HHS/ED COMM #2
July 30, 2012
Discussion

MEMORANDUM

July 26, 2012

TO: Health and Human Services Committee
Education Committee

FROM: Vivian Yao, Legislative Analyst

SUBJECT: **Obesity Prevention**

The Health and Human Services (HHS) and Education Committees will discuss obesity prevention strategies in the County. The following individuals expected to participate in the discussion:

- Ulder Tillman, Health Officer & Chief of Public Health Services, Department of Health and Human Services (DHHS)
- Dourakine Rosarion, Special Assistant to the DHHS Director
- Marla Caplon, Director, Division of Food and Nutrition Services, Montgomery County Public Schools (MCPS)
- Betsy Brown, Director, Department of Curriculum and Instruction, MCPS
- Marcos Pesquera, Chair, Montgomery County Commission on Health
- Ron Bialek, Vice Chair, Montgomery County Commission on Health
- Judy Stiles, Chair, Montgomery County Obesity Prevention Strategy Group
- Carol Garvey, Montgomery County Obesity Prevention Strategy Group

Other representatives of DHHS and stakeholder groups are expected to attend the meeting.

During the FY13 budget review of grant-funded afterschool programming delivered by DHHS, Committee members expressed interest in discussing obesity prevention efforts in Montgomery County including efforts of MCPS to deliver fitness, nutrition, and obesity prevention education and services.

The Committees will also hear from the Department of Health and Human Services about available data that reports on obesity and overweight prevalence in the County; the need to collect better data that tracks the prevalence of overweight or obesity

in children; and recent efforts of the Healthy Montgomery Obesity Prevention Work Group.

In addition, the Committees will hear from the Montgomery County Commission on Health and the Obesity Prevention Strategy Group about their strategies and recommendations related to obesity prevention.

OBESITY DATA

Overweight and obesity[1] are serious public health concerns as they increase the risk of many health conditions including hypertension, heart disease, type 2 diabetes, certain cancers, liver and gallbladder disease, sleep apnea and respiratory problems; joint problems, and social and psychological problems. Addressing weight issues early on is important as obese children are more likely to become obese adults.

National Statistics

The following information summarizes national information published by the Centers for Disease Control (CDC) on obesity rates and trends and attached at ©1-12:

- Between 1980 to 2008, obesity rates doubled for adults and tripled for children. In 2009-2010, 35.7% of adults in the United States were obese.
- Between 1999-2000 and 2009-2010, the prevalence of obesity increased among men (27.5% to 35.5%) but not significantly among women (33.4% to 35.8%).
- 16.9% of children and adolescents in the United States were obese in 2009-2010. The prevalence of obesity was higher among adolescents than preschool-aged children (18.4% among 12-19 year olds compared to 12.1% among 2-5 year olds) and for boys than girls (18.6% for boys compared to 15.0% for girls).
- One out of seven low-income, preschool-aged children is obese.

Local Statistics

The Department will present a Childhood Obesity Update, which is attached to the packet at ©13-27. In addition, the Healthy Montgomery Obesity Work Group has also provided information on local county obesity and overweight rates at ©28-62 and describes its efforts in this area ©63-68. Council staff notes that the processes for collecting local childhood obesity differs significantly from, and are thus not comparable to, other state and federal processes (see ©14).

Some of highlights from data include:

- Over half (54.3%) of adults in Montgomery County are overweight ***or*** obese.
- 36.3% of children in the County are overweight ***or*** obese.
- More African American/Black and Hispanic adults are overweight or obese compared to adults of other races.

[1] An individual is considered overweight by having a Body Mass Index (BMI) between 25-29.9, and obese by having a BMI of 30 or more. A person's BIT is calculated by taking a person's weight and dividing it by their height squared in metric units.

- Since 2000, the rate of hospitalizations per 10,000 residents with a primary or secondary diagnosis of obesity has increased three-fold for adults and more than four-fold for children (1.2 in 2000 to 5.3 in 2009).

The DHHS presentation at ©24-27 suggests that future efforts to capture weight status and health and well-being risk factors through the Maryland Youth Risk Behavior Survey and the roll out of the Health Information Exchange through federal healthcare reform may lead to more reliable and useful data that can be compared to state and national estimates.

The Committees may be interested in exploring whether other methods for collecting BMI data, in addition to self-report, may be worthwhile. The Commission on Health recommended (see discussion below) that MCPS measure weight and height from students and provide anonymous BMI data to DHHS to track obesity rates and set a baseline for future obesity prevention programs (©90) as part of its recommended strategy to increase opportunities for extracurricular physical activity.

MCPS Programs and Services

During the FY13 budget review of School Health Services, the Committees discussed a proposed increase in grant-funding from the Mead Family Foundation to provide a school-based, obesity prevention program called Healthy Choices, Happy Students. The program was designed to increase physical activity; help students make healthier food choices; and form partnerships with MCPS and the federally-funded Food Supplement Nutrition Education program. Additional information about the program is attached at ©69-70.

Committee members expressed interest in understanding what fitness, nutrition, and obesity prevention education and services MCPS provides and how much is budgeted for these activities annually. MCPS written response attached at ©71-76 states that the school system addresses "the dangers of childhood obesity through both nutrition and physical education programs."

Marla Caplon with the MCPS Division of Food and Nutrition Services will discuss what the school system is doing to promote healthy eating and wellness. Betsy Brown with the Department of Curriculum and Instruction will talk about the school system's health and physical education curriculum and instruction and extracurricular physical and fitness activities.

ADDITIONAL RECOMMENDATIONS ON OBESITY PREVENTION

The Committees will hear from two groups that have identified strategies and developed recommendations for obesity prevention: Montgomery County Commission on Health and the Obesity Prevention Strategy Group.

Montgomery County Commission on Health

Marcos Pesquera and Ron Bialek will present to the Commission on Health recommendations on obesity prevention to the Committees. The presentation is included at ©77-148. In addressing the problem, the Commission identifies four things that County Government can do including (1) revising policies to integrate CDC recommended strategies; (2) serving as a model for the private sector, (3) creating an environment within the County that promotes strategies that can prevent or reduce obesity; and (4) taking policy action without increasing expenditures.

The Commission selected four of the 24 CDC recommended strategies to focus on:

- Community should improve the availability of affordable food and beverage choices in public service venues (see ©82-84).
- Community should provide incentives for the production, distribution, and procurement of foods from local farms. Communities should provide incentives to food retailers to locate in and/or offer healthier food and beverage choices in underserved areas (see ©84-85).
- Community should increase support for breastfeeding (see ©86-88).
- Communities should increase opportunities for extracurricular physical activity (see ©89-92).

Additional materials provided by the Commission are attached at ©96-148.

Montgomery County Obesity Prevention Strategy Group

Judy Stiles and Carol Garvey will provide information on the work and recommendations of the Montgomery County Obesity Prevention Strategy Group. The group is a public-private coalition dedicated to reversing the obesity trend in Montgomery County. The group's brochure, "Make a Move Montgomery: Take Action for a Healthier County," attached at ©149-150, identifies 11 recommendations in combating obesity and its resulting diseases in areas including Data Collection; Coordination/Infrastructure; Food Environment; Built Environment; Target Children/Youth; Target Adults and Seniors; Target Disadvantaged Communities; Target Healthcare Providers; Worksites; Public Safety; and Media.

The group describes on ©151 its current project to improve healthful behaviors in County employees. The group recommends changing vending machine options in County buildings by offering snacks that meet the guidelines developed by the Institute of Medicine and pricing items so that healthful items are not more expensive than items that do not meet IOM criteria.

Council staff comments:

That several county groups are actively working on the important issue of obesity prevention is very positive. Council staff understands that the groups have made efforts to link with each other and avoid duplicating efforts. However, the separate, but overlapping recommendations provided by the different groups, present some challenges in moving forward. Consequently, the Committees may want to explore the possibility of increasing coordination among the groups in order to develop a single, comprehensive, prioritized set of recommendations for reducing obesity and promoting healthy activities in the County that can inform policy and program development and resource allocation.

The packet contains the following attachments:

NCHS Data Brief ■ No. 82 ■ January 2012

Prevalence of Obesity in the United States, 2009–2010

Cynthia L. Ogden, Ph.D.; Margaret D. Carroll, M.S.P.H.; Brian K. Kit, M.D., M.P.H.; and Katherine M. Flegal, Ph.D.

Key findings

Data from the National Health and Nutrition Examination Survey, 2009–2010

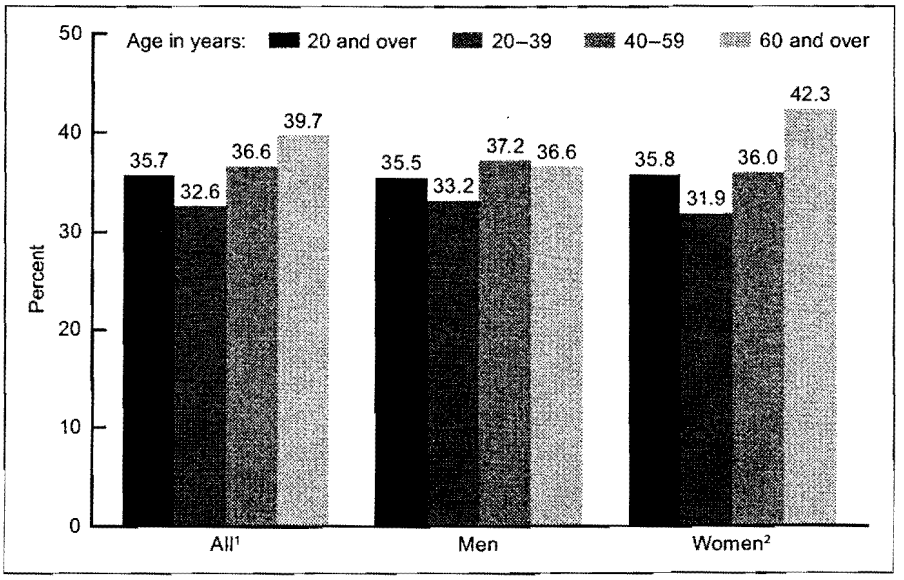
- More than one-third of adults and almost 17% of youth were obese in 2009–2010.
- There was no change in the prevalence of obesity among adults or children from 2007–2008 to 2009–2010.
- Obesity prevalence did not differ between men and women.
- Adults aged 60 and over were more likely to be obese than younger adults.

Obesity increases the risk of a number of health conditions including hypertension, adverse lipid concentrations, and type 2 diabetes (1). The prevalence of obesity in the United States increased during the last decades of the 20th century (2,3). More recently there appears to have been a slowing of the rate of increase or even a leveling off (4,5). Given the health risks of obesity and its high prevalence, it is important to continue to track the prevalence of obesity among U.S. adults and children. This report presents the most recent national estimates of obesity in the United States based on measured weight and height.

Keywords: National Health and Nutrition Examination Survey • adults • children

In 2009–2010, 35.7% of U.S. adults were obese.

Figure 1. Prevalence of obesity among adults aged 20 and over, by sex and age: United States, 2009–2010



[1]Significant increasing linear trend by age ($p < 0.01$).
[2]Significant increasing linear trend by age ($p < 0.001$).
NOTE: Estimates were age adjusted by the direct method to the 2000 U.S. Census population using the age groups 20–39, 40–59, and 60 and over.
SOURCE: CDC/NCHS, National Health and Nutrition Examination Survey, 2009–2010.

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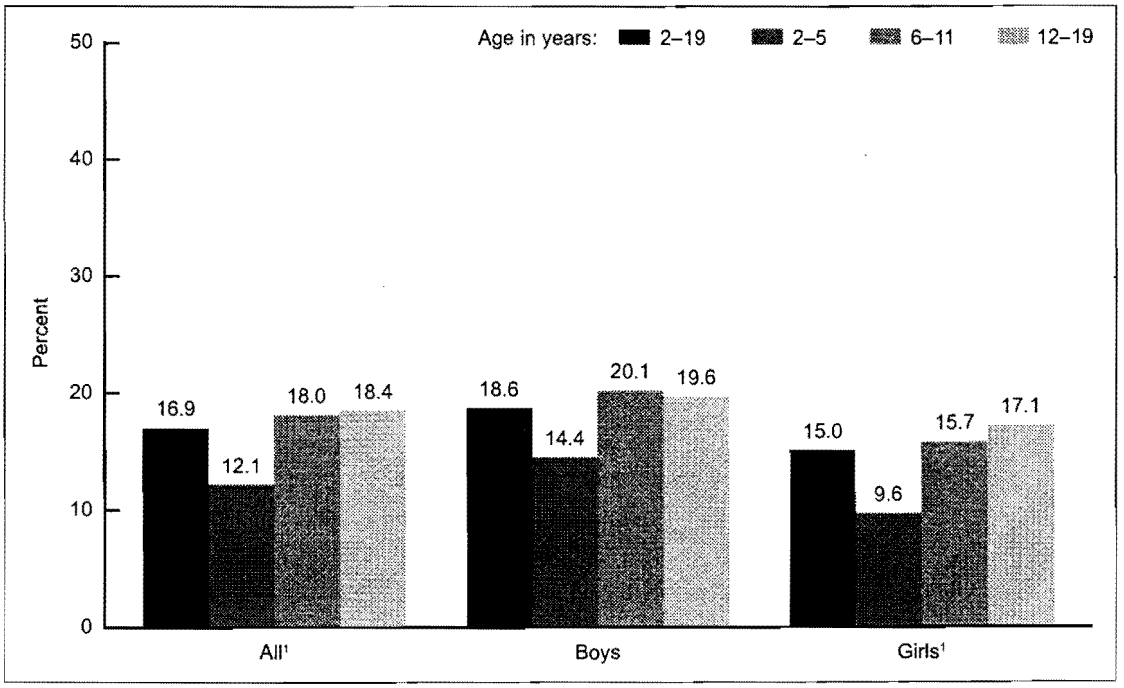
Centers for Disease Control and Prevention
National Center for Health Statistics

More than 35% of U.S. men and women were obese in 2009–2010. There was no significant difference in prevalence between men and women at any age. Overall, adults aged 60 and over were more likely to be obese than younger adults. Among men there was no significant difference in obesity prevalence by age. Among women, however, 42.3% of those aged 60 and over were obese compared with 31.9% of women aged 20–39 (Figure 1).

In 2009–2010, 16.9% of U.S. children and adolescents were obese.

The prevalence of obesity was higher among adolescents than among preschool-aged children (Figure 2). The prevalence of obesity was higher among boys than girls (18.6% of boys and 15.0% of girls were obese).

Figure 2. Prevalence of obesity among children and adolescents aged 2–19, by sex and age: United States, 2009–2010



[1]Significant increasing linear trend by age ($p < 0.005$).

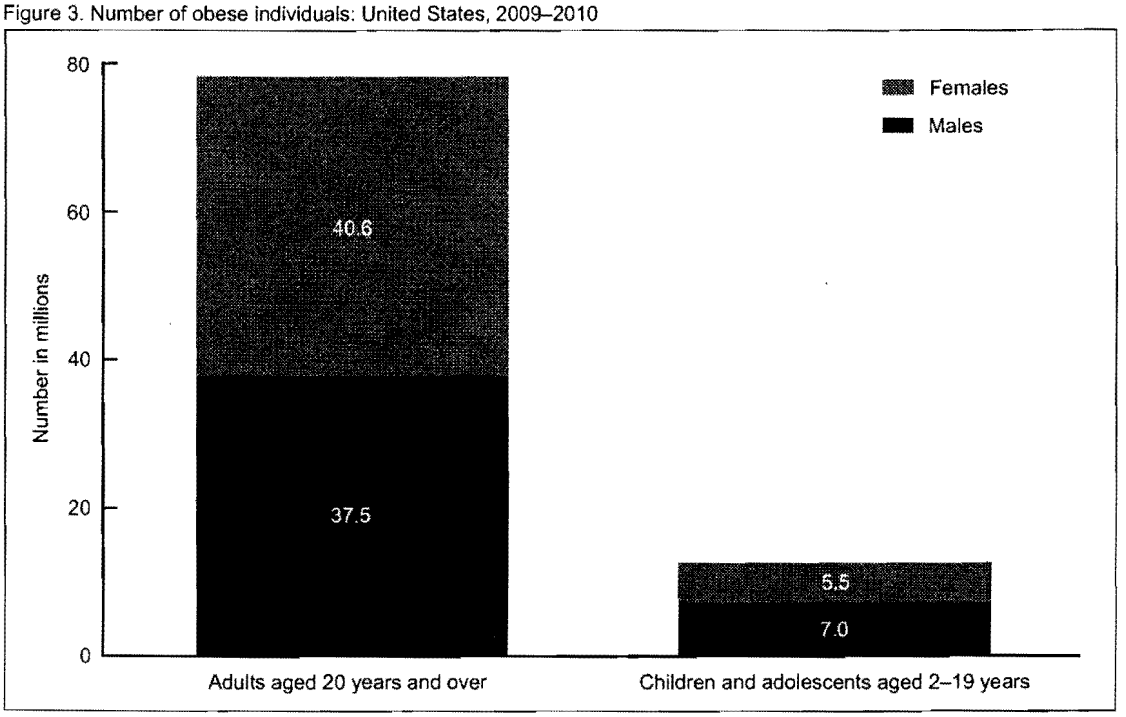
SOURCE: CDC/NCHS, National Health and Nutrition Examination Survey, 2009–2010.

(2)

In 2009–2010, over 78 million U.S. adults and about 12.5 million U.S. children and adolescents were obese.

Almost 41 million women and more than 37 million men aged 20 and over were obese in 2009–2010 (Figure 3). Among children and adolescents aged 2–19, more than 5 million girls and approximately 7 million boys were obese.

Figure 3. Number of obese individuals: United States, 2009–2010

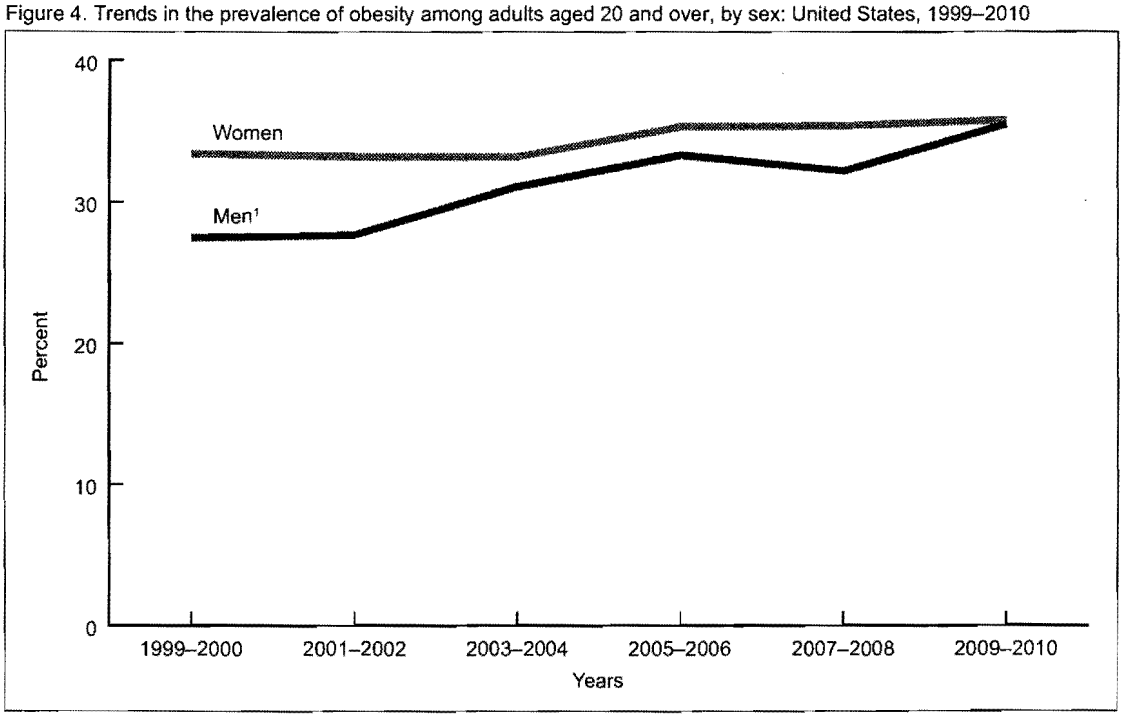


SOURCE: CDC/NCHS, National Health and Nutrition Examination Survey, 2009–2010.

