hernando resident and bicyclist who helps manage the city’s bicycle club. “Anything to do with bicycling, they highly encourage. There’s been a big improvement since Chip has been mayor.” The mayor himself takes advantage of the new sidewalks and bike lanes: he often walks to work from his downtown home, and bikes around town.

In 2006, Johnson convinced city officials to create a parks department — Hernando didn’t have one. The new agency has revamped all seven of the town’s parks, adding modern playgrounds to several. KaBoom, a national non-profit group that works to increase children’s playtime, has recognized Hernando as a one of the country’s most “Playful” cities, for improving its parks and playgrounds.

Three years ago, the city started a weekly farmers’ market, which offers fresh fruits, vegetables, and meats raised by approximately 65 farmers and vendors from North Mississippi. From March to November, about 400 people visit the market every weekend. This spring, to encourage lower-income families to participate, the market began accepting food stamps. The city started a community garden, which is cultivated by a range of community organizations, including churches and youth groups. Much of this produce ends up in the kitchens of Hernando’s lower-income residents.
Health — An Unrecognized Engine of Growth

Johnson sees healthy living as a mechanism to increase private investment. The city is now marketing itself as a site for corporate headquarters. The city’s efforts to improve health play a key role in that campaign, Johnson said.

“We want to recruit corporations to Hernando,” he said. “They’re not stupid. When they make their decisions, they look at health care costs.” In addition, he notes that in addition to helping people burn calories, new sidewalks and greenways also raise property values.

Over the past six years, Johnson himself has become a poster boy for active living. He regularly talks to public officials around the state and the country about Hernando’s efforts. His message is simple: Get started now, with the resources you have.

“We are doing the best we can without a lot of money,” he said. “I tell people to go out and do something, and do it now.” And he points out that for enterprising towns and counties, help is available: Hernando has worked with and received funding from a range of private groups, as well as state and federal agencies. Shelly Johnstone, Hernando’s director of community development, said that over the past six years, the city has received more than $800,000 from various sources for programs that encourage activity and healthy eating.169

Some local companies have also joined in. Williams, Pitts & Beard, a local accounting firm with 18 employees, has held two weight-loss contests for employees over the past three years. This year, one employee lost 25 pounds.170

Johnson realizes that his policies and programs won’t reach everyone. “Your personal health is a personal choice,” he said. “My job is to create an atmosphere and an opportunity for good health. If you want to take advantage of it, that’s great. If you want to stay home on your couch, go ahead.”

But many residents have bought in. At Oak Hill Baptist Church in Hernando, Rev. Michael Minor persuaded his flock to start a walking club, and to measure a walking track in the church parking lot.171

With support from groups including the Robert Wood Johnson Foundation’s faith initiative, Rev. Minor started Healthy Congregations, which helps local churches set up programs to help members lose weight and improve their health. So far, more than 60 churches in North Mississippi have joined. He is also working with the National Baptist Convention to install “health ambassadors” in the group’s nearly 10,000 churches around the nation by September 2012.172

“If we can do this in Mississippi,” said Minor, “then we can do it anywhere.”
Endnotes


3 Ibid.


7 Ibid.


9 Ibid.


13 Mason T, Alliance for a Healthier Minnesota, personal communication, September 2011.


16 Cohen R, Minnesota Department of Health, personal communication, August 2011.

17 Minnesota Department of Health. “Statewide Health Improvement Program Progress Brief”

18 Ibid.

19 Ibid.

20 Ibid.

21 Ibid.

22 Ibid.

23 Ibid.

24 Cohen R, personal communication, August 2011.


26 Target Corporation Medical Affairs Department, “Target Fact Sheet,” 2011

27 McNulty C, Target, personal communication, July 2011.


29 McNulty C, personal communication, July 2011.

30 Minnesota Department of Health. “Statewide Health Improvement Program Progress Brief”

31 McNulty C, personal communication, July 2011.


33 Ibid.

34 Ibid.

35 *F as in Fat: How Obesity Threatens America’s Future* 2011.

36 Ibid.

37 Ibid.


40 Thompson M, San Antonio CPPW program manager, personal communication, July 2011.

41 Ibid.

42 Ibid.

43 Ibid.


46 Thompson M, personal communication, July 2011.


48 Thompson M, personal communication, July 2011.

49 Ibid.


51 Kelly M, Paso Del Norte Foundation, personal communication, July 2011.


53 Ibid.

54 Rogers K, HEB, personal communication, July 2011.

55 Ibid.


57 Rogers K, personal communication, July 2011.
58 Gaining Costs, Losing Time: The Obesity Crisis in Texas. 
59 Ibid.
61 Gaining Costs, Losing Time: The Obesity Crisis in Texas.
63 Combs S, Texas State Comptroller, personal communication, July 2011.
64 F as in Fat: How Obesity Threatens America’s Future 2011.
65 Beyer V, Texas Department of Agriculture, personal communication, August 2011.
66 F as in Fat: How Obesity Threatens America’s Future 2011.
68 Ibid.
70 Kelder S, University of Texas Houston Health Science Center, personal communication, July 2011.
71 Ibid.
73 Marchman S, Texas Education Agency communications office, personal communication, July 2011
77 Wald P, USAA, personal communication, July 2011.
78 Ibid.
79 Ibid.
80 Gaining Costs, Losing Time: The Obesity Crisis in Texas. 
81 Ibid.
82 Wald P, personal communication, August 2011.
83 Ibid.
88 Johnson BD, Office of Mayor Dean, Press Secretary, personal communication, July 2011.
89 Campbell D, Nashville Metro Public Health Department, personal communication, July 2011.
90 Ibid.
91 DeVille N. “Mayor’s walks inspire many.” *The Tennessean* May 25, 2011.
93 Campbell D, personal communication, July 2011.
94 Shurney D, Vanderbilt University, personal communication, July 2011.
96 Shurney D, personal communication, July 2011.
97 Ibid.
98 Chesley Y, HCA, personal communication, July 2011.
99 Ibid.
101 Ibid.
102 Carr F, Nashville Metro Public Schools, Chief Operating Officer, personal communication, July 2011.
103 Ibid.
104 Campbell D, personal communication, July 2011.
105 Behavioral Risk Factor Surveillance System (BRFSS), CDC, 2011.
106 Ibid.
107 Ibid.
110 Trogdon et al, 1-7.
111 Berggoertz B. “Out of shape.” *The Indianapolis Star* May 1, 2011
117 Fore A, personal communication, August 2011.
ACKNOWLEDGEMENTS

**Trust for America’s Health (TFAH)** is a non-profit, non-partisan organization dedicated to saving lives and making disease prevention a national priority. For more information, visit [www.healthyamericans.org](http://www.healthyamericans.org)

The **Robert Wood Johnson Foundation (RWJF)** focuses on the pressing health and health care issues facing our country. As the nation’s largest philanthropy devoted exclusively to improving the health and health care of all Americans, the Foundation works with a diverse group of organizations and individuals to identify solutions and achieve comprehensive, meaningful and timely change. For more than 35 years the Foundation has brought experience, commitment, and a rigorous, balanced approach to the problems that affect the health and health care of those it serves. Helping Americans lead healthier lives and get the care they need — the Foundation expects to make a difference in our lifetime. For more information, visit [www.rwjf.org](http://www.rwjf.org).

About The California Endowment **The California Endowment**, a private, statewide health foundation, was established in 1996 to expand access to affordable, quality health care for underserved individuals and communities, and to promote fundamental improvements in the health status of all Californians. The Endowment challenges the conventional wisdom that medical settings and individual choices are solely responsible for people’s health. The Endowment believes that health happens in neighborhoods, schools, and with prevention. For more information, visit The Endowment’s Web site at [www.calendow.org](http://www.calendow.org).

Established in 1930, the **W.K. Kellogg Foundation** ([www.wkkf.org](http://www.wkkf.org)) supports children, families and communities as they strengthen and create conditions that propel vulnerable children to achieve success as individuals and as contributors to the larger community and society.

This report was supported by the Robert Wood Johnson Foundation, The California Endowment and the W.K. Kellogg Foundation.

**TFAH BOARD OF DIRECTORS**

- **Lowell Weicker, Jr.**
  President
  Former three-term U.S. Senator and Governor of Connecticut

- **Cynthia M. Harris, PhD, DABT**
  Vice President
  Director and Professor
  Institute of Public Health, Florida A & M University

- **Robert T. Harris, MD**
  Secretary
  Former Chief Medical Officer and Senior Vice President for Healthcare
  BlueCross BlueShield of North Carolina

- **John W. Everets**
  Treasurer

- **Gail Christopher, DN**
  Vice President for Health
  WK Kellogg Foundation

- **David Fleming, MD**
  Director of Public Health
  Seattle King County, Washington

- **Arthur Garson, Jr., MD, MPH**
  Director, Center for Health Policy, University Professor, and Professor of Public Health Sciences
  University of Virginia

- **Alonzo Plough, MA, MPH, PhD**
  Director, Emergency Preparedness and Response Program
  Los Angeles County Department of Public Health

- **Eduardo Sanchez, MD, MPH**
  Chief Medical Officer
  Blue Cross Blue Shield of Texas

- **Jane Silver, MPH**
  President
  Irene Diamond Fund

- **Theodore Spencer**
  Senior Advocate, Climate Center
  Natural Resources Defense Council

**REPORT AUTHORS**

- **Jeffrey Levi, PhD.**
  Executive Director
  Trust for America’s Health
  and Professor of Health Policy
  The George Washington University School of Public Health and Health Services

- **Laura M. Segal, MA**
  Director of Public Affairs
  Trust for America’s Health

- **David Kohn, MA**
  Senior Communications Manager
  Trust for America’s Health

---

Trust for America’s Health

[www.healthyamericans.org](http://www.healthyamericans.org)

1730 M Street, NW, Suite 900 • Washington, DC 20036 • (t) 202-223-9870 • (f) 202-223-9871
Return on Investments in Public Health and Prevention: A Summary of Groundbreaking Research Studies

Background

The Patient Protection and Affordable Care Act (PL 111-148) included the creation of the Prevention and Public Health Fund, a 10-year, $15 billion commitment to support programs, medical screenings, and research related to public health and prevention.

Mandatory funding for this groundbreaking initiative includes $5 billion between Fiscal Year (FY) 2010 and FY2014, with an additional $10 billion between FY2015 and FY2019. The fund is designed to be ongoing, so funding will continue beyond FY2019. Since its creation, $1.25 billion has already been appropriated for FY2010 ($500 million)\(^1\) and FY2011 ($750 million).\(^2\)

This funding will be distributed to programs aligned with the National Prevention and Health Promotion Strategy, our country’s first-ever comprehensive action plan for improving the health of all Americans. The Strategy outlines four overarching areas on which the nation’s prevention efforts should focus: building healthy and safe communities; expanding quality preventive services in both clinical and community settings; empowering people to make healthy choices; and eliminating health disparities.\(^3\)

This national commitment to and investment in preventing disease before it occurs is in line with evidence from a variety of recent reports and studies indicating that strategic investments in proven, community-based prevention programs could result in significant U.S. health care cost savings and overall economic cost savings. This brief summarizes the findings and recommendations from four major studies released between 2008 and 2011.

Key Findings and Recommendations

- A July 2011 study published in the journal *Health Affairs* found that increased spending by local public health departments can save lives currently lost to preventable illnesses.\(^4\) Researchers Glen P. Mays and Sharla A. Smith mapped spending by local public health agencies from 1993-2005 with preventable mortality rates in each agency’s respective jurisdiction. The report found:

  1. Chronic conditions such as heart disease, cancer, stroke and diabetes are responsible for seven in 10 deaths among Americans each year, and account for nearly 75 percent of the nation’s health spending.\(^8\)
  2. More than 40 percent of the population has more than one chronic health condition.\(^9\)
  3. Preventing disease and injury is the most cost-effective, common-sense way to improve health in the United States. Too often, however, the health care system focuses more on treating disease and injury after they happen. America spends more than $2 trillion annually on health care—more than any other nation.
  4. The United States spends hundreds of billions of dollars annually to treat preventable illnesses and diseases. For instance, health care expenditures tied just to smoking total $96 billion.\(^10\) Costs associated with conditions caused by obesity are also astronomical, including nearly $17 billion for diabetes and more than $43 billion for hypertension.\(^11\)
  5. For every dollar spent on health care in the United States today, only about four cents goes towards public health and prevention.\(^12\)
– On average, local public health spending rose from $34.68 per capita in 1993 to $40.84 per capita in 2005 – an increase of more than 17 percent.

– For each 10 percent increase in local public health spending, there were significant decreases in infant deaths (6.9 percent drop), deaths from cardiovascular disease (3.2 percent drop), deaths from diabetes (1.4 percent drop), and deaths from cancer (1.1 percent drop).

– The 3.2 percent decrease in cardiovascular disease mortality cited above required local health agencies to spend, on average, an additional $312,274 each year. In contrast, achieving the same reduction in deaths from cardiovascular disease by focusing on treatment and other traditional health care approaches would require an additional 27 primary care physicians in the average metropolitan community. To put this comparison in perspective, the median salary for a single primary care physician was $202,392 in 2010 – as a result, 27 primary care physicians would cost nearly $5.5 million, or more than 27 times the public health investment.

– Recommendation: Sustain public health investments to improve community health outcomes and reduce medical costs in the long-term. Additional public health spending would be expected to generate substantial health improvements over time.

– A 2011 Urban Institute study concluded that it is in the nation’s best interest from both a health and economic standpoint to maintain funding for evidence-based, public health programs that save lives and bring down costs. Authors Timothy Waidmann, Barbara Ormond and Randall Bovbjerg examined the financial costs and health ramifications of ignoring disease prevention. The study found:

  – The American health care system currently spends $238 billion per year in “excess costs” – defined as the difference between the cost of care for people with preventable chronic disease and those without – to treat people with type 2 diabetes, hypertension, heart disease and stroke. More than half of those costs are financed through Medicare and Medicaid. Left unchecked, those excess costs would rise to $466.5 billion per year by 2030, with nearly $300 billion financed by Medicare and Medicaid.

  – By 2030, if current trends continue for chronic diseases among all persons ages 45-64, one-third will have hypertension, more than one-quarter will have diabetes, more than 11 percent will have heart disease, and nearly two percent will have strokes. Similar prevalence rate increases can be expected for persons ages 65 or

POLICY PERSPECTIVE
Community Transformation Grants

– Community Transformation Grants (CTG’s) were announced in May 2011 by the Department of Health and Human Services as the newest component of the Prevention and Public Health Fund.