Between 1999–2000 and 2009–2010, the prevalence of obesity increased among men but not among women.

In 1999–2000, 27.5% of men were obese, and by 2009–2010 the prevalence had increased to 35.5%. Among women, 33.4% were obese in 1999–2000 with no significant change in 2009–2010 (35.8%). In 1999–2000, the prevalence of obesity was higher in women than in men. Between 1999–2000 and 2009–2010, the difference in the prevalence of obesity between men and women decreased so that in 2009–2010, the prevalence of obesity in men was virtually equal to that in women (Figure 4). There was no significant change in the prevalence of obesity from 2007–2008 to 2009–2010 overall or among men or women.

Figure 4. Trends in the prevalence of obesity among adults aged 20 and over, by sex: United States, 1999–2010

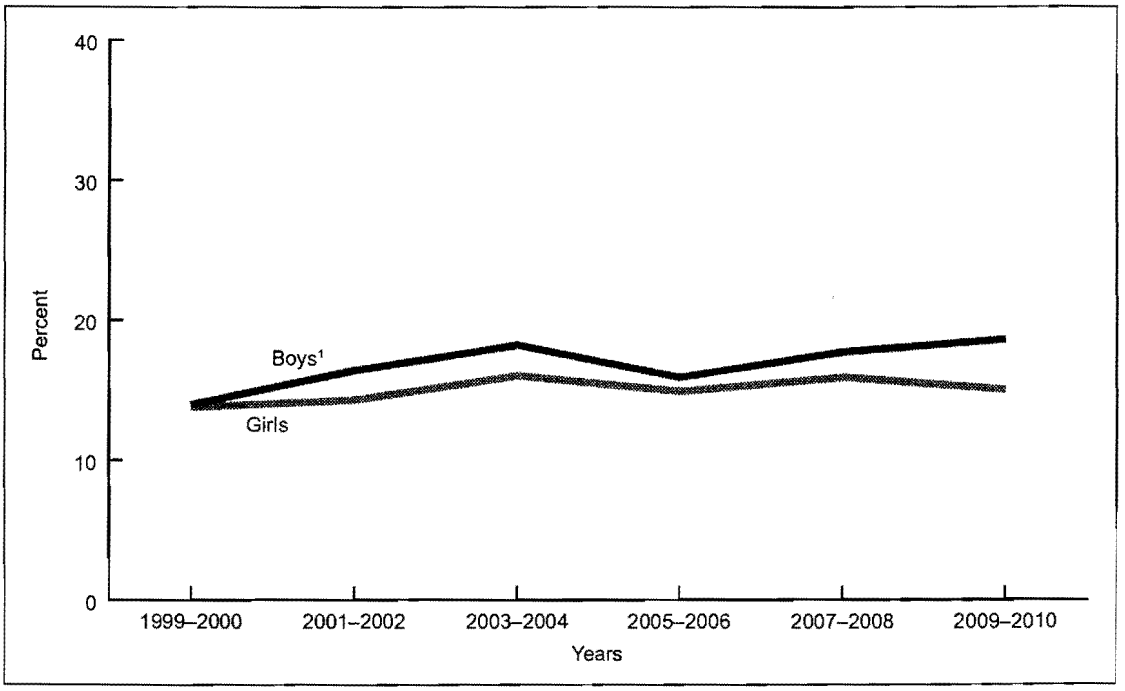


[1]Significant increasing linear trend 1999–2000 to 2009–2010 ($p < 0.0001$).
NOTE: Estimates were age adjusted by the direct method to the 2000 U.S. Census population using the age groups 20–39, 40–59, and 60 and over.
SOURCE: CDC/NCHS, National Health and Nutrition Examination Survey, 2009–2010.

Between 1999–2000 and 2009–2010, there was an increase in the prevalence of obesity among boys but not among girls.

The prevalence of obesity among boys increased from 14.0% in 1999–2000 to 18.6% in 2009–2010. There was no significant change among girls: the prevalence was 13.8% in 1999–2000 and 15.0% in 2009–2010 (Figure 5). There was no significant change in obesity prevalence from 2007–2008 to 2009–2010 overall or among boys or girls.

Figure 5. Trends in the prevalence of obesity among children and adolescents aged 2–19, by sex: United States, 1999–2010



[1]Significant increasing linear trend 1999–2000 to 2009–2010 ($p < 0.05$).
SOURCE: CDC/NCHS, National Health and Nutrition Examination Survey, 2009–2010.

5

Summary

The most recent national data on obesity prevalence among U.S. adults, adolescents, and children show that more than one-third of adults and almost 17% of children and adolescents were obese in 2009–2010. Differences in prevalence between men and women diminished between 1999–2000 and 2009–2010, with the prevalence of obesity among men reaching the same level as that among women.

Age differences in obesity prevalence varied between men and women. The prevalence of obesity was higher among older women compared with younger women, but there was no difference by age in obesity prevalence among men. Among children and adolescents, the prevalence of obesity was higher among adolescents than among preschool-aged children.

There has been no change in obesity prevalence in recent years; however, over the last decade there has been a significant increase in obesity prevalence among men and boys but not among women and girls overall. The Healthy People 2010 goals of 15% obesity among adults and 5% obesity among children were not met (6).

Definition

Obesity: Body mass index (BMI) was calculated as weight in kilograms divided by height in meters squared, rounded to one decimal place. Obesity in adults was defined as BMI greater than or equal to 30 (1). Examples of adult obesity cut points at specific heights are shown in the Table. The definition of obesity for children is not directly comparable with the definition for adults. Obesity in children was defined as a BMI greater than or equal to the age- and sex-specific 95th percentiles of the 2000 CDC growth charts (7).

Table. Obesity cut points for adults 5'4" and 5'9" in height

Height	Obesity weight range
5'4"/1.63 meters	174 pounds or more/79 kilograms or more
5'9"/1.75 meters	203 pounds or more/92 kilograms or more

Data source and methods

The National Health and Nutrition Examination Surveys (NHANES) conducted from 1999 through 2010 were used for these analyses. NHANES is a cross-sectional survey designed to monitor the health and nutritional status of the civilian noninstitutionalized U.S. population (8). The survey consists of interviews conducted in participants' homes, standardized physical examinations conducted in mobile examination centers, and laboratory tests utilizing blood and urine specimens provided by participants during the physical examination.

The NHANES sample is selected through a complex multistage probability design that includes selection of primary sampling units (counties), household segments within the counties, households within household segments and, finally, sample persons from selected households. In 2009–2010, non-Hispanic black and Hispanic persons, persons with low income, and those aged 60 and over were oversampled in order to obtain reliable estimates of health and nutritional measures for these population subgroups. In 1999, NHANES became a continuous survey fielded on an ongoing basis. Each year of data collection is based on a representative sample covering all ages of the civilian noninstitutionalized population. Public-use data files are released in 2-year cycles.

(6)

Sample weights, which account for the differential probabilities of selection, nonresponse, and noncoverage, are incorporated into the estimation process. All variance estimates accounted for the complex survey design by using Taylor series linearization.

Estimates of the number of obese individuals were calculated using the average Current Population Survey totals for 2009–2010 (available from: http://www.cdc.gov/nchs/nhanes/response_rates_CPS.htm).

Prevalence estimates for the total adult population were age adjusted using the direct method to the 2000 U.S. Census population using the age groups 20–39, 40–59, and 60 and over. Differences between groups were tested using a univariate t statistic at the $p < 0.05$ significance level. All differences reported are statistically significant unless otherwise indicated. Adjustments were not made for multiple comparisons. Statistical analyses were conducted using the SAS System for Windows (release 9.1; SAS Institute, Cary, N.C.) and SUDAAN (release 9.0; RTI International, Research Triangle Park, N.C.).

About the authors

Cynthia L. Ogden, Margaret D. Carroll, and Brian K. Kit are with the Centers for Disease Control and Prevention's (CDC) National Center for Health Statistics (NCHS), Division of Health and Nutrition Examination Surveys. Katherine M. Flegal is with CDC's NCHS, Office of the Director.

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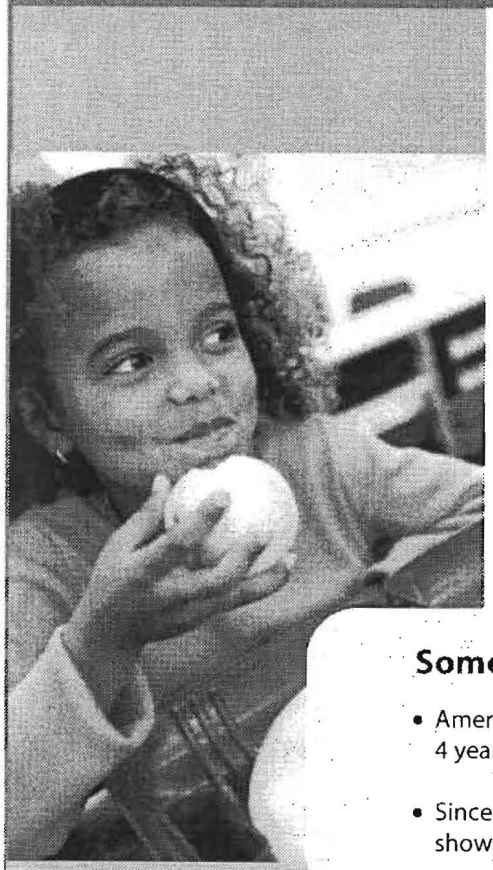
Obesity Among Low-Income Preschool Children



1 of 3 Children Are Obese or Overweight Before Their 5th Birthday

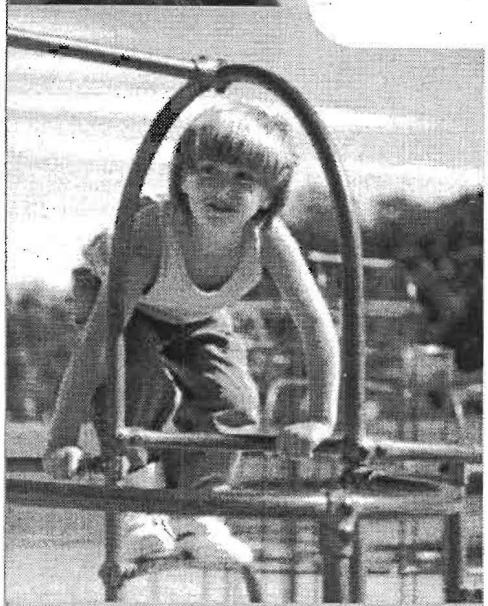
According to the 2009 *Pediatric Nutrition Surveillance System* (PedNSS) data, nearly one-third of the 3.7 million low-income children aged two to four years surveyed were obese or overweight, and 541,000 were obese.
Learn more at: *www.cdc.gov/obesity/childhood/lowincome.html*.

Health Risk Now and Later for Obese Children

- Obese children are more likely to have high blood pressure, high cholesterol, and type 2 diabetes, which are risk factors for cardiovascular disease.
- Obese children are more likely to become obese adults.
- The tracking of body mass index (BMI) that occurs from early childhood to adulthood has been documented, and early adiposity rebound in young children is associated with increased risk of obesity in young adulthood. [1,2]

Some Children Burdened More Than Others

- American Indian and Alaska Native (20.7%) and Hispanic (17.9%) children aged 2 to 4 years have the highest rates of obesity.
- Since 2003, American Indian and Alaska Native children are the only ones that have shown a significant increase in obesity rates (1.7%) since 2003.



Overweight for children is defined as a BMI at or above the 85th and less than the 95th percentile, and obesity is defined as a BMI greater than the 95th percentile for age and gender per the 2000 CDC Growth Charts.
See www.cdc.gov/growthcharts.

Importance of Reaching Low-Income Families

- According to the U.S. Census, in 2009, the number of U.S. people in poverty is the largest number in the 51 years poverty estimates have been published.
- Low-income families generally have less access to both healthy food choices and opportunities for physical activity. Many need nearby retail stores that provide healthy, affordable foods, as do many rural and predominantly minority communities. At the same time, many low-income communities lack or have restricted access to sidewalks, green space, parks, and recreation centers that may be perceived as unsafe; all are possible barriers to leisure time physical activity.
- More families are turning to public health programs, such as the *Special Supplemental Nutritional Program for Women, Infants and Children Program* (WIC), to meet the needs of their children younger than 5 years.

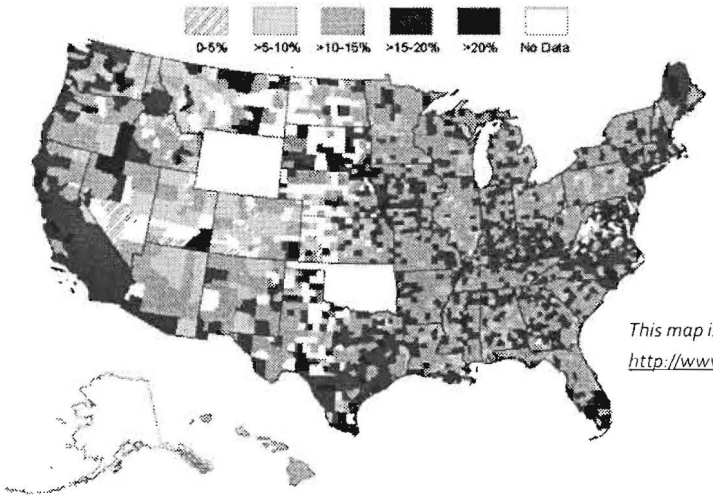
The PedNSS is a child-based public health surveillance system that describes the nutritional status of low-income U.S. children who attend federally-funded maternal and child health and nutrition program, primarily the WIC Program.
Learn more at: http://www.cdc.gov/PedNSS.

Obesity Rates Among U.S. Low-Income Preschool Children

Obesity Rates Exceed Health Goals

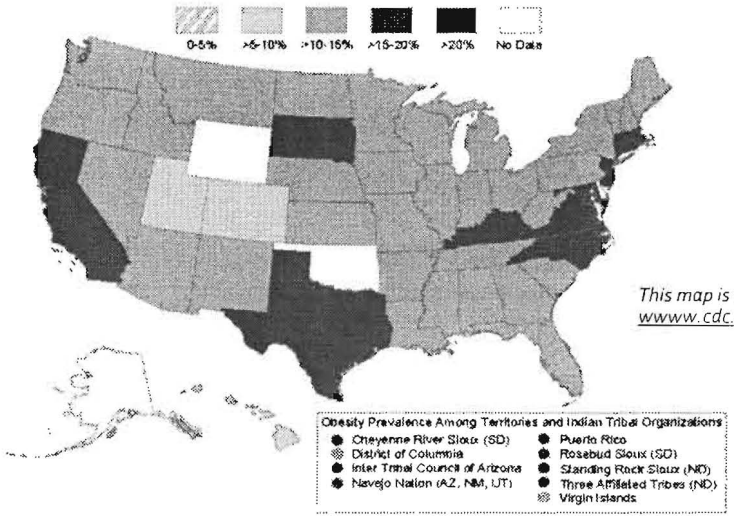
Few states, U.S. territories, or Indian Tribal Organizations had an obesity rate among low-income preschoolers participating in the 2009 PedNSS at or less than the *Healthy People 2020* target of 9.6%.

2007–2009 County Obesity Prevalence Among Low-Income Children Aged 2 to 4 Years



This map is accessible at
http://www.cdc.gov/obesity/childhood/lowincome.html

2009 State Obesity Prevalence Among Low-Income Children Aged 2 to 4 Years



This map is accessible at
wwww.cdc.gov/obesity/childhood/lowincome.html

Key Statistics

- 1 of 7 low-income, preschool-aged children is obese.
- 37.4% of counties with at least 100 records in the PedNSS have childhood obesity rates exceeding 15%.
- 5.5% of such counties have childhood obesity rates exceeding 20%.
- In 2009, American Indian or Alaska Native children had the highest prevalence of obesity (20.7%), followed by Hispanic (17.9%), n Hispanic white (12.3%), non-Hispanic black (11.9%), and Asian/Pacific Islander (11.9%) children. The only increase in obesity rates since 2004 occurred among American Indian or Alaska Native children (1.7% increase).
- County obesity rates are variable within states. Even states with the lowest prevalence of obesity have counties where many income children are obese and at risk for chronic diseases.

Obesity Rates Among U.S. Low-Income Preschool Children

Action on Early Childhood Obesity: Priority Strategies

Increasing Physical Activity

- Priority strategies include increasing access with informational outreach, and conducting community-wide campaigns.
- Use the CDC's *State Indicator Report on Physical Activity, 2010*, to identify your state's needs, develop solutions, and work together within your community to promote physical activity among young children and their families. Available at http://www.cdc.gov/physicalactivity/downloads/PA_State_Indicator_Report_2010_Indicators.pdf.
- Access national guidelines at http://www.cdc.gov/physicalactivity/everyone/guidelines/children.html and http://www.aahperd.org/naspe/standards/nationalGuidelines/ActiveStart.cfm.

Increasing Fruit and Vegetable Consumption

- Priority strategies include starting or expanding *Farm to Where You Are* programs (e.g., farm to school, farm to health care, and farmers markets in communities), improving retail access, and promoting food policy councils.
- Use CDC's *State Indicator Report on Fruits and Vegetables, 2009*, to identify your state's needs, develop solutions, and work together within your community to promote fruits and vegetables. Available at http://www.fruitsandveggiesmatter.gov/health_professionals/statereport.html.
- Learn more about the WIC food package revisions that improves retail access to farmer's markets. Available at http://www.fns.usda.gov/wic/benefitsandservices/foodpkgallowances.HTM.
- Research-tested interventions, including a nutrition and physical activity self-assessment tool, resources related to *Eat Well Play Hard* in Child Care Settings, *KaBOOM*, and supporting communities to build play spaces, are accessible at www.center-trt.org.

Reducing Energy Dense Food and Sugar Consumption

- Priority strategies include ensuring that regulations and policies at all levels promote healthier foods and beverages in places where young children eat. Limiting access to sugar beverages and applying nutrition standards in child care settings are priority strategies.
- Standards for preventing obesity in early care and education programs are available at http://nrckids.org/CFOC3/PREVENTING_OBESITY/index.htm.
- Access *Head Start Body Start!* Resources for promoting physical activity and healthy eating are available at http://www.aahperd.org/headstartbodystart/.

Breastfeeding Initiation and Duration

- Priority strategies include developing state coalitions to support breastfeeding and implementing supports in maternity care and work site settings.
- Access state results on the *Maternity Care Practices Survey* at http://www.cdc.gov/breastfeeding/data/mpinc/index.htm.
- Use the *CDC Breastfeeding Report Card* to identify your state's needs, develop solutions, and work together within your community to promote and support breastfeeding. Also access the *CDC Guide to Breastfeeding Interventions at* http://www.cdc.gov/breastfeeding/resources/index.htm.
- The *WIC Program* is expanding breastfeeding peer counseling services. Learn more at http://www.fns.usda.gov/wic/resources/.
- Read the latest national breastfeeding recommendations at http://www.surgeongeneral.gov/topics/breastfeeding/index.html.

Obesity Rates Among U.S. Low-Income Preschool Children

Action on Early Childhood Obesity: Priority Strategies

Decreasing Television Viewing

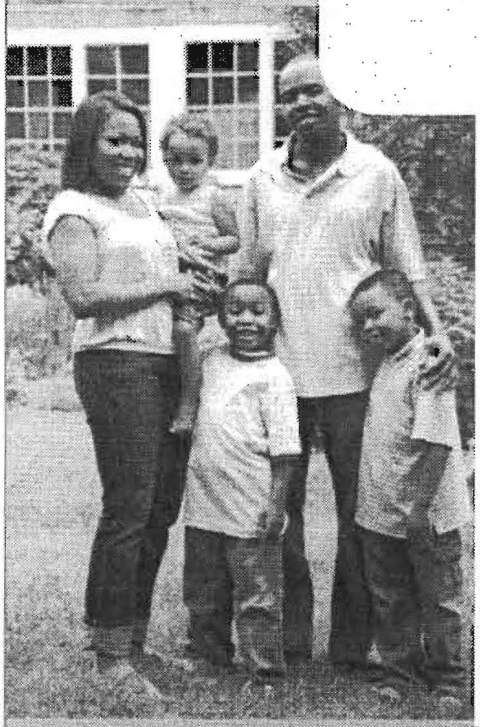
- Priority strategies include establishing policies to limit TV viewing in childcare settings. Childcare providers are sharing responsibility with parents for children during important developmental years.
- Research links eating nutritious food and limited screen-time, to more healthy childhood weight. Young children need places and time to play instead of watching television In addition, foods high in sugar, fat, and salt are highly advertised on television, influencing children's eating habits.[3,4,5,6]
- Apply television and screen-time standards recommended by the *American Academy of Pediatrics*. Learn more at http://aappolicy.aappublications.org/cgi/content/full/pediatrics;107/2/423.

First Lady Obama Launches Let's Move

- Seeks to eliminate obesity in a generation.
- Campaign's main points of action are
  - Empowering parents and care givers,
  - Providing healthy food in schools,
  - Improving access to healthy affordable foods.

LET'S MOVE!

http://www.letsmove.gov/



CDC State and Community Obesity Programs and Recommended Strategies

Through the *Nutrition and Physical Activity Program to Prevent Obesity and Other Chronic Diseases*, and the *Communities Putting Prevention to Work initiatives*, CDC provides funding to all 50 states to invest in policy, system and environmental approaches to improve dietary quality, increase physical activity, and reduce obesity. Visit *CDC's State-Based Nutrition and Physical Activity Program to Prevent Obesity and Other Chronic Disease* at http://www.cdc.gov/obesity/stateprograms/statestories.html. Read about *Communities Putting Prevention to Work* at http://www.cdc.gov/chronicdisease/recovery/.

CDC Recommended Community Strategies and Measurements to Prevent Obesity in the United States, 2009, offers guidance to improve local policies and the physical environment that influence daily choices that affect our health. Learn more at http://www.cdc.gov/obesity/downloads/community_strategies_guide.pdf.

NCCHPHP Atlanta
Centers for Disease Control and Prevention
1600 Clifton Road, NE, Atlanta, GA 30333
Telephone: 1-800-CDC-INFO (232-4636)
TTY – 1888-232-63548
Email: cdcinfo@cdc.gov
Web: wwwcdc.gov

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1. Freedman DS, Kettel-Khan L, Serdula M, Dietz WH, Srinivasan SR, Berenson GS. The relation of childhood BMI to adult adiposity: The Bogalusa Heart Study. *Pediatrics* 2005;115(1):22-27.
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Presentation to HHS Committee, County Council
July 30, 2012

Childhood Obesity Update

Montgomery County

Department of Health and Human Services
Public Health Service, Planning and Epidemiology

(13)

Health And Well-Being Status of Children: Data Limitations

- While some sources exist to capture weight status on children, there are substantial limitations on their utility due to:
  - Population(s) being measured,
  - Differences in the sampling methods, and the biases the methods introduce
  - Lack of comparability to other state and/or federal data sources

Data Sources Include

Current

- Maryland Behavioral Risk Factor Surveillance System (MD BRFSS)
- Maryland Healthcare Services Cost Review Commission (HSCRC)
- Women's Infants and Children (WIC) data reported through Pediatric Nutrition Surveillance System (PedNSS)

Future

- 2013 Maryland Youth Risk Behavior Survey (MD YRBS)
- 2014+ Maryland Health Information Exchange
  - Stage 1 Meaningful Use data elements include Height/Weight measurements at each encounter

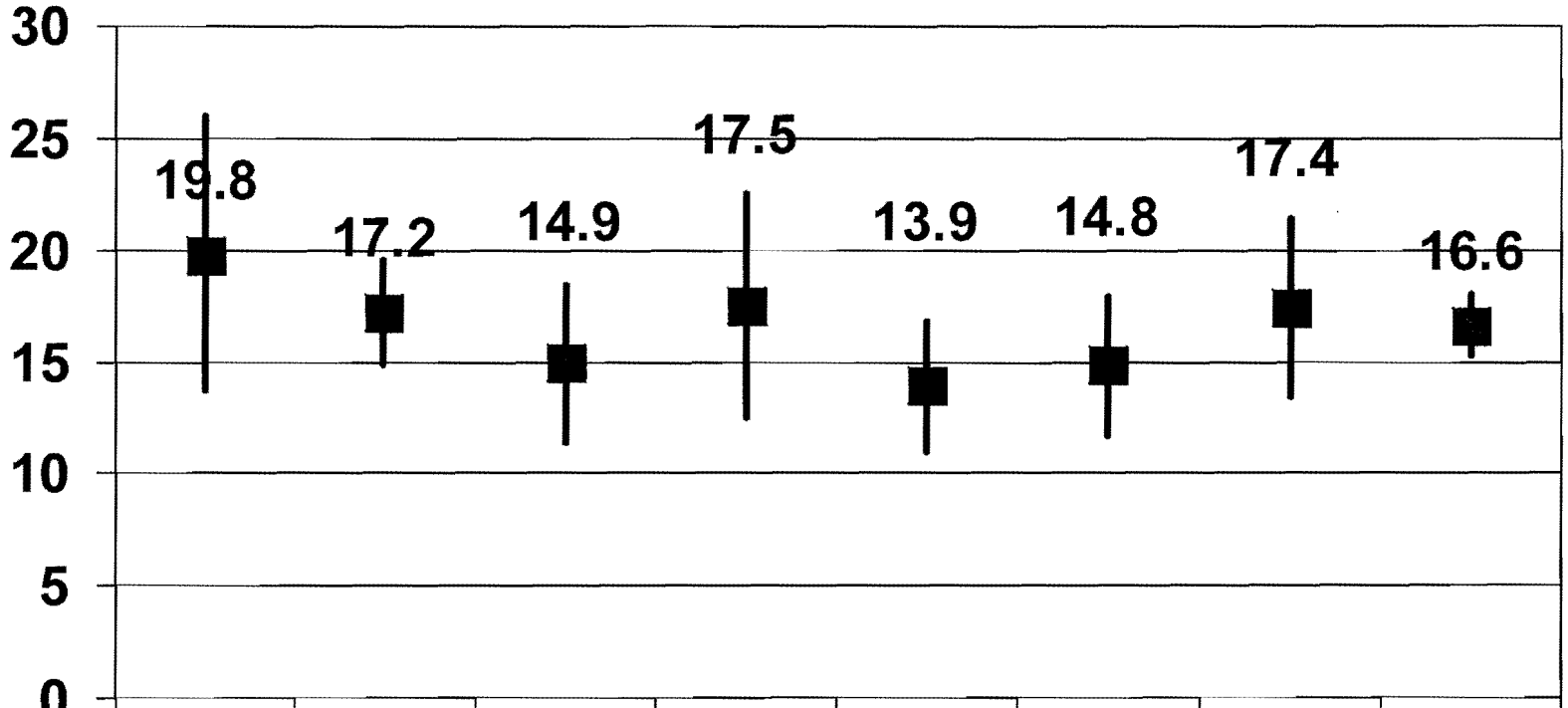
Maryland BRFSS: Limitations

- Telephone-based survey of Maryland adult residents with a land line *(efforts underway to build in mobile phones into sample)*
- Sampling frame is representative of Maryland but not sampled to be representative Maryland jurisdictions
  (Montgomery County residents comprise 16.5% of state sample (1,000 of 9,100)
- Includes a module that compiles select attributes on children in household as reported by the adult, low responses among adult households with children limits ability to attributes for children by subgroups (like age, race/ethnicity)
- No other standardized data collection tool currently exists to capture <u>population-wide</u> estimates on children in Montgomery County (until YRBS comes online to capture children IN school)

Maryland Behavioral Risk Factor Surveillance System

Overweight means BMI = 25.0 - 29.9

Percent of Overweight* Children by select jurisdictions, 2008-2010



	Baltimore City	Baltimore Metro	Mont-gomery	Prince Georges	Eastern Shore	Northwest	Southern	All Maryland
lower 95% CI	13.7	14.8	11.4	12.5	11	11.7	13.4	15.3
upper 95% CI	26	19.6	18.4	22.5	16.8	17.9	21.4	18
■ Estimate	19.8	17.2	14.9	17.5	13.9	14.8	17.4	16.6

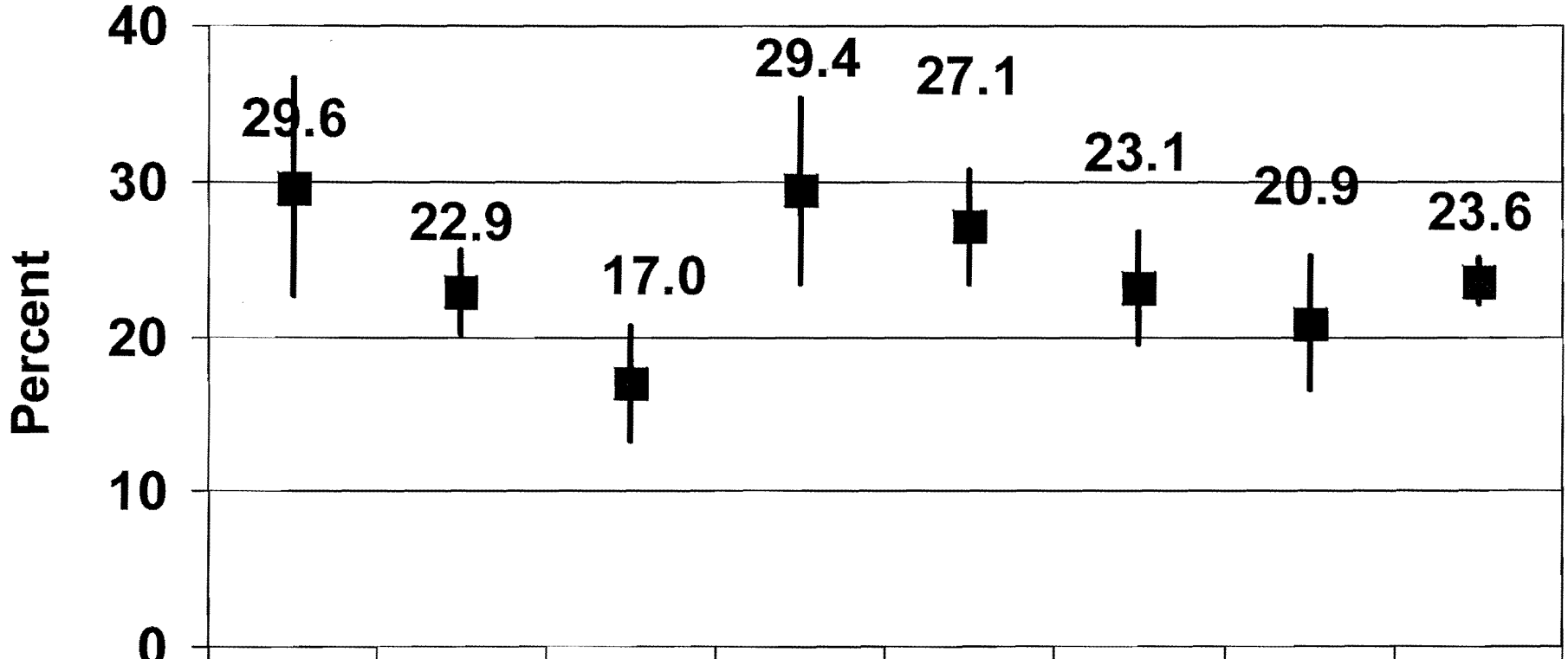
** Excluding obese children*

17

Maryland Behavioral Risk Factor Surveillance System

Obese means BMI = 30.0 and up

Percent of Obese Children by select jurisdictions, 2008-2010 Combined

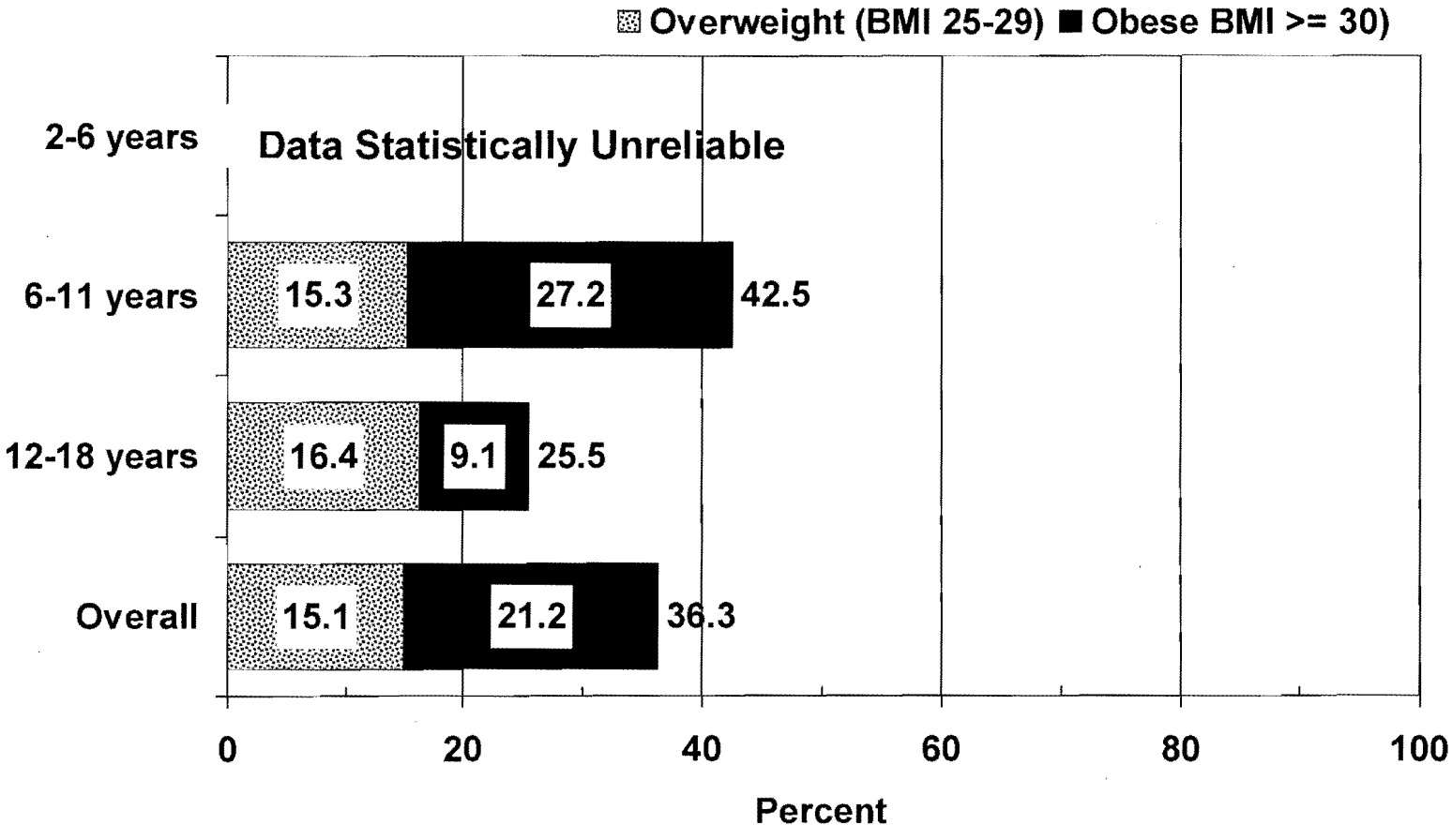


	Baltimore City	Baltimore Metro	Mont-gomery	Prince Georges	Eastern Shore	Northwest	Southern	All Maryland
lower 95% CI	22.6	20.2	13.3	23.4	23.4	19.5	16.6	22.1
upper 95% CI	36.6	25.6	20.7	35.4	30.8	26.8	25.2	25.1
■ Estimate	29.6	22.9	17.0	29.4	27.1	23.1	20.9	23.6

Montgomery County is statistically significantly LOWER in percent of obese children 2-17 years from 2008-2010 combined

Maryland Behavioral Risk Factor Surveillance System

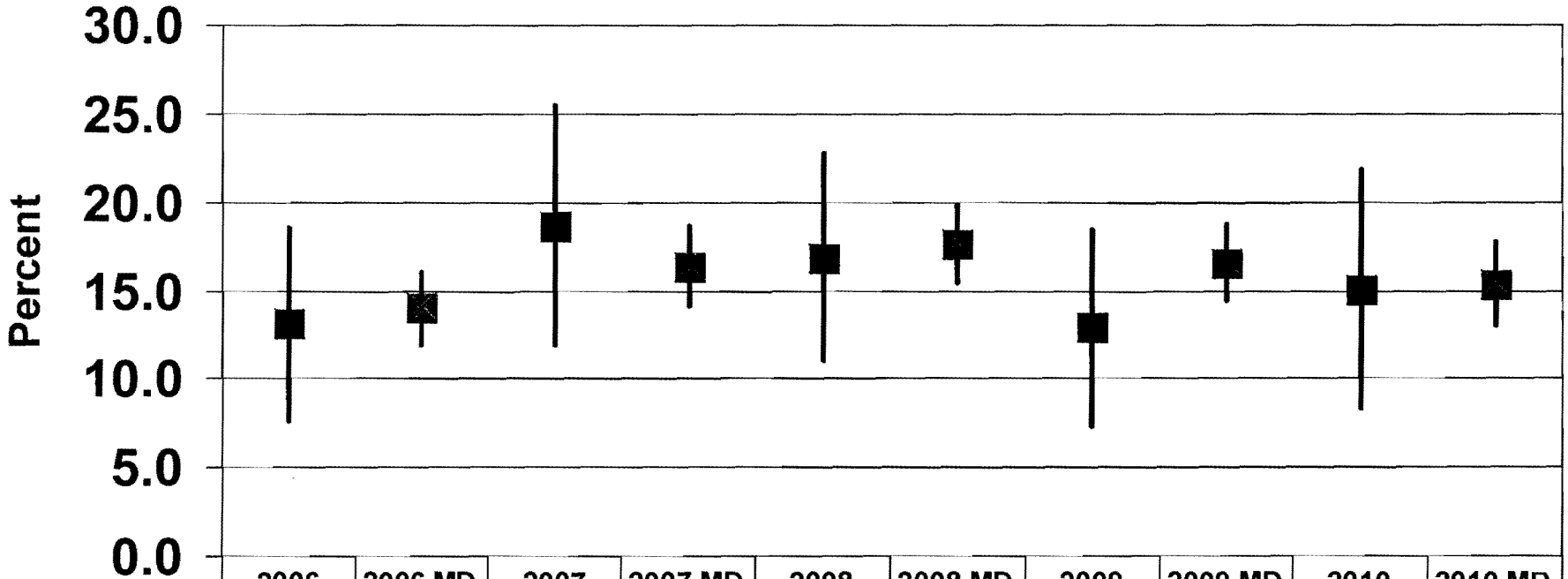
Montgomery County Children Reported Being Overweight or Obese By Age, 2010