  – CTG’s are aimed at helping communities implement projects proven to reduce chronic diseases.

  – An initial $103 million in grant funding was awarded to 61 states and communities in September 2011 to support the following priority areas: tobacco-free living; active living and healthy eating; and quality clinical and other preventive services, with a specific focus on controlling high blood pressure and high cholesterol.

  – Of the 61 grantees – which are located in 36 states and serve a combined 120 million residents – 35 will implement proven health and wellness interventions, while 26 will work to lay a foundation for sustainable community prevention efforts.
older – in particular, more than half of persons in this age group will have diabetes and/or hypertension. These increases will affect not just public sector budgets but private sector costs and competitiveness.

– Slowing the rate of growth of these chronic diseases will save lives and money. For instance, cutting the rate of chronic disease growth by even five percent would save Medicare and Medicaid $5.5 billion per year by 2030; cutting the rate of chronic disease growth by 25 percent would save $26.2 billion per year; and cutting the rate of chronic disease growth by 50 percent would save $48.9 billion per year.

– Investments in primary prevention programs will not only help slow the chronic disease rate, but have also been shown to lower private insurance costs and improve economic productivity while reducing worker absenteeism. In fact, savings achieved through prevention programs can significantly and quickly outweigh initial, upfront investments.

– Recommendation: Preserve and sustain primary prevention programs for chronic diseases in order to save lives and reduce costs.

• A May 2011 study published in *Health Affairs* showed that a combination of three strategies – expanding health insurance coverage, delivering better preventive and chronic care, and focusing on “protection” (a specific prevention strategy defined as enabling healthier behavior and safer environments) – is more effective at saving lives and money than implementing any one of these strategies alone. A team of researchers led by Bobby Milstein tested all three strategies in a dynamic simulation model of the United States health care system. The report found:

– While all three strategies save lives and improve economic conditions, insurance coverage and medical care for chronic conditions lead to an increase in health costs.

– Of the three, only the preventive steps taken through protection efforts slow the growth in the prevalence of disease and injury, alleviating the demand on limited primary care capacity.

– Adding preventive protection elements to an expansion of insurance coverage and medical care could save 90 percent more lives and reduce costs by 30 percent within 10 years; those figures rise to 142 percent and 62 percent, respectively, within 25 years.

– Recommendation: Ensure that efforts to protect health and encourage healthy behavior– are a core element of disease prevention.
In 2008, Trust for America’s Health and the Robert Wood Johnson Foundation released a report showing that an investment of $10 per person annually in proven, community-based public health programs could save the United States more than $16 billion within five years—a $5.60 return for every $1 invested. The report—based on a model developed by researchers at the Urban Institute and a review of studies conducted by the New York Academy of Medicine—focused on community-based disease prevention programs that do not require medical care. Additional findings included:

- The $16 billion in savings would be spread through Medicare ($5 billion), Medicaid ($1.9 billion), and private payers ($9 billion).

- Every state in the nation would be on the receiving end of potential return on investment within that five-year period, ranging from a rate of 3.7 to 1 at the low end to 9.9 to 1 on the high end.

- Recommendation: As a significant cost-saving measure, policymakers at all levels of government should invest in disease prevention programs that are separate and distinct from those that require traditional medical care.

Endnotes

1 http://www.hhs.gov/news/press/2010pres/06/20100618g.html
4 http://content.healthaffairs.org/content/early/2011/07/19/hlthaff.2011.0196.full.pdf+html
5 http://www.mgma.com/physcomp/
6 http://content.healthaffairs.org/content/30/5/823
7 http://healthyamericans.org/reports/prevention08/Prevention08.pdf
8 http://www.healthreform.gov/newsroom/preventioncouncil.html
9 http://healthreformgps.org/resources/chronic-disease-management/
11 http://chronicdiseaseimpact.org
15 http://www.hhs.gov/recovery/programs/cppw/granteesbystate.html
Obesity Prevention on a Budget: Low- and No-Cost Policy Options to Increase Healthy Eating and Active Living
In response to the national childhood obesity epidemic, many local, state and federal leaders have advanced policies that provide children with greater opportunities to eat nutritious foods and engage in safe physical activity. Yet, the recent recession has made it much more difficult for officials at every level of government to provide services that meet the ongoing needs of their communities. As of February 2011, at least 46 states and the District of Columbia had to make cuts to social services, with most cuts affecting children, the elderly and the disabled.¹

Compounding the daunting economic climate is the fact that childhood obesity results in severe financial and health consequences that cannot be ignored.² Obesity and its related health care expenses are estimated to cost the United States as much as $147 billion annually,³⁴ with additional costs associated with lost worker productivity. Moreover, obese individuals are more likely to experience burdensome chronic diseases, such as type 2 diabetes, cardiovascular disease and high blood pressure. These steep financial and human costs make obesity prevention both an economic and health necessity.

In order to support policymakers who want to address obesity in communities and states with limited budgets, Leadership for Healthy Communities has developed the following low- and no-cost policy toolkit. The toolkit presents a range of budget-conscious policy approaches that leverage existing resources and partnerships to reduce local obesity rates by increasing opportunities for healthy eating and physical activity.

Organized by policy option, each section includes an explanation of the suggested policy approach, steps that policymakers and others can take to implement it, a brief discussion of fiscal and practical considerations and a case study of a community that implemented a similar policy.

The toolkit presents a range of budget-conscious policy approaches that leverage existing resources and partnerships to reduce local obesity rates by increasing opportunities for healthy eating and physical activity.
The policy options include:

- Establishing an Obesity Prevention Council or Task Force
- Developing a Public-Use Plan, Public Dedication Ordinance or Zoning Code that Promotes Active Living
- Establishing Joint-Use Agreements for Recreational Areas
- Implementing Supervised Recess in Schools
- Setting Up and Promoting Farmers’ Markets
- Encouraging Government and Public Facilities to Procure Healthier Foods and Beverages
- Restricting Marketing of Unhealthy Foods In and Near Schools

**Establishing an Obesity Prevention Council or Task Force**

Obesity prevention councils and task forces can be used in states and localities to develop tailored obesity prevention strategies. These councils and task forces can take a range of forms, from interagency and public-private partnerships to special policy or legislative committees. Traditionally, members either volunteer or are appointed to serve on the committee or task force. The advisory bodies are typically cooperative in nature, and are authorized to develop policy recommendations that promote opportunities for community residents to live healthy, active lives. By using local or state obesity data and enlisting participation from residents, businesses and universities, these councils and task forces can make considerable progress in preventing and reducing obesity.

**ACTION STEPS**

- **Government officials** can build support for an obesity prevention council by communicating to public and private stakeholders, including the community at large, the costs of obesity as well as the social and economic benefits of addressing it. They also can encourage participation in the obesity prevention council.

- **State legislators and city and county council members** can authorize the establishment of an obesity prevention council and/or legislative task force.

- **Governors and mayors** can create local advisory committees and recruit agencies, individuals and organizations to participate.