Maryland Behavioral Risk Factor Surveillance System

Overweight means BMI = 25.0 - 29.9

Overweight Children in Montgomery County and Maryland, 2006-2010

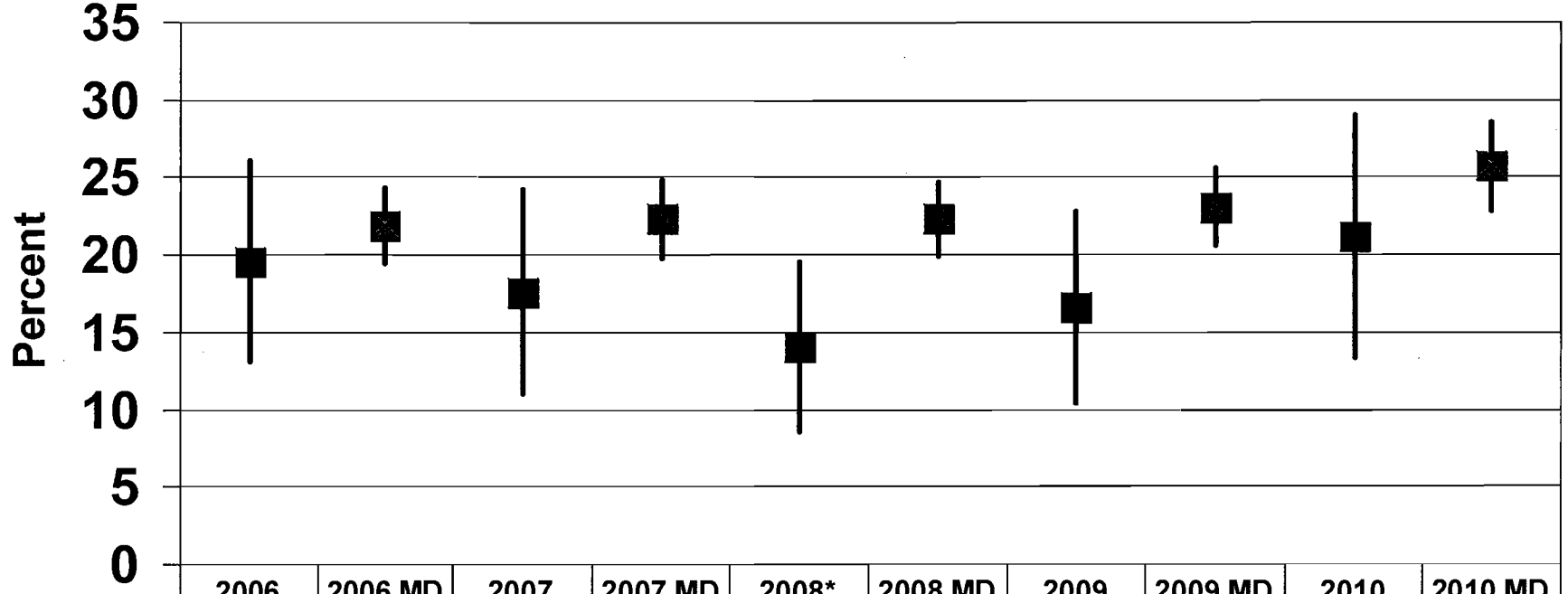


	2006	2006 MD	2007	2007 MD	2008	2008 MD	2009	2009 MD	2010	2010 MD
lower 95% CI	7.6	11.9	11.9	14.1	11.0	15.5	7.3	14.4	8.3	13.0
upper 95% CI	18.6	16.1	25.5	18.7	22.8	19.9	18.5	18.8	21.9	17.8
■ Estimate	13.1	14.0	18.7	16.4	16.9	17.7	12.9	16.6	15.1	15.4

No statistically significant change in percent of overweight (but not obese) children 2-17 years from 2006-2010

Obese means BMI = 30.0 and up

Obese Children in Montgomery County and Maryland, 2006-2010



	2006	2006 MD	2007	2007 MD	2008*	2008 MD	2009	2009 MD	2010	2010 MD
lower 95% CI	13.1	19.4	11	19.8	8.6	19.9	10.4	20.6	13.4	22.8
upper 95% CI	26.1	24.4	24.2	24.8	19.6	24.7	22.8	25.6	29	28.6
■ Estimate	19.6	21.9	17.6	22.3	14.1	22.3	16.6	23.1	21.2	25.7

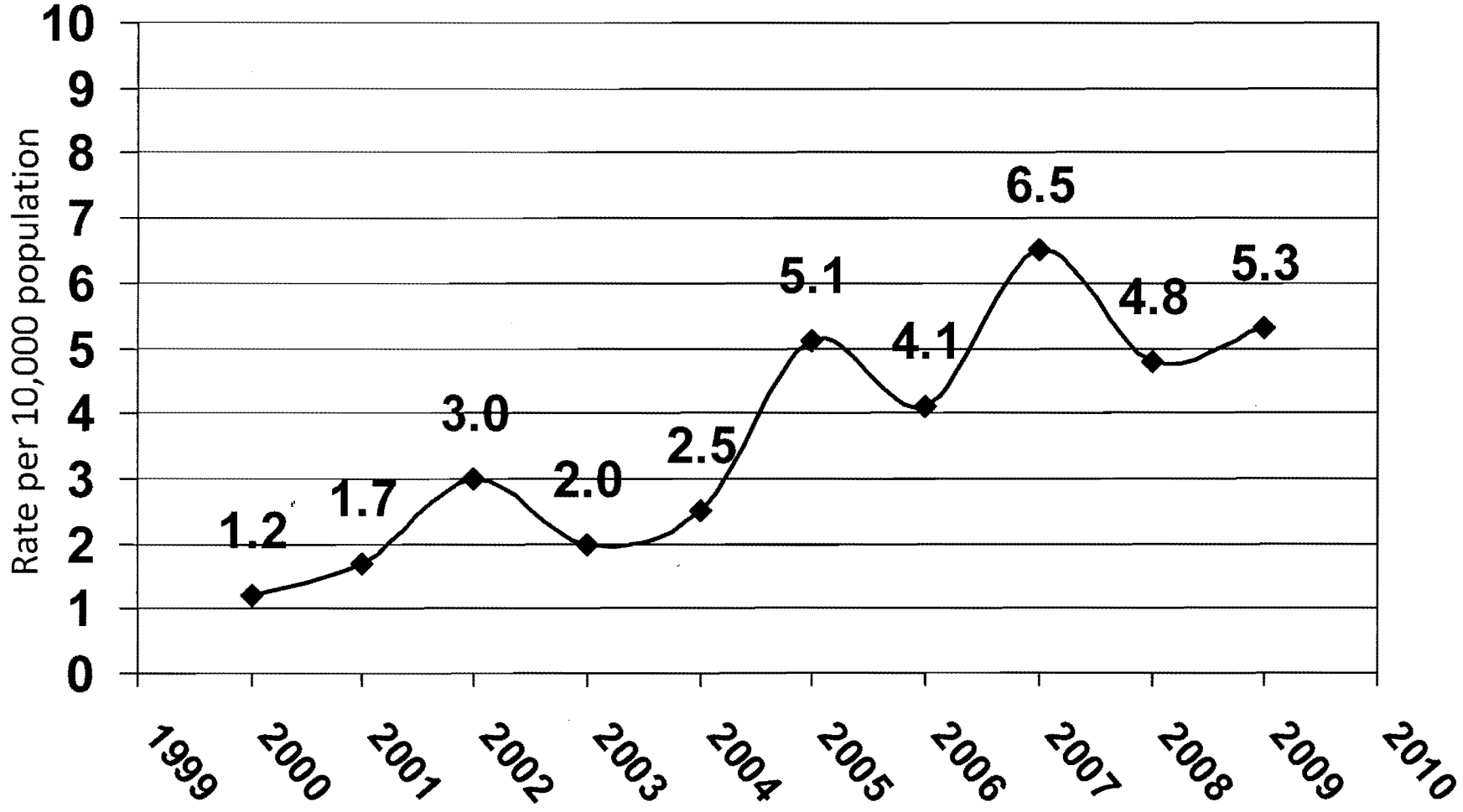
No statistically significant change in percent of Montgomery County obese children 2-17 years from 2006-2010.

*In 2008 Montgomery County had a statistically significant lower percent of obese children compared to Maryland.

Maryland HSCRC: Limitations

- Data for all encounters by Montgomery residents to Maryland hospitals; Multiple encounters could be for one resident
- Hospital admissions capture seriously ill childhood population and not the whole county population of children (predominantly healthy).
- In 2008, approximately 6% of Maryland hospital discharges among children 5-19 years cited obesity as part of the reason for hospital stay.

Hospital Discharges with Obesity as Co-Morbidity for Young People, Ages 5-19, per 10,000 County Residents, 2000-2009



Maryland Youth Risk Behavior Survey - 2013

- Survey of middle and high school students
- Self-reported
- Captures health and well-being risk factors in addition to weight status (self-report)
- County-level estimates can be compared to state and national estimates for benchmarking

Selection of Potential 2013 YRBS Indicators Related to Weight Status

(by age, grade, gender, race/ethnicity, and risk factors)

- Percent of students that are overweight
- Percent of students that are obese
- Percent of students that describe themselves as slightly or very overweight
- Percent of students that did not eat vegetables
- Percent of students that drank a can, bottle, or glass of soda or pop three or more times per day

WIC-PedNSS

- Data are based on low-income children participating in WIC and not representative of diverse socio-demographic composition of children in the County.
- HHS does not have reliable data to update what was reported in 2007.

HIE

- As part of the rollout of the Health Information Exchange, Stage I Meaningful Use includes biometric measurements of patient- including height and weight.
- Upon completion of MHCC HIE regulations and policies- the access, roles and responsibilities of providers, LHDs, researchers and others in the HIE to acquire aggregate reports (secondary use) will better frame how HHS will be able to access and report on BMI of Montgomery County patients in the HIE.

Healthy Montgomery Obesity Work Group
Montgomery County Obesity Profile
July 19, 2012

Prepared by:
Rachel Simpson, BS
Colleen Ryan-Smith, MPH
Ruth Martin, MPH, MBA
Hawa Barry, BS

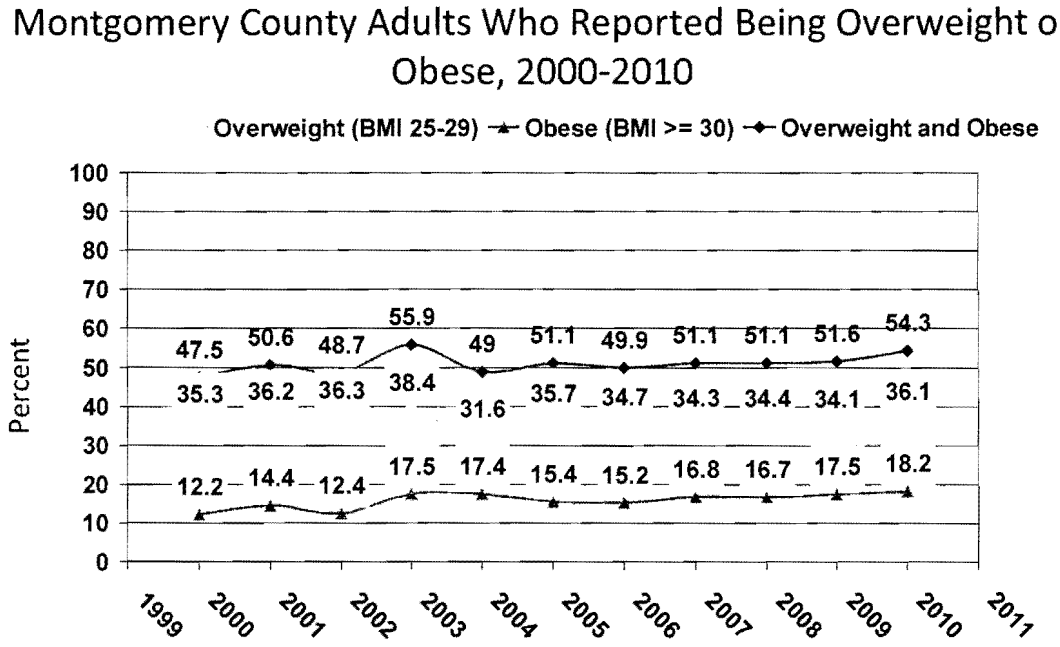
Executive Summary

- Over half (54.3%) of all adults in Montgomery County are overweight or obese.
- More African American/Black and Hispanic adults are overweight and obese compared to adults of other races.
- Nearly four out of every ten children (36.3%) in Montgomery County are overweight and obese.
- Since 2000, the rate of hospitalizations per 10,000 residents with a primary or secondary diagnosis of obesity has increased three-fold for adults and more than four-fold for children.
- Asians and African Americans/Blacks are less likely to engage in recommended moderate physical activity and leisure time physical activity than other racial ethnic groups.
- Chronic diseases and conditions, such as high blood pressure, high cholesterol and diabetes, are related to overweight and obesity, and are experienced in a large proportion of Montgomery County residents.
- High blood pressure affects nearly one in four adults (24.5%) in Montgomery County, and is a frequent reason for hospital visits among County residents.
- In Montgomery County, women are more likely than men to have high blood pressure; seniors are more likely than younger age groups to have high blood pressure; and African Americans/Blacks are more likely than other race groups to have high blood pressure.
- Over a third of Montgomery County adults have high cholesterol. Women are more likely than men to have high cholesterol and Asians are more likely than individuals of other race groups to have high cholesterol.
- Diabetes is the eighth leading cause of death among Montgomery County residents and is a frequent reason for hospital visits among residents.
- Seniors are more likely than adults of younger ages to have diabetes and adults who are overweight or obese are more likely to have diabetes than adults of healthy weight.

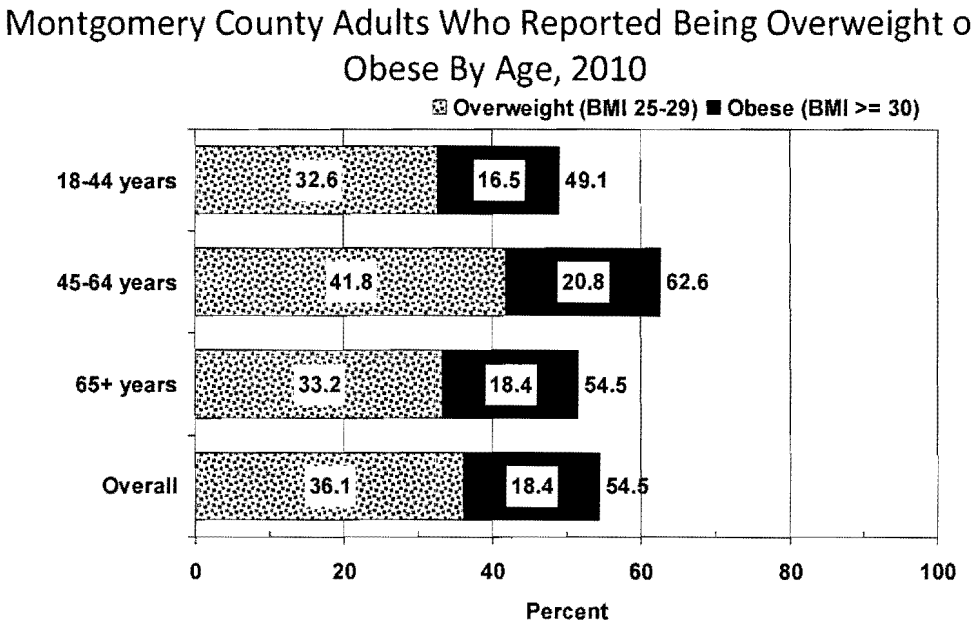
Obesity, Physical Activity and Healthy Eating in Montgomery County

Obesity

According to the 2010 Behavioral Risk Factor Surveillance Survey (BRFSS), 54.3% of adult respondents in Montgomery County were either overweight or obese. Since 2000, the percent of adult respondents in Montgomery County who were obese has increased from 12.2% to 18.2%.

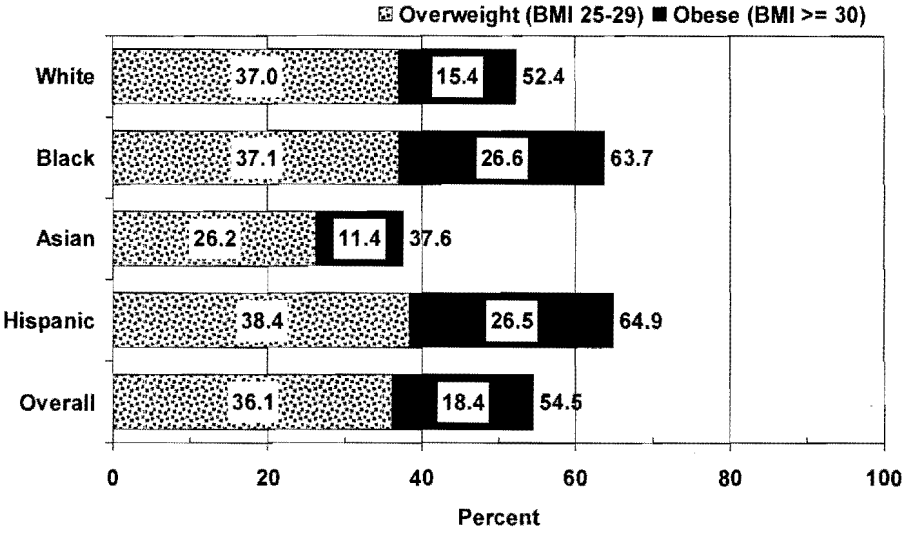


As shown in the figure below, middle-aged adults were more likely to be overweight or obese than other age groups and may be likely to carry their additional weight into old age.



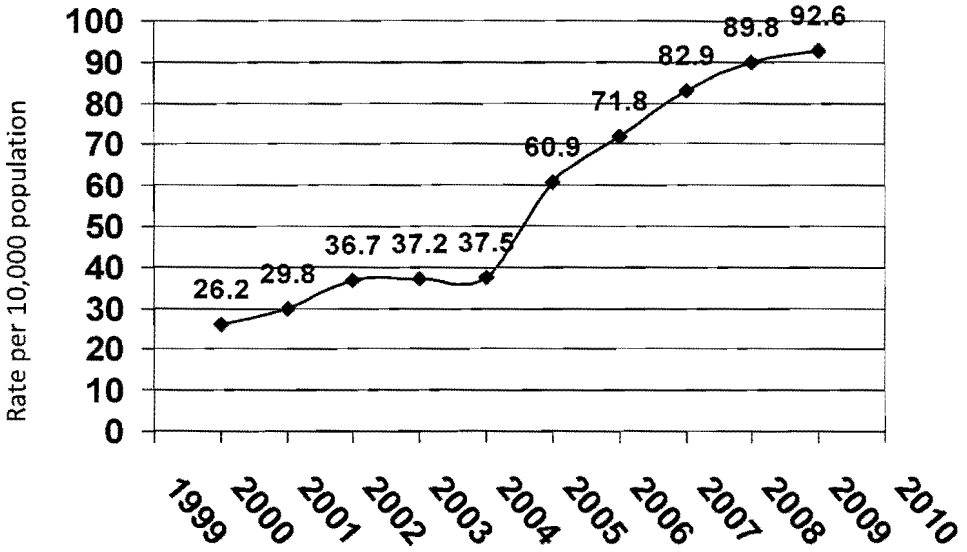
More men (63.2%) than women (46.0 %) were overweight or obese: more African Americans/Blacks and Hispanics were overweight or obese than individuals of other races.

Montgomery County Adults Who Reported Being Overweight or Obese By Race/Ethnicity, 2010

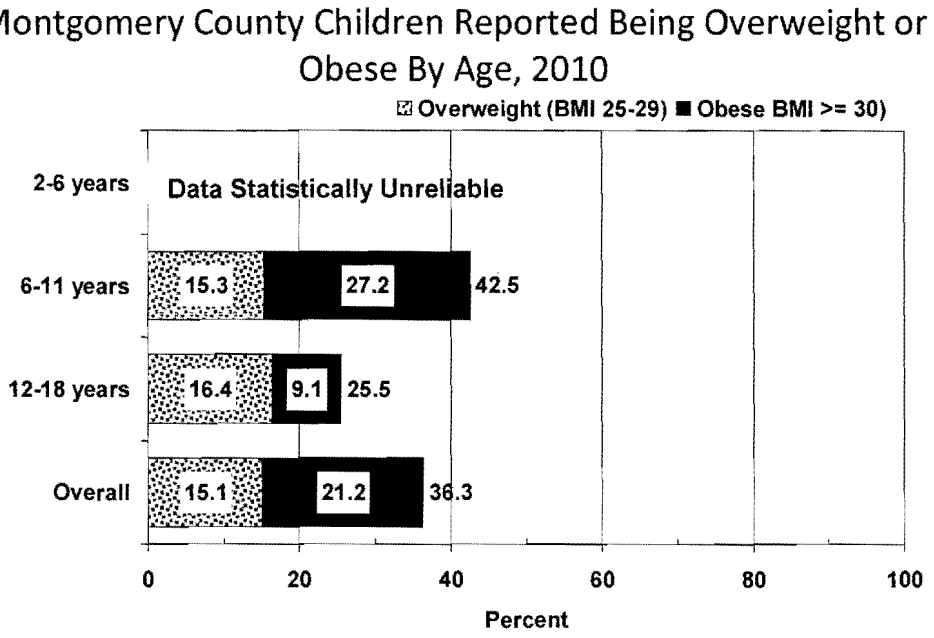


Since 2000, obesity has become increasingly prevalent in hospital discharges for Montgomery County residents. During the period 2000-2009, the rate of adult hospital discharges with obesity as co-morbidity that required medical attention during the hospital stay per 10,000 county residents rose three-fold.

Hospital Discharges with Obesity as Co-Morbidity for Adults per 10,000 County Residents, 2000-2009

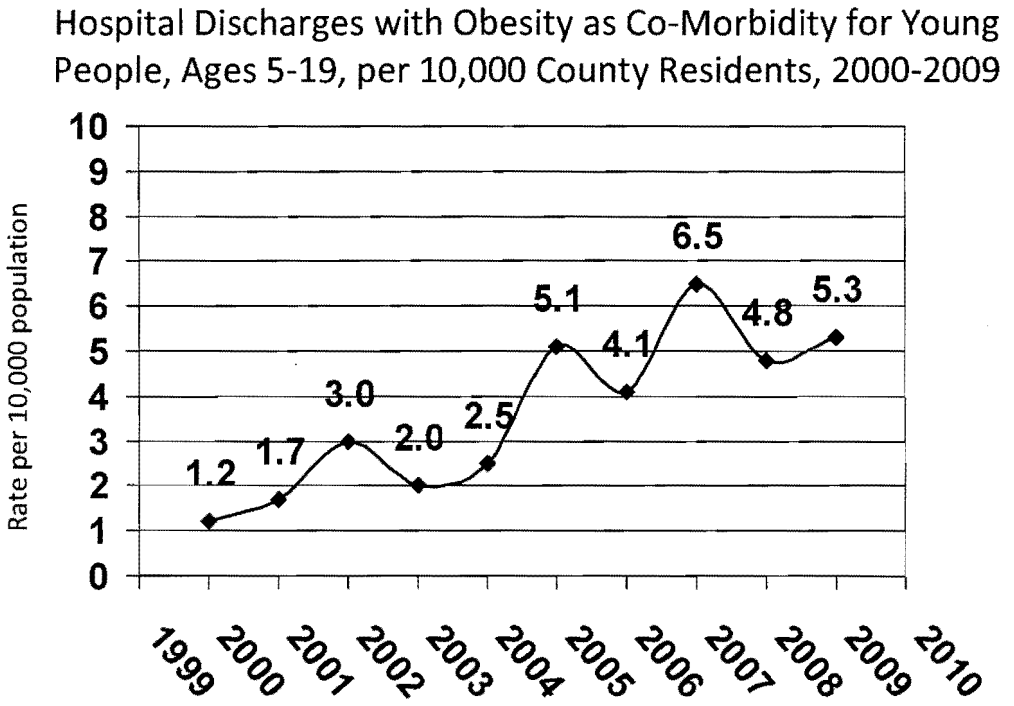


According to the BRFSS, almost four out of ten children (36.3%) in Montgomery County were overweight or obese in 2010. Unlike adults, where more adults were overweight (36.1%) than obese (18.2%), more children were obese (21.2%) than overweight (15.1%).



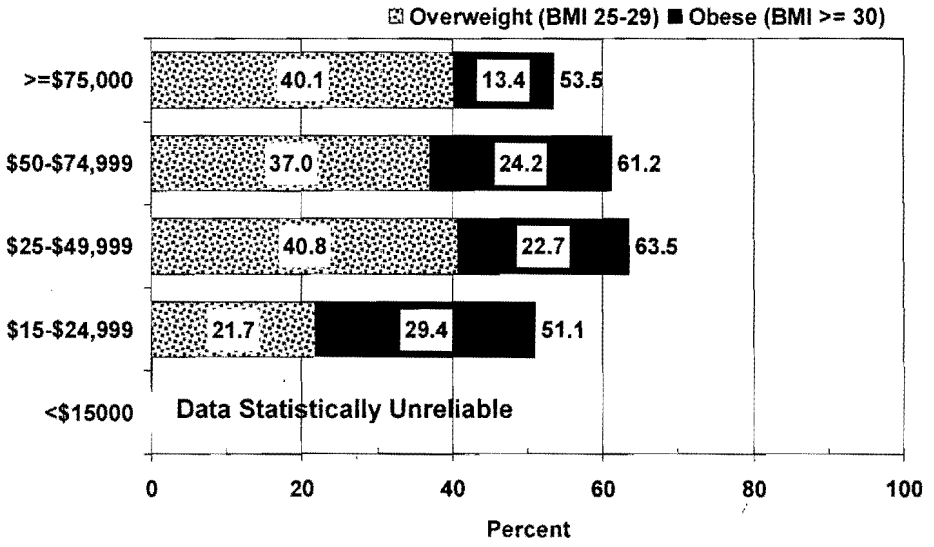
There is a similar proportion of male (35%) and female (36.3%) children who were overweight and obese, yet a greater percentage of female children were obese (22.8%) than male children (18.7%). The overall picture of higher than desired weight in children and adolescents is a warning that we may have new generations that have risk factors for various chronic diseases starting at an early age.

County-wide data on exercise, nutrition, and weight is limited for children in Montgomery County. Therefore, hospital discharge data available for children is an important resource to measure the impact of obesity on Montgomery County children. Since 2000, there has been an increasing rate of hospital discharges for Montgomery County young people, ages 5-19 years, who had obesity-related diagnoses that required medical attention during their hospital stays.



In 2010, Montgomery County BRFSS respondents in the $25-$49,000 income bracket were more likely to be overweight and obese (63.5%) than respondents in other income brackets. This pattern of overweight and obesity and income differs from the 2010 Maryland average. Statewide, adults in the less than $15,000 income bracket were more likely to be overweight and obese (70.3%) than adults in other income brackets.

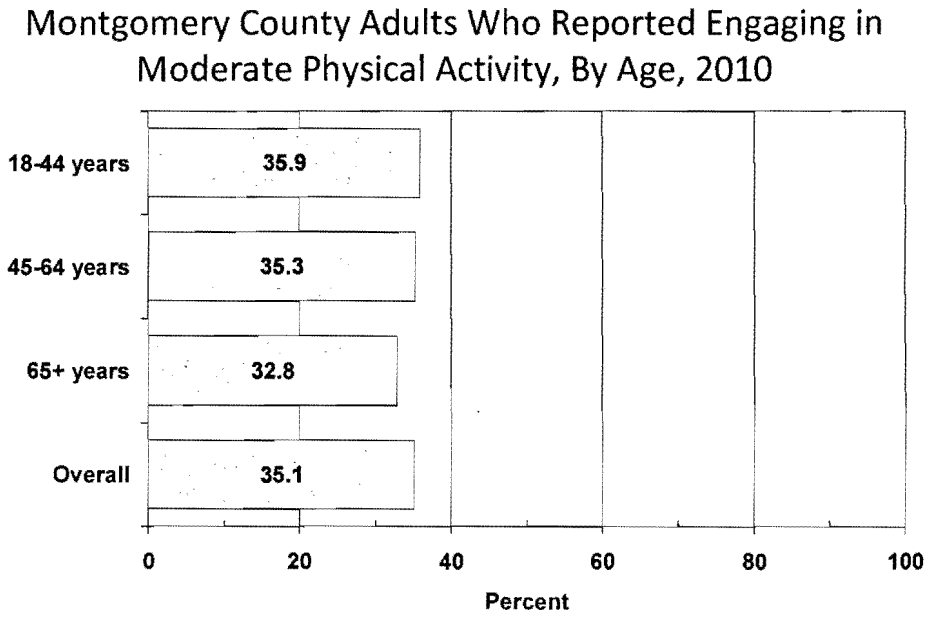
Montgomery County Adult Weight Status, By Income Level, 2010



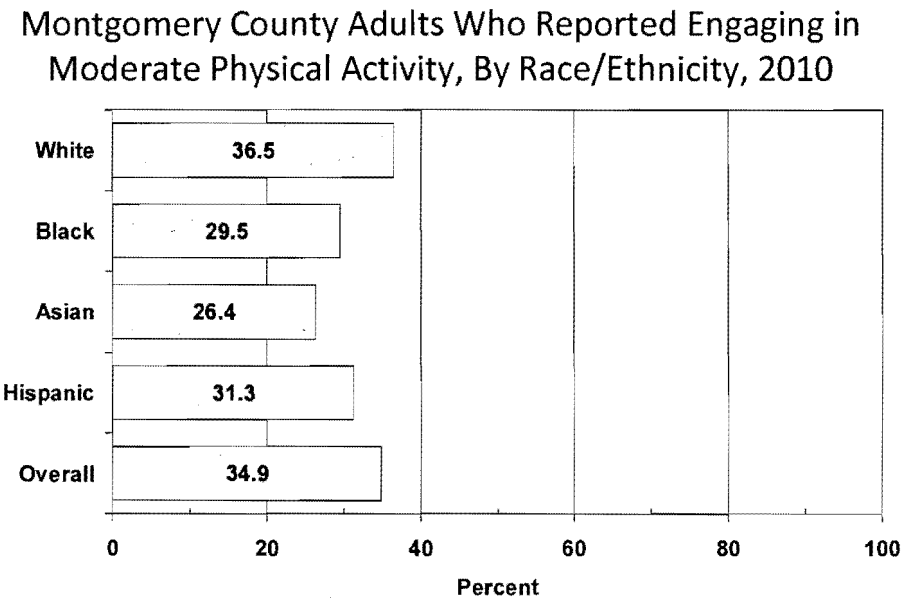
There were few differences in levels of overweight and obesity across education levels in respondents to the Montgomery County BRFSS, when averaged over the years 2007-2010.

Physical Activity

Physical activity is a key element to maintaining a healthy weight. In 2010, only 35.1% of respondents to the BRFSS reported doing 30 or more minutes per day for five or more days per week of moderate physical activity. More women (38.1%) than men (31.3%) reported engaging in moderate physical activity. Essentially the same proportion of younger adults (18-44 years) and middle-aged adults (45-64) reported moderate physical activity (about 35%). Fewer older adults (32.8%) reported moderate physical activity.

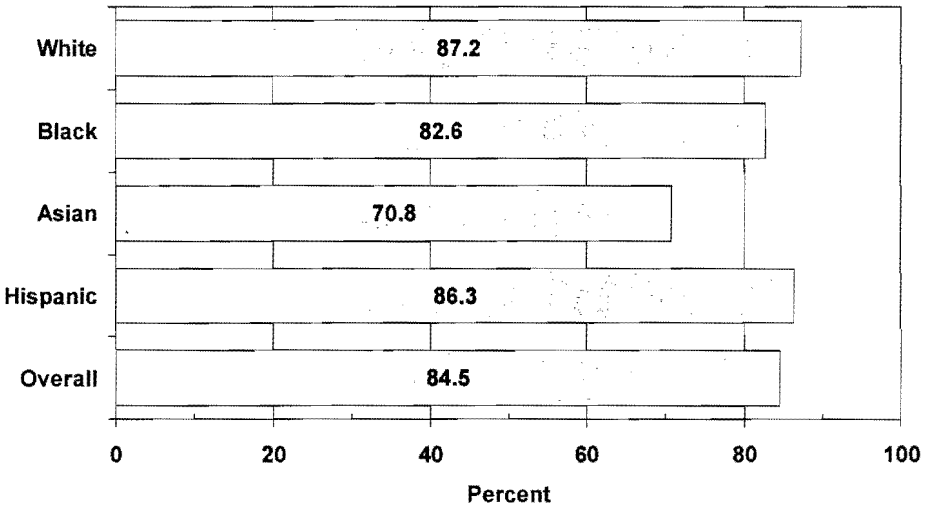


As shown in the next table, Asians and African Americans/Blacks were less likely to report engaging in moderate physical activity than individuals of other races.



As shown in the following table, Asians were less likely to report engaging in leisure time physical activity than adults of other races.

Montgomery County Adults Who Reported Engaging in Leisure Time Physical Activity, By Race/Ethnicity, 2010

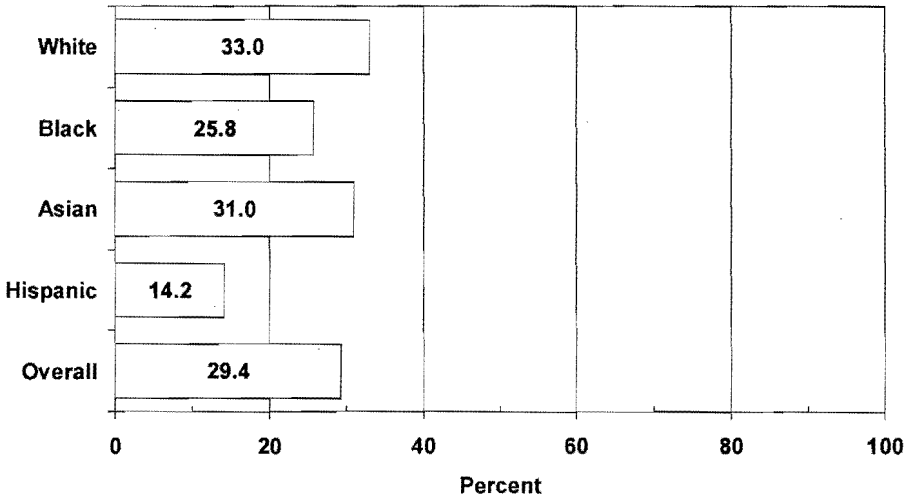


Healthy Eating

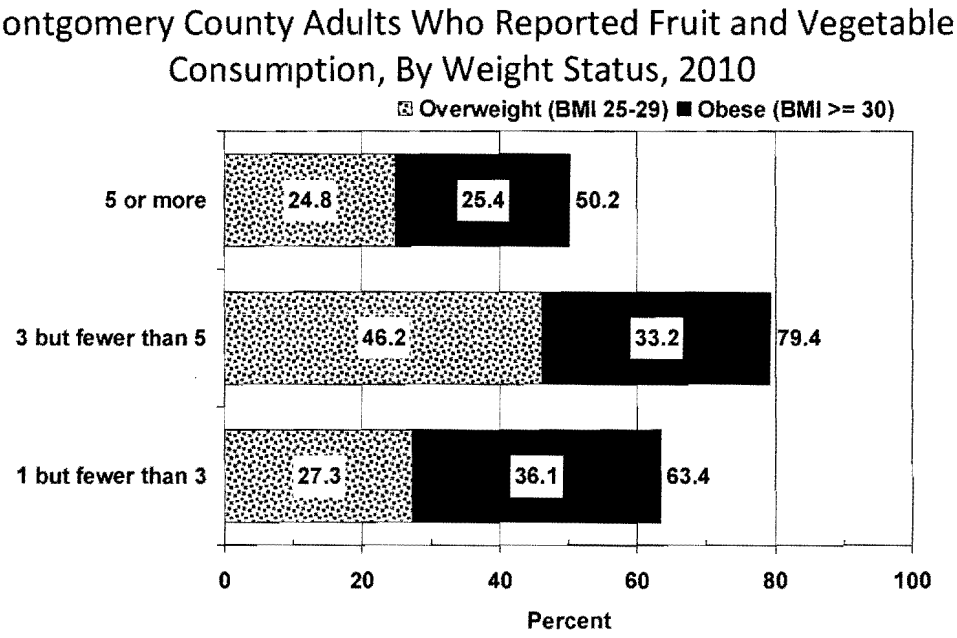
Healthy eating is key both to achieving and to maintaining a healthy weight. 29.4 % of respondents to the 2010 BRFSS stated that they consumed five or more servings of fruits and vegetables per day. More women (36.9%) than men (21.4%) reported eating five or more servings of fruits and vegetables daily.

As shown in the table below, more Whites and Asians reported eating five servings of fruits and vegetables than did Blacks and Hispanics.

Montgomery County Adults Who Reported Fruit and Vegetable Consumption of 5 or Greater Servings, By Race/Ethnicity, 2010



Adult fruit and vegetable consumption is related to overall weight status. In 2010, BRFSS respondents who reported they consumed fewer than five servings of fruit or vegetables per day were more likely to be overweight or obese.

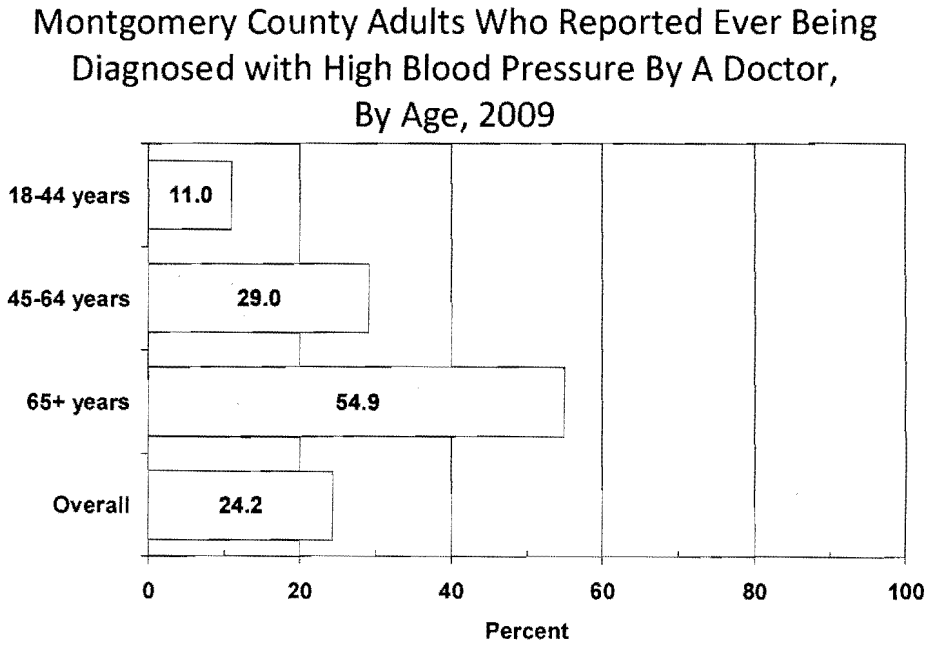


Chronic Diseases Related to Obesity

In adults, being overweight or obese is related to Type 2 diabetes and chronic cardiovascular conditions, such as high blood pressure, heart disease and stroke. Unfortunately, these conditions are becoming more prevalent in children and adolescents as they become more overweight or obese.