- **Residents** can reinforce the value of the obesity prevention council by holding policymakers to account for its establishment and follow through on the council’s findings and recommendations.
FISCAL NOTE

The direct cost of an obesity prevention council to the public is likely to be negligible and mainly for the space and meeting resources needed to convene and staff the committee. If needed, leaders can engage members of businesses and the nonprofit sector as partners to defray costs associated with meeting logistics, staffing and communicating, and implementing recommendations. That being said, it is likely that obesity councils and/or task forces may provide recommendations for policies that may impact public budgets. State and local governments can minimize the cost of such recommendations by leveraging resources across governmental agencies and/or engaging other public and private entities to implement and fund solutions.

POLICY AND PROCESS CONSIDERATIONS

- **Legislative authority.** Enacting a policy to authorize the council lends legitimacy and creates accountability for participants.
- **Building support.** Engaging the community early in the process can help garner support for the council’s efforts and ensure buy-in for its findings and recommendations. Publicizing the council’s efforts also can increase prestige associated with participation and increase the interest of funders and the community.
- **Recruiting participants.** Establishing partnerships with the private sector can help defray costs and ensure that the council considers their interests. Recruiting those from various sectors with an interest in preventing and reducing obesity, including health officials, researchers, businesses, schools and community members, can help ensure that councils and/or task forces represent a broad perspective.
- **Staffing.** Ensuring that the council is adequately and professionally staffed will allow it to function efficiently and effectively while keeping participants engaged.
- **Sustainability.** The timeframe for councils or task forces can be very long or very short depending on the manner in which they are established. In order to ensure long-term sustainability and impact, committee members should continually assess, evaluate and report on the implementation of its recommendations.

CASE STUDY

In 1999, the Louisiana legislature authorized the Louisiana Council on Obesity Prevention and Management (LA Obesity Council). Housed in the Department of Health and Hospitals, the council is comprised of representatives from government agencies, healthcare facilities, universities, research facilities, professional associations, insurance, business/industry and nonprofit organizations. The council meets quarterly to “strengthen the alignment, development and implementation of programs, projects and research to respond to the public health challenge of obesity.” Working from a three-year strategic plan, council objectives focus on environmental change, capacity building, education and awareness. A part-time coordinator staffs the council, which is responsible for publishing an annual report,
organizing events and making periodic presentations to the state legislature on the council’s activities. In their 2008 summary report, the LA Obesity Council lists many accomplishments including the implementation of a school wellness policy, a report card on physical activity in the state, a healthy food retail study and the continuation of an award program for excellence in education to prevent childhood obesity.\(^7\)

**Developing a Public-Use Plan, Public Dedication Ordinance or Zoning Code that Promotes Active Living**

Research has identified the role that the built environment—or lack thereof—plays in mitigating or exacerbating obesity.\(^8,9\) Studies show that community development that includes sidewalks, greenways, traffic-calming areas, and walkable spaces are not only more attractive but safer as well.\(^10,11\) Communities that provide their residents with safe, attractive and accessible places to walk, run, bike and play are less likely to have a high prevalence of obesity.\(^12\) Recognizing this, many policymakers have embraced public-use plans as a mechanism to increase opportunities for active living. **Public-use plans**, **public dedication ordinances** and **zoning codes** can be used by governments to develop parks, sidewalks and bike trails. To ensure that new development in their communities is consistent with this goal, policymakers can create plans and codes that require new projects to set aside space to support active transportation and physical activity, such as trails, fields and parks.

**ACTION STEPS**

- **State officials** can consider requiring that new developments supported by state funds include plans for ensuring spaces for active living.
- **City and county officials** can explore the legality, feasibility and potential constraints of imposing a public use or public dedication plan on developers.
- **Mayors** can engage developers, builders associations and others in the private sector to assess the need, feasibility and impact of any proposed public dedication or public use plan.
- **Community members** can participate in public hearings, comment periods and other processes during which the public dedication or public use plan is being developed.

**FISCAL NOTE**

The costs associated with the development and adoption of a public-use plan, public dedication ordinance or zoning code will include plan preparation, surveying, scoping, draft plans, public notices and meetings, and any personnel and contractor services costs. It is important to note that if executed incorrectly, a public-use or public dedication plan could be quite costly and result in protracted legal action.
POLICY AND PROCESS CONSIDERATIONS

✓ **Best practices.** Many national organizations, such as the National Parks and Recreation Association, are familiar with this approach and can offer guidance and resources to help communities develop similar plans.\(^\text{13}\)

✓ **Buy-in.** Engaging developers and the community in plan development will help build and broaden a base of support.

✓ **Goals and objectives.** Establishing and publicizing clear goals and objectives for a community’s public use plan, including promoting physical activity and reducing overweight and obesity, also will help build support.

✓ **Compliance issues.** Although lessons can be gleaned from ordinances adopted in other states, policymakers should make sure that ordinances are customized to fit local needs and are compliant with their own state’s laws.

✓ **Evaluation and impact.** Including feedback mechanisms—like public hearings and surveys—in a community’s plan development process can help minimize or eliminate challenges to the plan’s validity. Policymakers should assess, evaluate, and report on the development and implementation of the public use plan, including its ultimate impact on physical activity.

CASE STUDY

In 2009, Minneapolis, Minn., passed a public dedication ordinance in order to maintain “a healthy and desirable environment for residents and persons employed within the city.”\(^\text{14}\) The ordinance recognizes that open spaces and parks significantly enhance the value and attractiveness of the community. By requiring all new developments that increase the number of residential units or employees in the city set aside land to develop parks, playgrounds, recreational facilities, wetlands, trails, or open spaces, the city is ensuring that residents have places for safe, active play.

establishing joint-use agreements for recreational areas

A joint-use agreement is a formal agreement between two separate public or private entities—often a school and a city or county—outlining the terms and conditions for sharing the use of facilities.\(^\text{15}\) For example, city governments can contract with local schools districts in order to allow members of a community to use of playgrounds and fields after school hours. These agreements can allow residents to enjoy recreational space in communities where parks, schoolyards and budgets are all limited. Maximizing a community’s use of existing structures can substitute for new site development when resources are scarce, particularly where there is a growing need to increase physical activity in communities fighting higher rates of childhood obesity. Formal joint-use agreements for using indoor and outdoor school facilities are more common in more populated locales, while less populated areas commonly use informal agreements.\(^\text{16}\) The long-term benefits of joint-use agreements include healthier and closer-knit communities that take greater collective pride in...
maintaining safe and clean school grounds. Joint-use agreements are most effective when partners recognize the benefits of pooling resources.

**ACTION STEPS**

- **State officials** can establish laws that open public school facilities for community use after hours, such as California’s Civic Center Act and the California Community College Civic Center Act.
- **City and county officials** can examine federal opportunities for funding to support local joint-use efforts, particularly in eligible lower-income communities. The 21st Century Community Learning Centers program, part of the 2002 Elementary and Secondary Education Act, provides funding for schools to host after-school academic and enrichment programs.
- **Mayors** can consult with their colleagues in neighboring cities or surrounding counties to assess whether facility needs can be met by creating local partnerships.
- **School administrators** can maintain accurate and up-to-date records of annual facility costs to support cost-benefit analyses of the shared space.