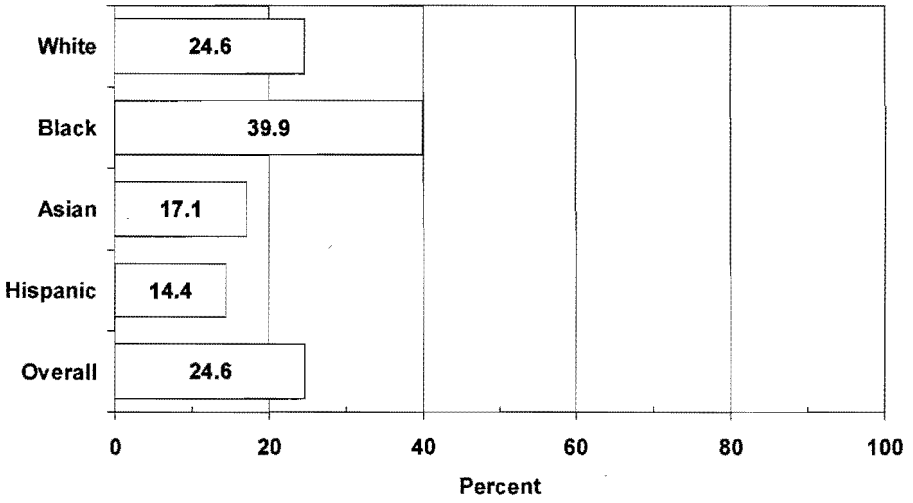
High Blood Pressure

High blood pressure is an early sign of cardiovascular disease and cerebrovascular disease. In Montgomery County, about one in every four adults who responded to the 2009 BRFSS had high blood pressure. 27.3% of women and 21.7% of men responding to the BRFSS reported that they had high blood pressure. The percent of individuals reporting that they had high blood pressure increased with age.

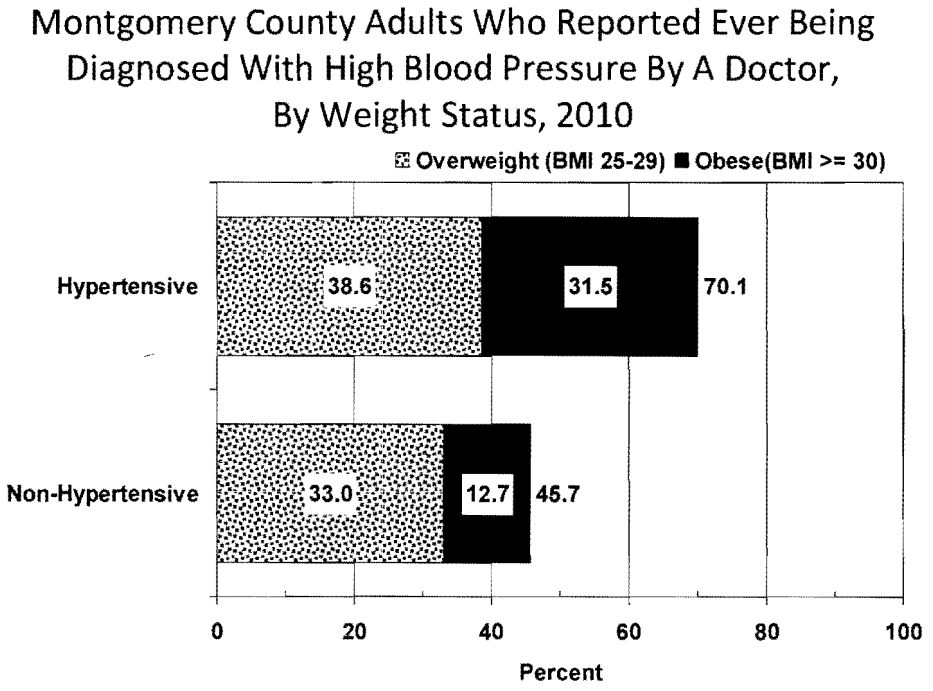


As with overweight and obesity, high blood pressure was most prevalent in the African American population. It was least prevalent in the Hispanic population, although this may reflect the younger Hispanic population in the County.

Montgomery County Adults Who Reported Ever Being Diagnosed With High Blood Pressure By A Doctor, By Race/Ethnicity, 2009



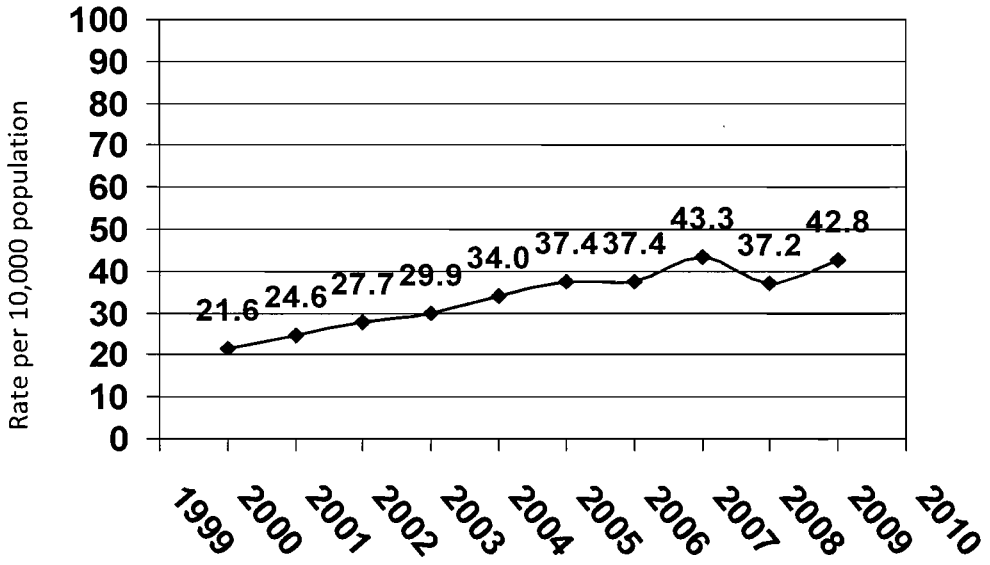
High blood pressure is related to weight status. In the 2009 BRFSS, more overweight and obese adults reported having high blood pressure. Furthermore, among adults with high blood pressure, almost half were obese. Of the 2009 BRFSS respondents, 70.1 % of the respondents diagnosed with hypertension were overweight or obese, and 45.7% of the respondents who were not diagnosed with hypertension were overweight or obese.



High blood pressure, or hypertension, is a frequent reason for hospital visits in Montgomery County. In 2009, 36.2% of all hospital discharges of Montgomery County residents required medical attention for their high blood pressure, regardless of whether or not high blood pressure was the reason for hospitalization. In 2010, there were 123.3 visits per 100,000 population for emergency department visits due to high blood pressure for Montgomery County residents.

Since 2000, the rate of hospital discharges with hypertension as co-morbidity for adults, ages 20-39, per 10,000 County residents has increased two-fold.

Hospital Discharges with Hypertension as Co-Morbidity for Adults Ages 20-39 per 10,000 County Residents, Ages 20-39, 2000-2009

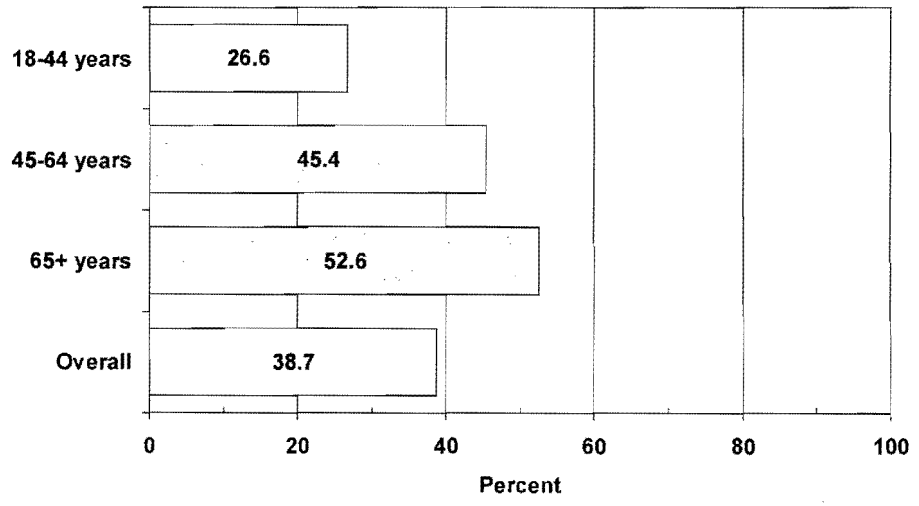


High Cholesterol

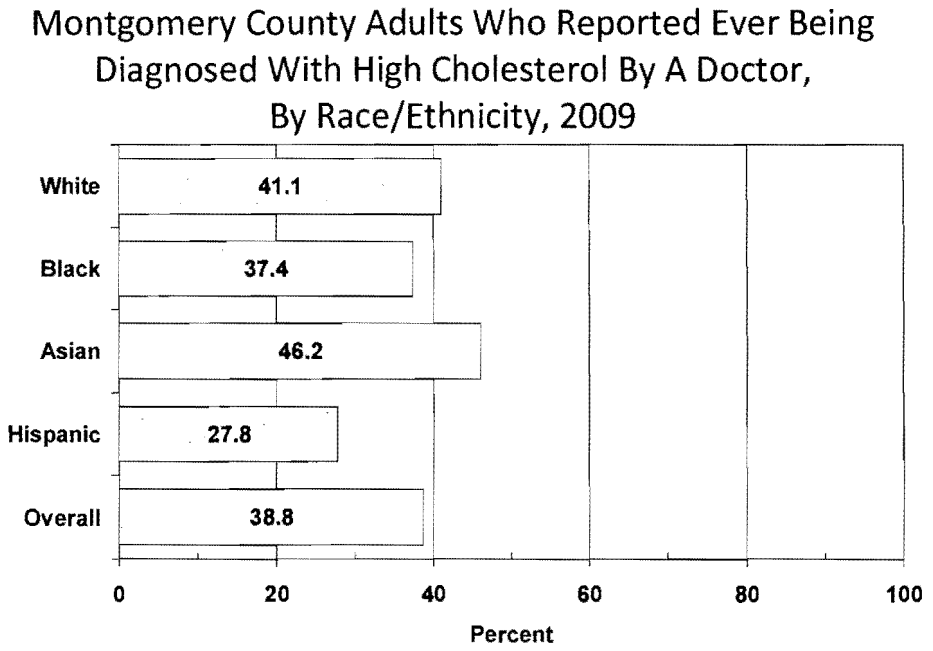
High cholesterol is also associated with overweight and obesity. It can also be associated with unhealthy food choices, although there is a genetic component to high cholesterol in some populations. High cholesterol can be a precursor of cardiovascular and cerebrovascular disease. 38.7% of respondents to the 2009 BRFSS reported having been told by a doctor or healthcare professional that their blood cholesterol was high, which is slightly higher than the Maryland average of 37.4%. The prevalence of high cholesterol in Montgomery County as reported through the BRFSS has increased from 30.4% in 2005 to 38.7% in 2009. In 2009, 43.8% of women and 33.8% of men reported that they had high cholesterol.

High cholesterol, like high blood pressure, increased with age. More than half of seniors had high cholesterol levels, which is a major risk factor for heart disease.

Montgomery County Adults Who Reported Ever Being Diagnosed With High Cholesterol By A Doctor, By Age, 2009

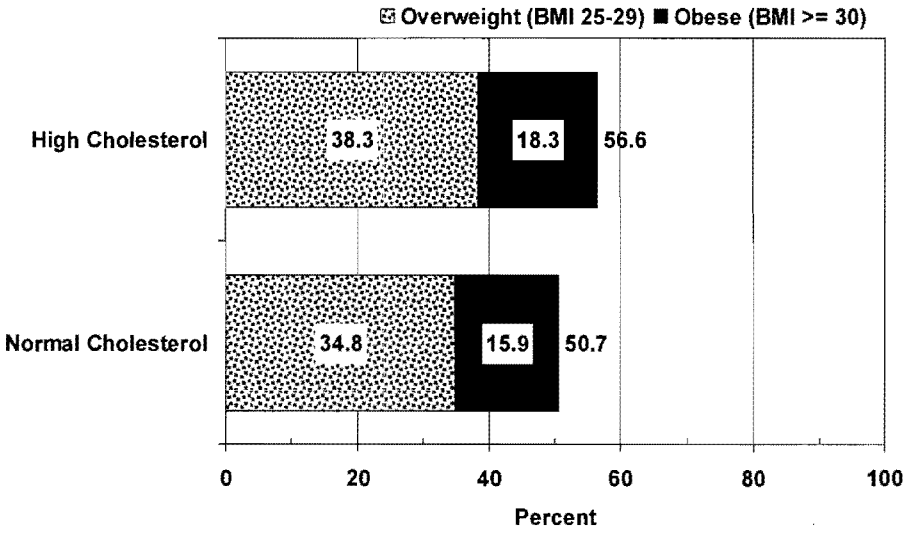


More Asians reported high cholesterol than did any other racial/ethnic group, followed by Whites, Blacks, and Hispanics.



High cholesterol is related to weight status. More adults who were overweight or obese reported having high cholesterol than adults of healthy weight. 56% of BRFSS respondents who reported having high cholesterol were overweight or obese, and 50.7% of BRFSS respondents who reported having normal cholesterol were overweight or obese.

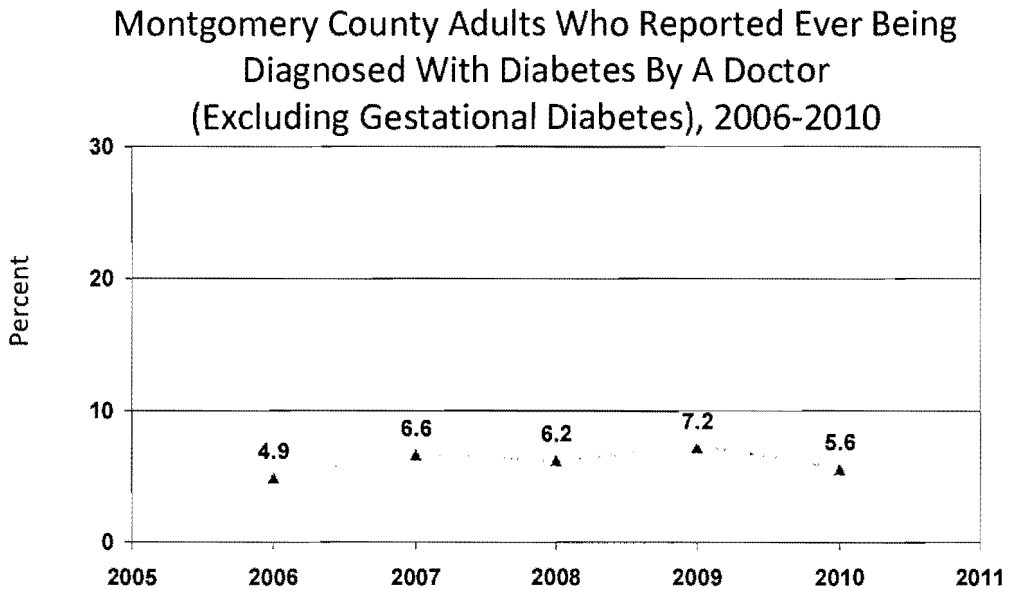
Montgomery County Adults Who Reported Ever Being Diagnosed With High Cholesterol By A Doctor, By Weight Status, 2009



Diabetes

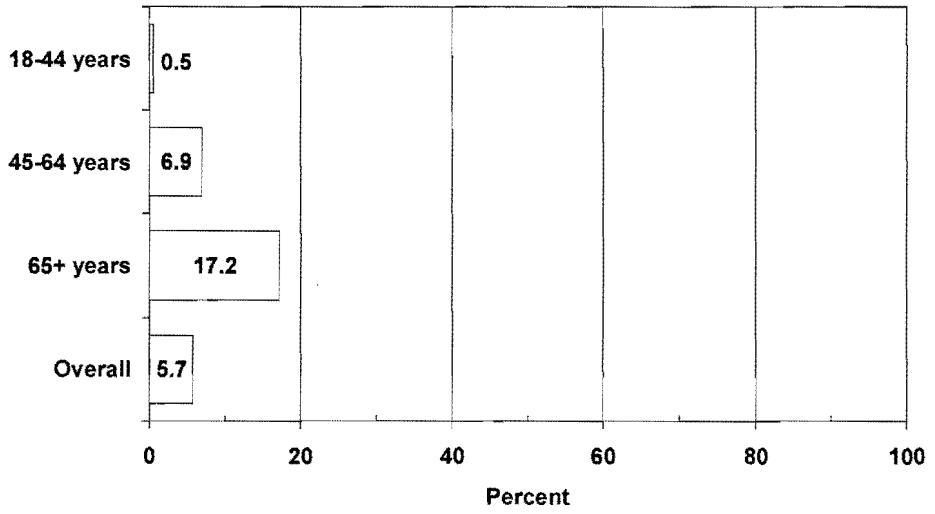
In 2010, 343 Montgomery County residents died of diabetes. Diabetes is the eighth overall leading cause of death among Montgomery County residents. It ranks as the fourth leading cause of death among African Americans/Blacks, fifth leading cause of death among Hispanics/Latinos, and sixth leading cause of death among Asians and Pacific Islanders. The age-adjusted death rate due to diabetes in 2010 was 12.2 deaths per 100,000 population.

The percent of people stating that they had ever been diagnosed with diabetes on the BRFSS decreased from 7.2% in 2009 to 5.6% in 2011. However, as shown in the chart below, this statistic has been variable over the past five years.

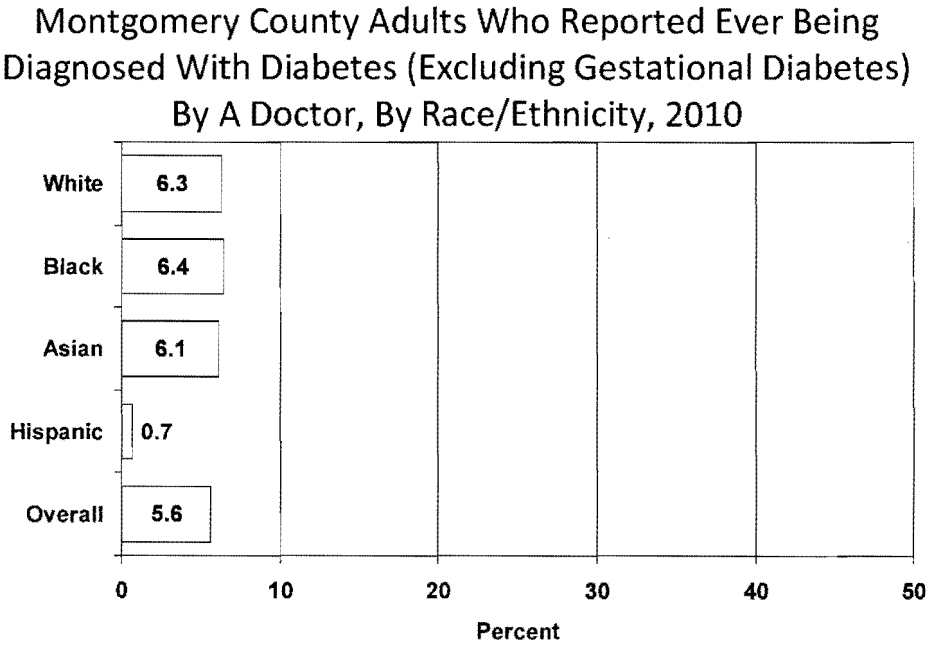


More women (6%) than men (5.2%) reported having been told by a doctor that they had diabetes in the 2010 BRFSS. The prevalence of diabetes rose sharply from young adulthood to the over-65 population. Complications of long-term diabetes, seen most often in the elderly, include heart and blood vessel disease, nerve damage, kidney damage, foot damage and blindness.

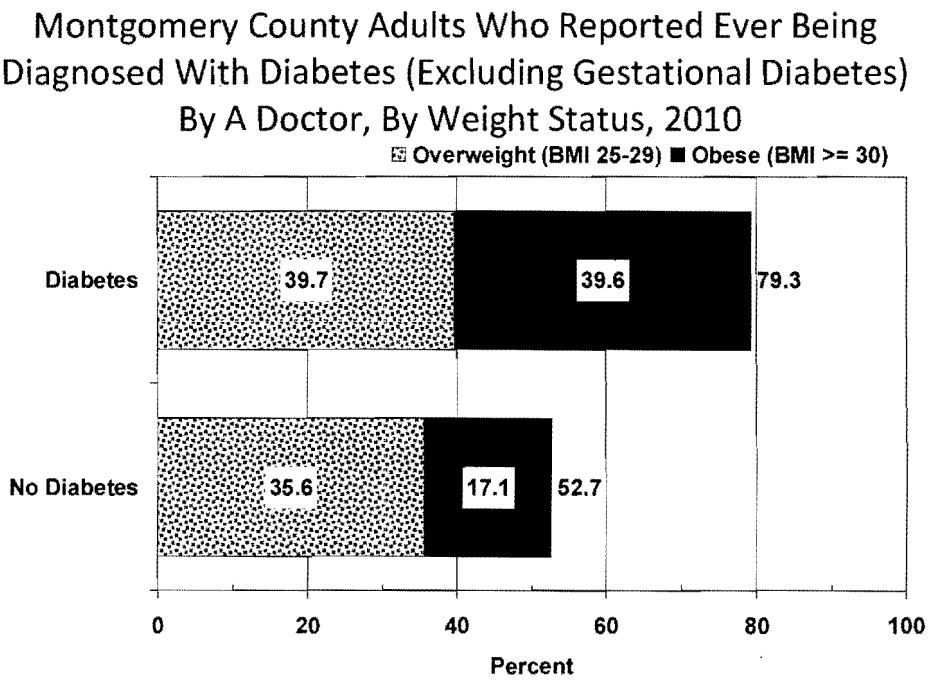
Montgomery County Adults Who Reported Ever Being Diagnosed With Diabetes (Excluding Gestational Diabetes) By A Doctor, By Age, 2010



The 2010 BRFSS results show a relatively similar prevalence of diabetes among all races/ethnicities, except for the Hispanic population (0.7%). The strikingly low level of diabetes in the Hispanic population may be a reflection of sampling issues. Only 62 Hispanic Montgomery County residents responded to this question in the 2010 BRFSS, of those two responded that they had been told by a doctor that they had diabetes.



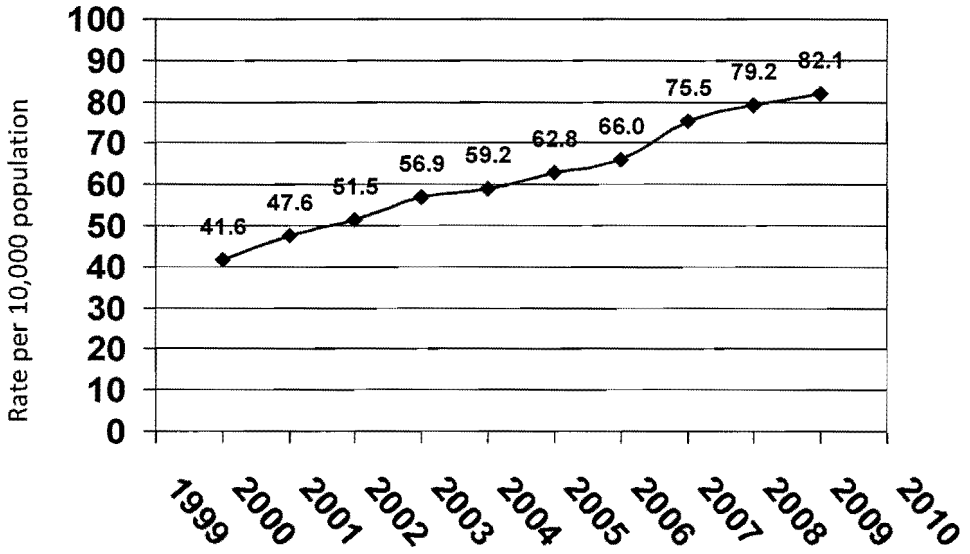
79.3% of 2010 BRFSS respondents who reported having a diagnosis of diabetes were overweight or obese, and 52.7% of respondents who reported not having a diagnosis of diabetes were overweight or obese.



Diabetes is a frequent reason for hospital visits in Montgomery County. In 2009, 17% of hospital discharges of Montgomery County residents required medical attention for their diabetes, regardless of whether or diabetes was the reason for hospitalization. In 2010, there were 168.8 visits per 100,000 population for emergency department visits due to diabetes for Montgomery County residents, according to the State Health Improvement Process data.

During the period 2000-2009, the rate of hospital discharges with diabetes as a condition requiring medical attention during the hospital stay for adults ages 20-59 per ten thousand county residents rose two-fold.

Hospital Discharges with Diabetes as Co-Morbidity for Adults, Ages 20-59, per 10,000 County Residents Ages 20-59, 2000-2009

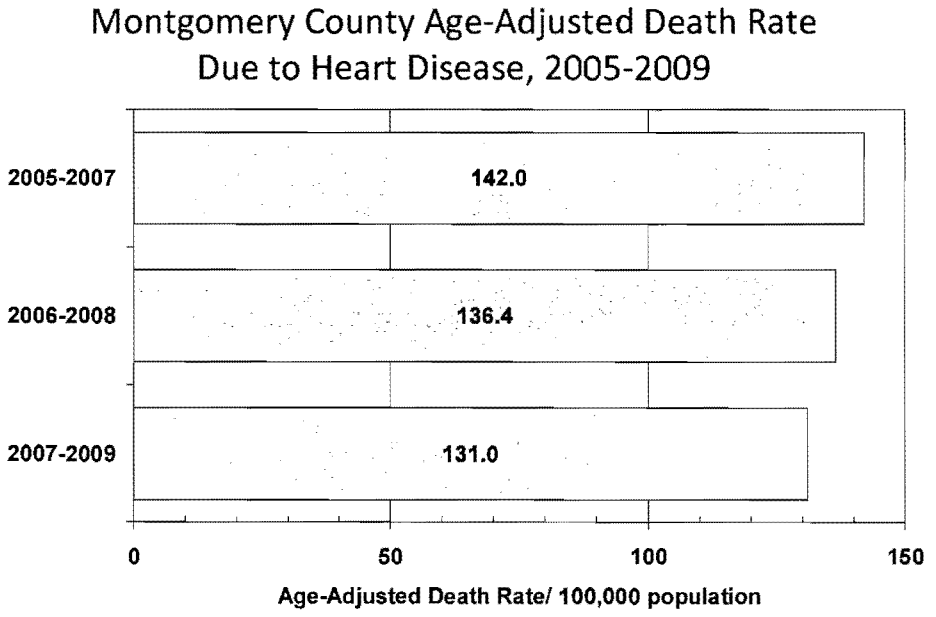


Heart Disease and Stroke

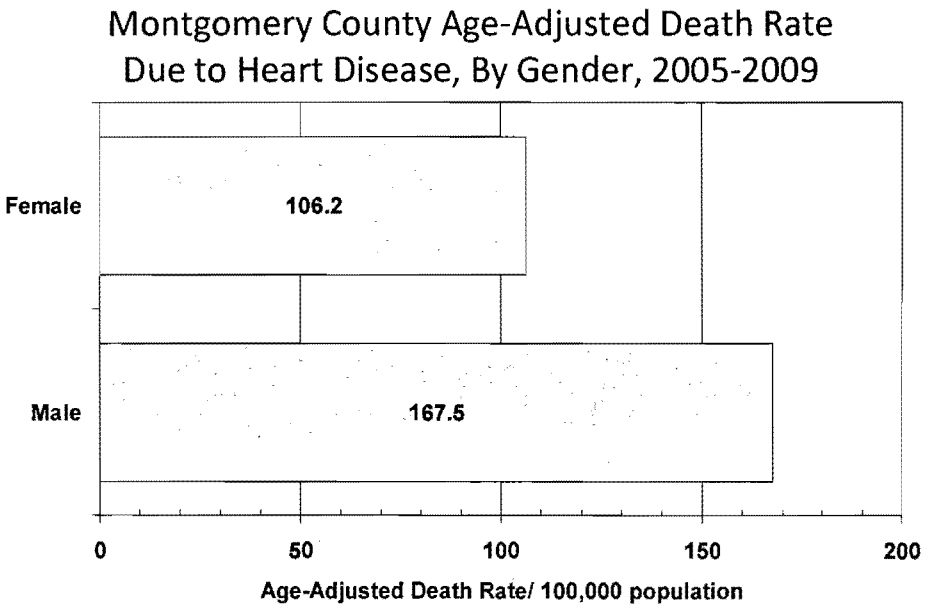
Major cardiovascular disease is the leading cause of death in Montgomery County. It is the leading cause of death for African American/Black, Hispanic/Latino and White residents and is the second leading cause of death among Asian and Pacific Islander residents. High blood pressure and high cholesterol both contribute to an increased prevalence of heart disease and stroke.

Heart Disease

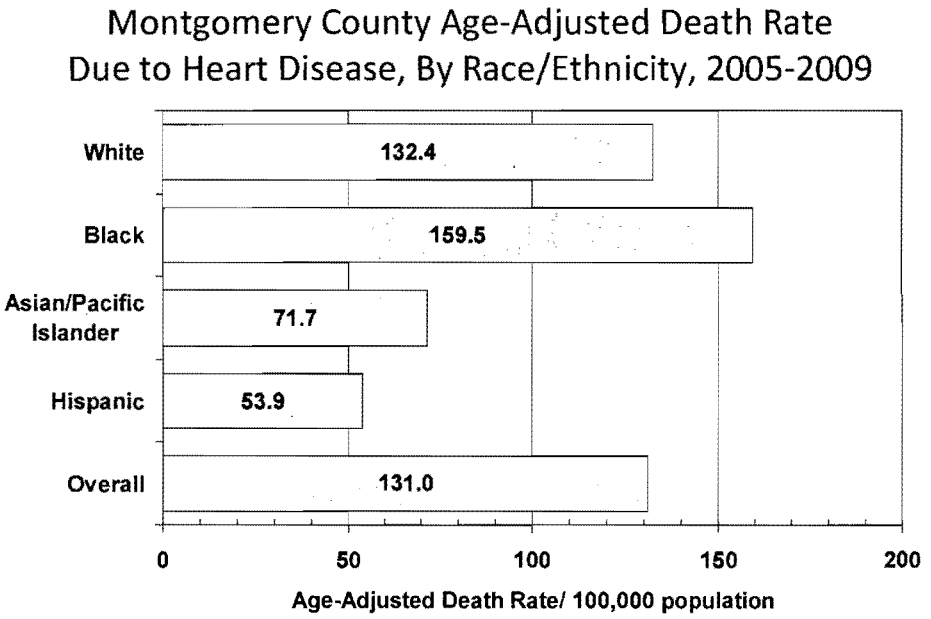
During the period 2007-2009, the age-adjusted death rate due to heart disease in Montgomery County was 131.0 deaths per 100,000 population. Though this rate has decreased 7% since 2005, disparities between gender and racial/ethnic groups remain.



The heart disease mortality rate among men (167.5 deaths per 100,000 population) is 63% higher than it is for women (106.2 per 100,000 population).

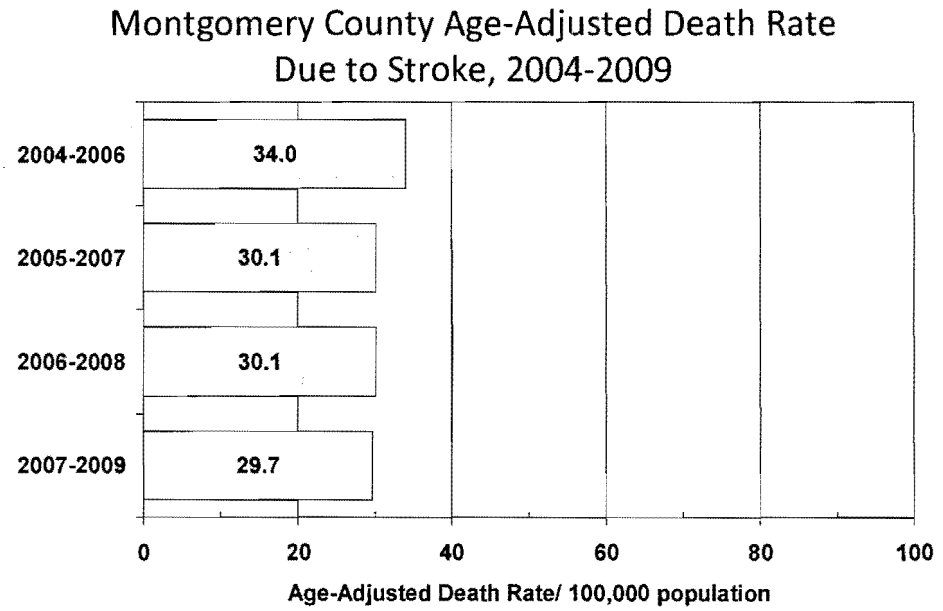


African American/Black residents experience a mortality rate (159.5 per 100,000 population) that is three times the rate of Hispanic/Latino residents (53.9 per 100,000 population) and more than double the rate experienced by Asians and Pacific Islanders (71.7 per 100,000 population).

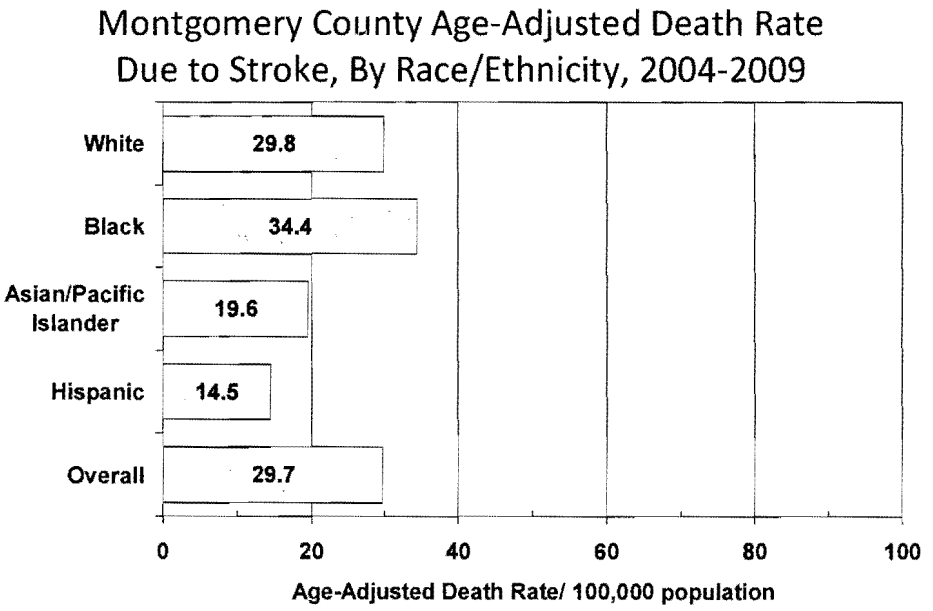


Stroke

During the period 2007-2009, the age-adjusted death rate due to cerebovascular disease, or stroke, was 29.7 deaths per 100,000 population, which reflects a slight decrease from 2004. However, there are important disparities among racial/ethnic groups.



Men and women have similar death rates due to stroke (29.9 deaths per 100,000 population, and 29.4 deaths per 100,000 population, respectively). African American/Black residents die from stroke (cerebrovascular disease) at a rate (34.4 deaths per 100,000 population) that is 15% higher than White residents (29.8 per 100,000 population) and more than double the rate experienced by Hispanic/Latino residents (14.5 per 100,000 population).



Healthy Living and Disease Prevention

Wellness and Lifestyle

Wellness and lifestyle can be measured through a number of different summary measures of health and wellbeing—from individual self-evaluation of health and mental health status to population-based death rates, life expectancy—to broader composite quality of life indices. Montgomery County has one of the highest life expectancies – the average number of years a baby born in 1997-2001 can expect to live from birth—in the National Capital Region. Further analysis is needed to identify disparities among the diverse communities that now reside in Montgomery County and that reflect the most current data available.

In 2010, 91.4% of Montgomery County adults reported to the BRFSS that their general health was excellent, very good, or good. Men rated their general health higher (93.7%) than women (89.3%). Adults, ages 45-64 years, had the lowest self-reported general health being good, very good or excellent (87%) compared to other ages. Hispanic/Latino adults reported the lowest percent of being in excellent, very good, or good general health (75%) compared to the other racial/ethnic groups; Asian and Pacific Islander adults had the highest at 96%.

Self-reported life satisfaction on the BRFSS increased slightly from 2009 (94.6%) to 2010 (96.8%) in Montgomery County. Men and women reported their life satisfaction as being relatively equal (97.4% to 96.2%, respectively). Both Asian/ Pacific Islander and Hispanic/Latino adults had the highest self-reported life satisfaction (both were 99%) compared to other racial ethnic groups. African American/Black adults had the lowest percent (88%). Seniors, aged 65 and older, had the highest self-reported life satisfaction (97%) compared to all other adults. Obese adults were more likely to report being dissatisfied or very dissatisfied with their life (4.4%) than Montgomery County adults in general (3.0%).

Self-reported physical health on the BRFSS increased in Montgomery County from 2009 (76.2%) to 2010 (82.2%). Women were less likely to report being in good physical health (77.1%) than men (87.8%). Adults ages 65 and older were least likely to report being in good physical health (74.1%), and adults ages 18-49 were most likely to report being in good physical health (85.2%). Asian adults were more likely than any other racial/ethnic group to report having good physical health (93.4%), and Hispanic adults were the least likely to report having good physical health (82.1%).

Key Definitions

- *At least light/moderate physical activity*= adults that reported doing 30 or more minutes per day and for five or more days per week of moderate physical activity or 20 or more minutes per day and three or more days per week of vigorous physical activity[1].
- *Cerebrovascular disease deaths*= Deaths with International Classification of Diseases (ICD)-10 codes I60–I69 (ICD-9 code 430–438) as the underlying cause of death among residents during a calendar year[2].
- *Diabetes* = Person who responded that he/she was ever been told by a doctor that he/she has diabetes (excludes pre-diabetes, borderline diabetes and females who reported the diagnosis was only when she was pregnant)[3].
- *Heart disease death* = death due to acute myocardial infarction, other ischemic heart disease, hypertensive heart disease, heart failure and all other heart disease (International Classification of Diseases (ICD)-10 codes I00–I09,I11,I13,I20–I51) as the underlying cause of death among residents during a calendar year)
- *High blood pressure (hypertension)* = Adults 18 years and older who report having been told by a doctor, nurse, or other health professional of having high blood pressure (140/90 mm HG or higher)[4].
- *High cholesterol* = Adults 18 years and older who report having been told by a doctor or health professional that your blood cholesterol is high[5].
- *Hospital Discharges with co-morbidity of diabetes* = Percentage of all hospital discharges with a co-morbidity of diabetes. Discharges are defined as the event that an individual is released from the inpatient care of a reporting institution, including: discharge to home, another care facility, or patient's death. A co-morbidity of diabetes is defined as a condition related to diabetes for which the patient required medical attention during their visit, regardless of whether or not the condition was the principal diagnosis. The co-morbidity of diabetes was coded if an ICD-9-CM code related to diabetes was detected within the entire set of diagnoses codes for the patient during their hospital stay[6].
- *Hospital discharges with co-morbidity of hypertension* = Percentage of all hospital discharges with a co-morbidity of hypertension. Discharges are defined as the event that an individual is released from the inpatient care of a reporting institution, including: discharge to home, another care facility, or patient's death. A co-morbidity of hypertension is defined as a condition related to diabetes for which the patient required medical attention during their visit, regardless of whether or not the condition was the principal diagnosis. The co-morbidity of hypertension was coded if an ICD-9-CM code

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[1] Behavioral Risk Factor Surveillance System. (August 31, 2010). Calculated Variables. Center for Disease Control, from http://www.cdc.gov/brfss/technical_infodata/surveydata/2009/calcvar_09.rtf.