**FISCAL NOTE**

The most significant direct costs of joint-use agreements are those incurred as a result of increased use of a facility, including personnel such as security guards and facilities maintenance crews. Officials should consider the full cost of maintenance for a given facility on a per square foot and per hour basis (i.e., an agreement governing the use of a pool may cost more than one for indoor basketball courts), as well as the role that school districts should play in subsidizing potential users.

**POLICY AND PROCESS CONSIDERATIONS**

- **Goals and objectives.** Agreements are more likely to succeed if goals, including identifying the benefits accrued to each partner, are clearly articulated.
- **Planning.** Identifying funding and oversight responsibilities among and between partners is essential to reducing problems in implementation. An effective joint-use agreement should include a projection of how increased usage would affect facility costs.
- **Sustainability.** Long-term commitments from all parties involved provide the time to reassess and improve the agreement if unanticipated difficulties arise. Anticipating conflicts and creating processes to resolve them will help sustain the agreement over time.
- **Communication.** Ongoing communication among partners and with the community is recommended, including periodic meetings and check-ins, even when the agreement is working as planned. By engaging the community, partners can ensure that they enter into an agreement that allows them to be responsive to community needs.
Liability. One of the most often-mentioned challenges to joint use agreements is how to handle liability and insurance issues. Anticipating and clarifying the respective responsibilities of the parties should an injury occur is advisable. Organizations such as the National Policy & Legal Analysis Network to Prevent Childhood Obesity can provide resources and guidance to address liability concerns.

**CASE STUDY**

In 2010, Seattle School District No. 1 and the City of Seattle Parks and Recreation department formalized an agreement for the joint use of facilities. The agreement allows the two entities to pool their resources to “meet continuous youth and community demands for more recreational opportunities.” The agreement includes a vision statement to outline the intent of the policy, the shared purpose, general agreement provisions and guidelines for joint use, processes for scheduling and managing the facilities, a process for cost and revenue sharing and a liability clause, among other features. In particular, each entity agrees to indemnify and hold harmless the other party in any liability claims. The agreement also specifies that the shared use be based on “fiscally sound considerations,” and that neither entity will be expected to subsidize the use of the facilities by the other party.

**Implementing Supervised Recess in Schools**

Despite growing rates of childhood obesity, schools across the country are reducing or eliminating physical activity programs from the school day in response to budget constraints and mounting pressure to improve standardized test scores. However, research shows that even 15 to 30 minutes of daily physical activity can improve academic focus and classroom behavior in all grades, while improving health. Under the supervision of trained staff, recess allows children to engage in physical activity and develop healthy bodies, as well as practice important life-skills, such as sharing, communication, negotiation and problem-solving.

**ACTION STEPS**

- **State officials** can implement policies and programs to support recess and/or physical activity breaks as necessary components of the school day.
- **City and county officials** can ensure that proper funding is available for the purchase and maintenance of recess equipment, such as swings or monkey bars.
- **Mayors** can engage the community and rally support to facilitate the implementation of daily recess in schools.
- **School administrators** can implement schedules that integrate supervised recess and physical activity breaks as a regular part of the school day.
FISCAL NOTE

Playground kits can be purchased to help schools implement more active recess. Kits include playground blueprints, equipment, activity guides and training videos for staff and teachers. Utilizing a kit and employing volunteers to supervise children during recess provides local officials with a low-cost, high-activity opportunity to increase physical activity. Policymakers should expect to incur costs related to volunteer recruitment, training and background checks. Additional resources may be necessary to maintain the play area and equipment, including performing safety inspections.

POLICY AND PROCESS CONSIDERATIONS

- **Regulations or standards.** Minimum standards could be adopted for daily physical activity or supervised recess for children at the local and state level.
- **Community support.** To garner support for physical activity-supervised recess at the local and state level, policymakers should consider engaging the community.
- **Planning and implementation.** School districts can establish committees composed of various stakeholders including community members, health officials and school administrators to help ensure appropriate planning and implementation.
- **Staffing.** Training staff and volunteers can help ensure that recess breaks feature moderate-to-vigorous physical activities.
- **Evaluating results.** Assessing and evaluating recess implementation at the school district level can help build the case for sustaining and expanding a successful program.

CASE STUDY

In 2006, the Hawaii State Board of Education Policy 1110-6 required the Department of Education (DOE) to establish guidelines for physical activity in response to resounding concerns over childhood obesity. The resulting Wellness Guidelines requires public schools to provide students in all grades with at least 20 minutes of supervised recess per day, provide qualified professionals to supervise physical activity and establish health committees at each school. To facilitate implementation of Policy 1110-6, the DOE created the Wellness Guidelines Toolkit to monitor progress. The policy took effect in 2007 and schools were required to complete implementation by the end of the 2010-2011 school year. In other parts of the country, schools that have implemented recess have reported some success associated with their programs, including a reduction of discipline referrals during unstructured time.
Setting Up and Promoting Farmers’ Markets

Farmers’ markets can provide fruits and vegetables in communities where options are expensive or scarce. Farmers’ markets have proliferated over the past two decades in the United States, growing from more than 1,500 in 1994 to approximately 6,200 in 2010. It is estimated that more than 60,000 farmers sell produce at these venues and 3 million consumers patronize them annually to the tune of $1.3 billion. Markets can be set up in locations that are either under-utilized or generally used for other purposes such as parking lots, empty or abandoned plots of land or town centers. By facilitating policies that support privately operated or establish publicly operated farmers’ markets, policymakers can create a new revenue stream for farmers, business owners and craftsmen while promoting healthy eating in their community.

Additionally, policymakers can help ensure that vendors at these markets are equipped to accept payment from those enrolled in the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and Supplemental Nutrition Assistance Program (SNAP) programs by requiring use of the electronic benefit transfer (EBT) system. With the EBT system, program beneficiaries use an electronic card, similar to a bank debit card, which transfers funds from the benefits account to the retailer. State agencies are responsible for authorizing retailers who wish to participate in WIC and SNAP and are charged with ensuring that a sufficient number of retailers receive such authorization. Many states use this system to encourage WIC and SNAP participants to use their benefits to purchase fresh fruits and vegetables.

**ACTION STEPS**

- **Mayors and city council members** can:
  - Establish a publicly operated farmers’ market and prescribe easily navigable rules and regulations for its operation;
  - Develop a local farmers’ market commission or advisory board;
  - Directly administer the functions of the farmers’ market, including providing staffing and implementing a WIC and SNAP redemption program; and/or
  - Encourage boards of directors for local farmers’ markets to develop a new WIC and SNAP redemption plan or publicize an existing plan.

- **City managers** can provide information on by-laws and zoning considerations and anticipate and address issues like parking, traffic and other neighborhood impacts of the proposed market.

- **State and local health and human services officials** can provide advice and technical assistance on key questions regarding the goods that are sold and requirements for inspections and safe handling of food products. They also can
provide guidance to farmers’ markets about how to accept WIC and SNAP benefits as payment.

- **Private partners** can promote the farmers’ market to potential vendors and community residents, and provide technical assistance with management and operation.

- **Nonprofit organizations and foundations** can provide information resources and funding. In particular, they can help defray costs associated with obtaining the equipment and technology necessary to redeem WIC and SNAP benefits, and publicize the redemption program to community residents.

- **Community residents** can patronize the market to ensure its success, serve on the market’s board of directors and volunteer to participate in the maintenance and upkeep of the market location.

**FISCAL NOTE**

The costs of setting up a farmers market will vary, and depend on the size of the market, its location, whether or not farmers and other vendors are charged a fee for operating a stall, the costs related to promotion, the frequency with which the market operates and its requirements for staff (volunteer or paid).

The cost to government associated with promoting a WIC and SNAP redemption program will include promotional and training materials and personnel time to develop and implement the promotional campaign. Policymakers should explore whether some of these costs can be offset with funding from nonprofit partners or the federal government. If the market is publicly operated, the costs may include private point-of-sale terminals (average cost of $700 per terminal) with monthly fees associated with terminal use and transaction costs. There is no fee associated with becoming authorized to accept WIC or SNAP benefits as payment and wired terminals to process EBT payments are generally free, except for telephone line usage charges and transaction fees. Many successful WIC and SNAP redemption programs at farmers’ markets train dedicated staff to manage the program. A volunteer could fill this role if needed.

**POLICY AND PROCESS CONSIDERATIONS**

- **Feasibility.** A feasibility assessment may help gauge the interest and need for a farmers’ market in your community. Policymakers should leverage the expertise of nonprofit partners that work on nutrition and food security issues in these assessments.

- **Form.** A range of legal entities, including associations, 501(c)(3) structures or others can be employed to manage the market and house its operations.

- **Community engagement.** Policymakers should communicate with residents early and often in the planning for the farmers’ market and its operation.
Governance and management. To encourage sustainability, officials should establish a governing body to develop a mission statement for the market, manage its operations and resolve conflict or difficulties as they arise.

Information resources. Researching and accessing federal, state, local and nonprofit resources for farmers’ markets, such as the Farmers Market Coalition and the U.S. Department of Agriculture’s tools and guides on the subject will help in the development and management of farmers’ markets.39,40

Funding. Enlisting private partners as sponsors can help defray costs associated with farmers’ markets.

Public relations. Engaging nonprofits, civic organizations and other advocates to encourage community patronage and to publicize the benefits to the local economy and residents, may help the market succeed. These partners can help develop messaging and campaigns to keep the community engaged and organize special events and incentives to encourage patronage.

Compliance, standards and liability. Investigate insurance and other liability considerations associated with selling food items and operating at the chosen location. Establish clear standards of conduct and memoranda of understanding for vendors, including standards related to pricing.

CASE STUDY

The Maple Grove Farmers’ Market in Maple Grove, Minn., a large suburban community, is an example of a successful, publicly operated farmers’ market.41 Established by Maple Grove’s city council in 2003, the market’s first year was dedicated to planning and developing processes including dates, times, location, guidelines and a fee structure. The Maple Grove market is managed like any other city program, with assigned staff and oversight by the city administrator. Staff members work with the Hennepin County Environmental Health Department to ensure compliance with food safety requirements and two city employees serve as market coordinators recruiting vendors and promoting the market. A market manager works onsite whenever the market is open. All vendors must complete an application process and their fees go directly to support the market, defraying the costs of advertising, special events, supplies and market staff salaries. To maintain community interest and engagement, the market manager organizes special events throughout the year, such as picnics and concerts.

Encouraging Government and Public Facilities to Procure Healthier Foods and Beverages

In 2008, nearly 17 million Americans were employed by state and local governments, and many more consume a significant portion of their diet at places operated, supported or regulated by the government, including vending machines in public facilities, child-care centers, senior centers, homeless shelters, public
hospitals, schools, correctional facilities and even highway rest stops. By supporting incentives that increase the availability of healthy, locally grown foods in public facilities through government procurement practices and vending policies, policymakers can increase the nutritional quality of foods offered to people whose diets are wholly or partially dependent on government-controlled sources. This can include requiring that food vendors and vending machines in public facilities follow prescribed nutritional guidelines and/or provide labeling for the food they serve. Additionally, by placing a preference for locally grown fruits and vegetables in procurement and vending policies, governments can increase opportunities for local businesses and stimulate economic development.

ACTION STEPS

- **State and local government leaders** can develop policies that require or recommend that vendors to state- or locally-controlled facilities and government-sponsored events offer foods that meet specific nutritional guidelines and/or use products from in-state and local farmers.
- **Public health officials** can provide specific data that shows the negative effect and high cost of poor nutrition and obesity in the state or locality.
- **Private partners and food vendors** can provide healthier options that are cost-effective.

FISCAL NOTE

The costs associated with implementing new vending standards include expenses related to the transition process, staff and public education about the program and initial compliance monitoring. Ongoing costs should not exceed the costs of any prior vending program, although vendors may argue that offering healthier foods increases their program costs. In those cases, vendors can explore cost-neutral changes, such as replacing whole milk with fat-free or low-fat milk. To further address these concerns, localities can combine their purchasing power or work with larger vendors in order to negotiate lower prices for healthier options.

Local food procurement has largely been examined in terms of its environmental and social benefits. While very little data exists to quantify the extent of the financial savings, there is anecdotal evidence to suggest that concerns about cost increases may be unwarranted. In Toronto, Ontario, where a local food procurement policy recently passed, the staff reported that there were “no immediate financial impacts” related to the adoption of the policy.

POLICY AND PROCESS CONSIDERATIONS

- **Scope and responsibility.** Ensuring that existing food vendors and public agencies understand who is affected by the new policy and who is responsible for its execution will help ease implementation challenges.
✓ **Policy and political climate.** Each policy (local food procurement policies and nutritional guidelines for vending) is distinct, so policymakers should assess whether one or both approaches are likely to succeed based on their political and legislative climate.

✓ **Nutritional guidelines.** Nutritional guidelines should be defined with precision to avoid confusion among vendors who seek to comply and maintain their contracts with the state/locality.

✓ **Public education.** The general public and other government agencies will need information about the economic, environmental and health benefits of locally grown food because their support is vital for the success of the initiative. Common myths about the quality of and safety standards for local food may have to be dispelled.

✓ **Partnerships.** By partnering with neighboring states and localities, policymakers can increase the likelihood of success of their procurement program.

✓ **Timelines and benchmarks.** Transition to any new system will include bumps along the way. Establishing reasonable timelines and benchmarks can help minimize difficulties.

✓ **Local food supply.** When considering whether to establish requirements that increase demand for locally grown foods, policymakers should ascertain whether the supply is able to meet that demand.

✓ **Legal checks.** Charges of anti-competitiveness, unfair competition or non-compliance with relevant rules, regulations and ordinances can doom a local procurement policy before it yields expected benefits.

✓ **Data collection.** If local procurement policies are instituted, officials can collect data regarding the relative cost of local fruits and vegetables as compared with those shipped from further distances.

**CASE STUDY**

California has been the leader in implementing policies that require specific nutritional standards for food and beverages sold in vending machines in public facilities. Some of the examples include:

- Los Angeles County requires that 100 percent of foods sold in vending machines on government property meet State of California’s Nutrition Guidelines. These standards also cover public schools.

- In 2004, Contra Costa County enacted a policy requiring that 50 percent of food and beverages sold in vending machines in county-owned or operated facilities meet specific nutrition standards.

- In 2006, Chula Vista County enacted a policy requiring that all vending machines at any city facility contain only healthy snack and beverage choices.

- In 2010, by executive order, San Francisco set nutrition standards for food and beverages sold in vending machines on city and county property.
prohibit sugar-sweetened drinks and require that 50 percent of foods meet standards for fat, saturated and trans fat, and sugars.\textsuperscript{30}

Additionally, New York has enacted multiple laws and regulations designed to promote the procurement of food produced in-state.\textsuperscript{51} State finance law section 165 provides that “state agencies may mandate that all or some food products” must be grown, produced or harvested in New York. Non-state agencies are encouraged to adopt the same standard. Executive order \#39 provides that agencies take feasible actions to increase the proportion of their food purchases that are locally grown. Several other bills have been considered that would apply similar standards to school districts and facilities controlled by the Department of Health. An additional measure would help finance the transportation and distribution of food products from in-state sources.

**Restricting the Marketing of Unhealthy Foods in Schools**

Children consume a significant portion of their daily calories during the school day, and many fast-food chains and processed food manufacturers specifically target children while they are at school.\textsuperscript{52} This is especially disconcerting because studies show that food marketing within the school environment can influence what children eat outside of school hours.\textsuperscript{53} Thus, it is important for school environments to reinforce healthy eating messages. Policymakers seeking to promote an overall wellness or obesity prevention strategy may consider restricting the marketing of unhealthy foods in the school environment by prohibiting all advertisements and promotions on campus, banning all food and beverage advertisements and promotions on campus, or forbidding the marketing of products that are not permitted to be sold on campus. This policy option may find additional support since the enactment of the Healthy, Hunger-Free Kids Act (P.L. 111-296), which requires that state and local governments adhere to stronger nutrition standards in schools.\textsuperscript{54}

**ACTIONS STEPS**

- **State legislators and school boards** can limit food marketing in schools with careful attention to constitutional parameters.
- **School administrators** can ensure that policies are implemented in a manner consistent with the law. They also can seek supplemental funding to offset the loss of non-tax based revenues from vendor contracts.
- **Health officials and nonprofit organizations** can provide technical assistance to school administrators and educators on how to implement the standards.
- **Private partners** can sponsor public relations and media advocacy campaigns to educate parents and the community about the new policies and the benefits of healthy eating and active living.
FISCAL NOTE

This approach does not have significant direct costs as it is mainly regulatory in nature. Policymakers should expect some costs related to educating people about the new standards and ensuring compliance. Some schools may be reluctant to reduce or regulate competitive sales, particularly given current economic challenges. However, schools that have replaced less-healthy competitive products with healthier items have reported no loss in revenues. The loss of that tool could place those districts in the position of having to make difficult decisions about programs previously funded by these contracts. To counteract this, schools can explore healthy fundraising activities, such as walk-a-thons, book fairs, non-food product sales and healthy food sales.

POLICY AND PROCESS CONSIDERATIONS

✓ Constitutional questions. The plan to restrict advertising of unhealthy foods in or around schools should be carefully crafted to avoid constitutional challenges. The National Policy & Legal Analysis Network to Prevent Childhood Obesity can provide resources and guidance to address these concerns.

✓ Offset of loss of funding. In some school districts, vendor contracts provide additional funding. Seeking out new fundraising sources to replace or even exceed those former sources can reduce opposition to the plan and maintain the availability of important activities. The Center for Science in the Public Interest found that beverage sales contracts are actually less profitable than other forms of fund raising, including non-food-related fund-raisers such as sales of gift wrap and candles. Further, among schools and districts that improved the nutritional quality of fund-raising products offered, most increased their revenues.

✓ Compliance. It is important to ensure that leaders throughout the school district are aware of the new guidelines and have the tools and resources to comply. The Healthy Schools Program from the Alliance for a Healthier Generation offers technical assistance to school, parents and community members on this and other related topics.

CASE STUDY

In 2005, the Maine legislature prohibited brand-specific advertising of any foods or beverages in school buildings or on school grounds that did not meet standards for sale or distribution on school grounds. The law further provides that the foods and beverages sold on school grounds be consistent with specific nutritional guidelines, thus effectively banning advertising of fast foods (which would include “brand-specific” foods) and other unhealthy foods that would not meet the prescribed guidelines.
Conclusion

Using these low- and no-cost policy approaches, elected and appointed officials can help to increase opportunities for children to eat nutritious foods and engage in safe physical activity. Policymakers who would like more information or assistance regarding the advancement of these policies can learn more at www.leadershipforhealthycommunities.org.

Notes


12. Sallis J and Glanz K.

13. The National Parks and Recreation Association has as one of its guiding principles, “policies that encourage walking, biking, and the development of alternative transportation networks that will create more livable and healthy communities” and maintains a research and policy database that can provide assistance to state and local policymakers seeking to promote this principle in their own communities.


16. Ibid.


18. Ibid.


26. Ibid.


30. Ibid.


36. Ibid.

38. WIC recipients are also eligible for the Farmers’ Market Nutrition Program, which provides benefit checks that can be used toward the purchase of fresh fruits, vegetables and herbs only.


47. Ibid.

48. Ibid.

49. Ibid.

50. Ibid.


58. A study by Michele Polacsek, PhD, MHS, of the University of New England, presented at the American Public Health Association annual meeting in 2010, revealed that despite the new law, 85% of schools surveyed were not in compliance.

ABOUT THE PROGRAM

Leadership for Healthy Communities is a national program of the Robert Wood Johnson Foundation.

Copyright 2011 Robert Wood Johnson Foundation.

This brief was produced by Global Policy Solutions with direction from the Robert Wood Johnson Foundation (RWJF) for RWJF’s Leadership for Healthy Communities program.

To request permission to reprint:
If you wish to reprint any portion of this document, please visit http://www.rwjf.org/policies/copywrite.jsp. You’ll need to download and complete the form that’s linked from that page, email it to creativerequests@rwjf.org and wait to receive a response.
IRS Notice and Request for Comments Regarding the Community Health Needs Assessment Requirements for Tax-Exempt Hospitals

By Sara Rosenbaum

Introduction

On July 7, 2011, the Treasury Department and the Internal Revenue Service (IRS) published a Notice and Request for Comment on a proposed policy regarding the Affordable Care Act's new requirements related to tax-exempt hospitals' community health needs assessment (CHNA) obligations. Section 9007 of the Act added new Section 501(r) to the Internal Revenue Code, which delineates a series of statutory requirements, outlined in a previous implementation brief, applicable to nonprofit hospitals that seek tax-exempt status under Section 501(c)(3). The purpose of the Treasury/IRS Notice is to both describe the agencies’ approach to implementing hospital organizations’ CHNA obligations and to invite comments regarding their proposals. The CHNA requirements are effective for taxable years beginning after March 23, 2012. However, the Notice specifies that hospitals currently engaged in conducting CHNA-related activities -- including development and wide publication of a needs assessment and adoption of an implementation strategy -- can rely on the policies contained in the Notice as they move forward.

Elements of the proposed CHNA policy

The Affordable Care Act addresses a range of issues: the scope of the obligation and the hospital organizations affected, including its impact on each facility owned by an organization; the methods to be used in developing a CHNA and implementation strategy; the public consultation process that will be required; the methods used to conduct the assessment; the adoption of an implementation strategy; penalties for failing to comply with the new requirements; and reporting requirements and effective dates. The Notice indicates that the IRS rule will address policies on the full range of matters related to the law.

Hospital organizations required to meet CHNA requirements. The Notice indicates that all hospital organizations operating state-licensed health care facilities will be covered, regardless of whether they are the sole operators or operate hospitals in partnerships or joint ventures that are treated as activities of the tax-exempt partner. The policy also reaches government hospitals operated under Section 501(c)(3) while inviting comments on alternative approaches to CHNA that might be used in the case of government facilities. The Notice also indicates that should the IRS determine that other types of organizations should be covered because their principal function or purpose is the provision of hospital care, its policies will apply only after formal notice and opportunity to comment through the rulemaking process.

Hospital organizations with multiple facilities. The IRS Notice provides that in the case of hospital organizations with one or more hospital facilities, the organization will be required to satisfy the CHNA requirements for each separate hospital facility. Thus, an organization with 20 hospitals will have to satisfy CHNA requirements for each hospital. Although a hospital organization will be permitted to
collaborate with other entities and organizations in conducting CHNA activities, the organization will also be expected to demonstrate CHNA compliance for each facility.

**Documenting the CHNA.** Under the ACA, a hospital organization must “conduct” a CHNA once every 3 years. The Notice defines a CHNA as a written document developed for a hospital facility that includes a description of the community served by the hospital facility; the process used to conduct the assessment including how the hospital took into account input from community members and public health experts; identification of any persons with whom the hospital has worked on the assessment; and the health needs identified through the assessment process.

A hospital organization will be required to prepare a written report:

(1) describing the community served and how the community was determined;

(2) describing the process and methods used to conduct the assessment including “a description of the sources and dates of the data and other information used in the assessment and the analytical methods applied to identify community health needs”;

(3) describing how the organization took into account input from persons representing the broad interests of the community served by the hospital facility, including a description of when and how the hospital consulted with these persons or the organizations they represent. The organization must “identify any individual providing input who has special knowledge of or expertise in public health by name, title, and affiliation and must provide a brief description of the person’s special knowledge.” The organization also must identify any individual providing input who is a “leader” or “representative” of certain populations;

(4) describing prioritized community health needs identified through the CHNA “as well as a description of the process and criteria used in prioritizing such needs;”

(5) describing the existing health care facilities and other resources within the community and available to meet community health needs. The organization must specify each of the community health needs identified through a CHNA for a hospital facility in its implementation strategy.

**How and when a CHNA is conducted.** The Notice provides that an organization must conduct a CHNA in the taxable year in which it is due or in the two immediately preceding years. A CHNA will be considered “conducted” in the taxable year that the written report of its findings, as described above, is “made widely available to the public,” as defined in the Notice. A CHNAs will be considered “conducted” only if it identifies and assesses the health needs of, and takes into account input from persons who represent the broad interests of, the community served by a specific hospital facility. Thus, while hospital organizations may base a CHNA on information collected by other organizations or to develop CHNAs in collaboration with other organizations (e.g., public health agencies, other hospital organizations), a
separate CHNA report must be written for each hospital facility that covers all required information. The agencies request comments on the circumstances under which documenting CHNAs for multiple hospital facilities together in one written report “might improve the quality of the CHNAs while still ensuring that the information for each hospital facility is clearly presented and easily accessible.”

Community served by a hospital facility. The agencies propose that hospital organizations may take a “facts and circumstances” approach to the question of what community is served by a hospital. “Generally Treasury and the IRS expect that a hospital facility’s community will be defined by geographic location.” However, a hospital’s community may take into account target populations served. The agencies caution that “[n]otwithstanding the foregoing, a community may not be defined in a manner that circumvents the requirement to assess the health needs of (or consult with persons who represent the broad interests of) the community served by a hospital facility by excluding, for example, medically underserved populations, low income persons, minority groups, or those with chronic disease needs. The agencies seek comments on different geographic definitions of “community.”

Persons representing the broad interests of the community. The agencies set forth minimum criteria aimed at determining whether the persons consulted with represent the “broad interests” of the community. At a minimum, consultations must take into account input from (1) persons with special knowledge of or expertise in public health; (2) federal, tribal, regional, state or local health or other departments or agencies with current data or information relevant to the health needs of the community served by the facility; (3) leaders, representatives, or members of medically underserved, low income, and minority populations, and populations with chronic disease needs, “in the community served by the hospital facility.” The agencies also suggest categories of people and organizations including healthcare consumer advocates, academic experts, health care providers including community health centers and other providers focusing on medically underserved populations, and others.

Making a CHNA widely available to the public. In order to be considered widely available to the public, the written report documenting the CHNA must be posted on the hospital facility’s website or that of its parent organization if it does not have its own website. Hospitals may use another website if links and access instructions are clear. Individuals must be easily downloadable and must be posted in a format that “when accessed, downloaded, viewed and printed in hard copy, exactly reproduces the image of the report.” No fees may be charged. The CHNA must remain widely available until the date that a subsequent CHNA is made widely available. The agencies request additional comments on the question of how CHNAs can be made widely available.

Implementation strategy. The agencies make clear that a hospital meets its CHNA requirements only if it also has “adopted an implementation strategy to meet the community health needs identified through the CHNA.” Each hospital facility must have a separate implementation strategy, which is defined as “a written plan that addresses each of the community health needs identified through a CHNA for such facility.” For each identified health need therefore, there must be an implementation strategy. A strategy is considered as addressing a health need identified through a CHNA for a particular hospital facility “if the written plan either (1) describes how the hospital facility plans to meet the health need; or (2)
identifies the health need as one the facility does not intend to meet and explains why the hospital facility does not intend to meet the health need.”

The description of how the hospital facility intends to meet a need must be “tailor[ed]” to the particular hospital facility, taking “into account its specific programs, resources, and priorities.” Hospital organizations must attach the most recent implementation strategy for each of their hospital facilities to their 990 forms, which are used to report their activities. The Notice allows an implementation strategy to be developed in collaboration with other organizations, in which case the strategy should list all collaborators. At the same time, the strategy must show the particular activities for the particular hospital facility covered by the strategy. The agencies seek comments regarding whether and under what circumstances a multi-hospital implementation strategy document might improve the quality of the strategy while “still ensuring that information for each hospital facility is clearly presented and easily accessible.”

*How and when an implementation strategy is “adopted.”* The agencies will consider an implementation strategy to be adopted on the date that it is approved by the hospital organization’s governing body. The strategy must be adopted “by the end of the same taxable year” in which the hospital organization conducts the CHNA.

*Penalty for failure to meet CHNA requirements.* The agencies will impose a $50,000 excise tax on any hospital organization that fails to satisfy the CHNA requirements with respect to “a” hospital facility. Each facility therefore will be subject to the tax in the case of a hospital organization with multiple facilities.

*Reporting requirements related to CHNAs.* Tax exempt organizations must file a 990 form annually and must respond to the CHNA questions already added to the form beginning March 23, 2012, attaching their “most recently adopted” implementation strategy for each hospital facility. (Government hospitals are not required to file form 990s or their implementation strategies, although the CHNA obligations apply to them).

*Effective dates.* The CHNA and implementation strategy requirements are effective the last day of a hospital’s first taxable year beginning after March 23, 2012. Hospitals working on CHNAs in advance of the mandatory effective date may rely on the Notice for federal policy to guide their efforts.