[2] CDC. (2008). Chronic Disease Indicators: indicator definitions. Center for Disease Control, from http://www.apps.nccd.cdc.gov/cdi/indDefinition.aspx?IndicatorDefinintionID=63.

[3] CDC. (July 1, 2010). Maryland Behavioral Risk Factor Surveillance System 2009 Codebook Report. Centers for Disease Control, from http://ftp.cdc.gov/pub/data/brfss/codebook_09.rtf.

[4] CDC. (2008). Chronic Disease Indicators: indicator definitions. Center for Disease Control, from http://www.apps.nccd.cdc.gov/cdi/indDefinition.aspx?IndicatorDefinintionID=25.

[5] CDC. (July 1, 2010). Maryland Behavioral Risk Factor Surveillance System 2009 Codebook Report. Centers for Disease Control, from http://ftp.cdc.gov/pub/data/brfss/codebook_09.rtf.

[6] Maryland Assessment Tool for Community Health (2009). Family Health Administration, from http://www.matchstats.org.

related to hypertension was detected within the entire set of diagnoses codes for the patient during their hospital stay[7].

- *Hospital discharges with co-morbidity of obesity* = Percentage of all hospital discharges with a co-morbidity of obesity. Discharges are defined as the event that an individual is released from the inpatient care of a reporting institution, including: discharge to home, another care facility, or patient's death. A co-morbidity of obesity is defined as a condition related to obesity for which the patient required medical attention during their visit, regardless of whether or not the condition was the principal diagnosis. The co-morbidity of obesity was coded if an ICD-9-CM code related to hypertension was detected within the entire set of diagnoses codes for the patient during their hospital stay[8].
- *Leisure time physical activity* = Physical activity performed outside of any physical activity that may have occurred at work[9].
- *Overweight or Obese adult* = Respondents aged >=18 years who have a body mass index that meets the criteria listed below[10].
    - An adult who has a BMI between 25 and 29.9 is considered overweight.
    - An adult who has a BMI of 30 or higher is considered obese.

See the following example:

Height	Weight Range	BMI	Considered
5'9"	124 lbs or less	Below 18.5	Underweight
	125 lbs to 168 lbs	18.5 to 24.9	Normal weight
	169 lbs to 202 lbs	25.0 to 29.9	Overweight
	203 lbs or more	30 or higher	Obese

- *Self-reported general health* = Percent of adults who responded good, very good, or excellent to the question "How is your general health?"[11].
- *Self-reported physical health* = Percent of adults who reported 2 or fewer days in the past 30 days that their physical health was not good[12].
- *Self-reported life satisfaction* = percent of adults who answered that they are very satisfied or satisfied when asked, "In general, how satisfied are you with your life?"[13].

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[7] Maryland Assessment Tool for Community Health (2009). Family Health Administration, from http://www.matchstats.org.

[8] Maryland Assessment Tool for Community Health (2009). Family Health Administration, from http://www.matchstats.org.

[9] CDC. (May 24, 2011). Maryland Behavioral Risk Factor Surveillance System 2010 Codebook Report. Centers for Disease Control, from http://ftp.cdc.gov/pub/data/brfss/codebook_10.rtf.

[10] CDC. (May 24, 2011). Maryland Behavioral Risk Factor Surveillance System 2010 Codebook Report. Centers for Disease Control, from http://ftp.cdc.gov/pub/data/brfss/codebook_10.rtf.

[11] CDC. (May 24, 2011). Maryland Behavioral Risk Factor Surveillance System 2010 Codebook Report. Centers for Disease Control, from http://ftp.cdc.gov/pub/data/brfss/codebook_10.rtf.

[12] CDC. (May 24, 2011). Maryland Behavioral Risk Factor Surveillance System 2010 Codebook Report. Centers for Disease Control, from http://ftp.cdc.gov/pub/data/brfss/codebook_10.rtf.

[13] CDC. (May 24, 2011). Maryland Behavioral Risk Factor Surveillance System 2010 Codebook Report. Centers for Disease Control, from http://ftp.cdc.gov/pub/data/brfss/codebook_10.rtf.

Data Sources Used

- County Health Rankings, 2012
- Maryland Assessment Tool for Community Health, 2009
- Maryland Behavioral Risk Factor Surveillance System, 2007-2010
- State Health Improvement Process Measures
- Vital Statistics Administration, Maryland Department of Health and Mental Hygiene, 2010

Data Gaps Identified

- County-wide data that characterize important health risk and lifestyle behaviors like nutrition, exercise, and sedentary behaviors are not available for children, a group that has an increasing risk for many health conditions in childhood and adulthood. With the anticipated rollout of the YRBS at the county level expected to begin biannual data collection in the Fall of 2012, this gap should be addressed for older children/adolescents.
- Diabetes prevalence is not available for children, a group that has had an increasing risk for type 2 diabetes in recent years due to increasing overweight/obesity rates.
- Health risk behaviors that increase the risk for many chronic health conditions—like diabetes, cancer and heart disease—are difficult to measure accurately among our sub-populations, especially the Hispanic/Latino populations because of survey methodology limitations.
- There is a need for better summary measures of health and well-being and annual life expectancy by gender, race, and ethnicity

Healthy Montgomery:
Obesity Prevention Work Group

Healthy Montgomery

Healthy Montgomery (HM) is a community-based health improvement process.

The improvement of the health and well-being of Montgomery County residents is at the core of this initiative.

Healthy Montgomery Leadership

Healthy Montgomery is under the leadership of the HM Steering Committee, which includes planners, policy makers, health and social service providers and community members.

3

Healthy Montgomery

The community health improvement process includes data collection, identification of areas for improvement, priority-setting, ***strategic planning***, implementation planning, and collaborative efforts to address the priority needs in Montgomery County and evaluate the success of the improvement efforts.

4

Healthy Montgomery Process

- Environmental Scan
- Needs Assessment
- Priority-setting
- Action

Priority-Setting

Six areas of focus were selected during the priority-setting phase:

- Behavioral Health
- Cancers
- Cardiovascular Disease
- Diabetes
- Maternal and Infant Health
- Obesity

Challenges

The areas of focus will be evaluated through the following lenses:

- Health Inequities
- Lack of Access
- Unhealthy Behaviors

Obesity Prevention Work Group

Work Group membership is comprised of representatives from:

- Montgomery County Public Schools
- Hospital Community
- Dept. of Health and Human Services
- Dept. of Recreation
- Dept. of Planning
- Content Experts

Obesity Prevention Work Group

The first Obesity Prevention Work Group meeting was recently convened.

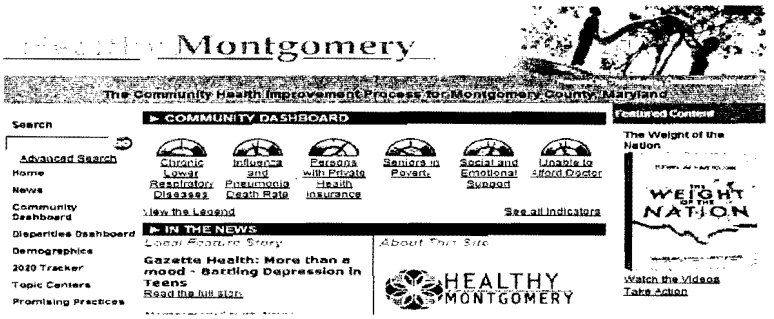
The group will meet throughout the coming months to develop the Obesity strategic plan for presentation to the HM Steering Committee.

Obesity Prevention Work Group

The Work Group's strategic plan will provide recommendations to address obesity within Montgomery County; including targeted efforts to combat childhood obesity.

Healthy Montgomery

For additional information please visit
www.healthymontgomery.org



Yao, Vivian

From: Brennan, Patricia
Sent: Wednesday, July 25, 2012 10:49 AM
To: Yao, Vivian
Cc: Glick, Joan; Tillman, Ulder; Lettlow, Helen
Subject: FW: Summary of Mead Grant activities - for County Council meeting July 30

Vivian: Here is our summary on the Mead Grant.

Pat

Patricia Brennan
Legislative Officer, Montgomery County DHHS
240-777-1344--Rockville
301-261-2461--Annapolis
pat.brennan@montgomerycountymd.gov

-----Original Message-----
From: Glick, Joan
Sent: Monday, July 23, 2012 5:09 PM
To: Tillman, Ulder; Lettlow, Helen
Cc: Sharif-Chikiar, Stella
Subject: Summary of Mead Grant activities - for County Council meeting July 30

Here is a summary statement on the Mead Grant.

In FY12, Montgomery County DHHS School Health Services was awarded a grant from the Mead Family Foundation to provide an outcomes, obesity prevention school-based program called *Healthy Choices, Happy Students.*

This program was designed to
- increase physical activity
- Help students make healthier food choices
- Form Partnerships with Montgomery County Public Schools and Food Supplement Nutrition Education to support program resources

This grant gave us the opportunity to expand our current participation in an after school program called *Nutrition Nuggets* in more schools (up to 10 elementary schools), as well as start a new program called *Student Strides Walking Club* in ten elementary schools throughout our county.

Nutrition Nuggets is Federally funded by a program called Food Supplement Nutrition Education (FSNE). It is designed for children in grades 4, 5 and 6. Each of the lessons (18-24 sessions) provides basic nutrition information with two activities that engage the students in a variety of food-related tasks. Every lesson includes food preparation and taste testing. These activities are designed to help students read food labels, develop cooking skills, provide opportunities to experience new foods and ingredients, and to make healthy food choices. This program is available to schools with a 50% or greater FARMS rate.

Student Strides Walking Club is designed to encourage students to increase physical activity. It is targeted for grades 3 through 5 and is implemented during recess, or before or after school. Students learn a variety of physical activity-based lessons while walking. Students also receive journals to track progress and other incentives to keep them moving. In addition, students get a healthy snack.

(69)

Outcomes measurement was done through self-report journals, and pre and post-surveys that were used to measure increased physical activity and healthier food choices. These surveys were given at the start, middle and end of each program.

Start up kits were provided for every child, as well as snacks, supplies and equipment which were purchased with the grant money. A stipend for a coordinator was given. Money was also used for incentives, giveaways, celebrations and recognitions.

The after school nutrition program was held last school year (2011-2012) at 7 schools; Broad Acres ES, Summit Hall ES, Rolling Terrace ES, Shriver ES, Parkland MS, Sligo MS, Gaithersburg ES (totaling 105 students – 15 at each school).

The Walking Clubs was held last school year (2011-2012) at Beall ES, Bells Mill ES, Brooke Grove ES, Diamond ES, Greenwood ES, Rosemont ES, Waters Landing ES, Weller Road ES, Whetstone ES, and Thurgood Marshal ES (totaling 120 students – 12 at each school).

The Mead Family Foundation has renewed the $20K grant to the Montgomery County Department of Health and Human Services/School Health Services for FY 13. The program includes a Student Strides Walking Club and an after school Nutrition Nuggets club (developed in partnership with the Food Supplement Nutrition Education (FSNE) Program). The goal for FY13 is to expand these programs in content as well as to additional sites in order to reach more students in support of lowering obesity rates across the County.

Joan Glick, R.N.-C. M.S.N.
Director - School Health Services

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Rockville, Maryland 20850

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MCPS MONTGOMERY COUNTY PUBLIC SCHOOLS
www.montgomeryschoolsmd.org
MARYLAND
279-3547

Malcolm Baldrige National Quality Award
2010 Award Recipient

May 8, 2012

Ms. Vivian Yao
Senior Legislative Analyst
Montgomery County Council
100 Maryland Avenue
Rockville, MD 20850

Dear Ms. Yao:

In response to follow-up questions from the April 26, 2012, joint meeting of the County Council Education and Human Services committees on early childhood services, Montgomery County Public Schools (MCPS) staff has prepared the following responses.

1. Please provide an accounting of how much MCPS spends on fitness, nutrition, and obesity prevention education and services by program.

Response:

MCPS maintains an extensive effort to combat the dangers of childhood obesity through both nutrition and physical education programs. The *Healthy, Hunger-Free Kids Act of 2010* (HHFKA) focuses on improving nutrition and reducing childhood obesity. HHFKA provides additional funding to schools that meet updated nutritional standards as well as giving the United States Department of Agriculture (USDA) the authority to set nutritional standards for all foods regularly sold in schools during the school day. Meals served to MCPS students currently comply and exceed USDA regulations, and a la carte items offered to students through the school building are in compliance with *JPG-RA, Wellness: Physical and Nutritional Health.* Studies show that students who consume school meals both during the school year as well as during the summer consume larger amounts of healthier foods, specifically fruits and vegetables, learn appropriate portion control and are less likely to be obese. It is the goal of the MCPS Division of Food and Nutrition Services (DFNS) to ensure that all students have access to meals and snacks, focusing on increasing student participation in all available programs.

Recognizing that 33.3 percent of MCPS students are eligible for the Free and Reduced-price Meals System (FARMS) services and that one out of every three children in America now are considered overweight, DFNS has taken the following steps:

1. Increased the number of after-school suppers served to eligible students by 114 percent from school year 2010–2011 to school year 2011–2012.

2. Received $30,000 in grants funds from the Mead Family Foundation, which permitted DFNS to deduct 10 cents of the 40-cent cost of a reduced-price meal to all middle school students in order to allow greater access to the school lunch program.

3. Offers all reduced-price-eligible students breakfast at no cost in order to allow more students to access breakfast.

4. Applied for a $25,000 grant from the Mead Family Foundation for school year 2012–2013, which is intended to offer a weekly fresh fruit and vegetable self-service bar to 4–6 middle schools with higher percentages of FARMS eligible students.

5. Has partnered with the Maryland State Department of Education (MSDE) and the Maryland Department of Health and Mental Hygiene (DHMH) to receive bimonthly downloads for students who are certified directly for free meals. The number of students increased by almost 3,100 between school year 2010–2011 to 2011–2012.

6. Partnered with the Department of Health and Human Services (DHHS) to provide after-school snacks and after-schools suppers to the *Healthy Choices, Happy Students* Program.

7. Partnered with the Maryland Food Supplement Nutrition Education Program in the *Nutrition Nuggets* and *Read of Health* programs.

8. Partnered with the University of Maryland in the *Nudge* activity program, which encourages students to make healthy eating choices.

9. Hired a wellness specialist to collaborate with schools and students and participate in programs that promote healthy eating and wellness.

10. Recognizes the importance of increased consumption of fresh fruits and vegetables and has introduced entrée salads in 26 elementary schools as an additional reimbursable lunch choice.

11. Has added salad bars as part of the reimbursable meal to 16 schools, including three elementary schools.

12. Has reformulated recipes to offer lower sodium menu items.

13. Is focusing on featuring new and less processed menu items. Several items have been introduced recently.

14. Is collaborating with the Governor's Partnership to End Childhood Hunger by 2015. Initiatives to increase breakfast participation and access to the summer meals program are in place.

15. Has been awarded the Healthy US Schools Challenge Award in all 132 elementary schools at the Bronze level; and awaiting award notice for 56 elementary schools to receive the Silver level award.

In order to meet the increase in nutritional quality of MCPS meals and snacks, the following are examples of areas of cost increase from Fiscal Year (FY) 2011 to FY 2012:

- Fresh Produce—33 percent ($368,000). As indicated above, salad bars in schools at all levels and entrée salads for elementary schools have resulted in an increase expense in this area. Direct costs for the elementary entrée salad averages $2.62, which exceeds the lunch price of $2.50 at the elementary level. In addition, fresh fruit is available on all serving lines at all times.

- Meat items—15 percent ($692,000). DFNS is focusing on less processed items in beef and poultry. Whole grain breading is specified on breaded meat items.

- Grains—7 percent ($138,000). DFNS continues to focus on converting breads, rice, and pasta to whole grain.

- Dairy items—10 percent ($350,000). DFNS purchases a reduced-sugar, fat-free flavored milk to encourage more children to select milk. In order to purchase yogurt that is free of high fructose corn syrup, a higher cost is incurred.

- The addition of the wellness specialist position increased costs for salary and employee benefits by $98,000.

- The reduction of revenue associated with the Mead Family Foundation grant, which paid 10 cents toward the reduced cost of lunch at all middle schools, is $29,500.

- Eliminating the reduced breakfast price of 30 cents to students lowered potential revenue by $150,000.

In order to afford the increase in costs, DFNS will continue to do the following:

- Maximize the utilization of food items through the USDA Commodity Food Program.

- Assure that all meals continue to meet the new regulations in order to take advantage of the additional 6 cents per meal reimbursement that is to begin October 1, 2012.

- Continue to work diligently to control costs.

- Continue to collaborate with agencies outside of MCPS and maximize all grant opportunities.

- Provide nutrition education and program outreach to increase program participation.

MCPS provides students with skills and knowledge to develop a healthy lifestyle through nutrition education, physical education, physical activity, and healthy food options in compliance with MCPS Regulation, JPG-RA, *Wellness: Physical and Nutritional Health.* The standards-based MCPS health education and physical education curriculum and instructional resources provide teachers and students with a continuous sequence of learning informed by contemporary

health-related fitness and nutrition best practices. Fitness, nutrition, and wellness concepts are integrated into instructional units across all grades, prekindergarten through Grade 8 and in high school courses.

The standards-based prekindergarten through Grade 12 physical education curriculum emphasizes the following:

- Participation in moderate to vigorous physical activity
- Development of knowledge, motor skills, and positive attitudes
- Identification, creation, and revision of goals (short-term and long-term) related to fitness and physical activity
- Engagement in meaningful activities as prescribed by the research-based guidelines of FITT (frequency, intensity, time, and type)
- Promotion of physical activity and sports involvement

Physical education instruction promotes understanding and application of the components of fitness and healthy lifestyles in the following ways:

- Developmentally appropriate instruction in a variety of motor skills designed to enhance the physical, mental/emotional, and social development of every student
- Fitness education and assessment (Fitnessgram®) to help students understand, improve, and/or maintain their physical well-being and develop their individual fitness plans
- Fitness equipment to improve muscular strength, muscular endurance, flexibility, and cardiorespiratory fitness for middle and high school students
- Adapted physical education and assessment (Brockport Physical Fitness Test, Functional Assessment for Students with Severe Disabilities, Maryland Physical Education Inventory, and Test for Gross Motor Development—2) for students with special needs

Health education instruction promotes understanding of personal well-being, healthy nutrition, healthy goal-setting, and fitness concepts. The curriculum includes the following:

- Nutrition and fitness education integrated into the health education and physical education curriculum for prekindergarten through Grade 5.
- Nutrition and fitness education is provided as part of the nine-week comprehensive health education curriculum in Grades 6 through 8.
- Nutrition and fitness education is provided within the required comprehensive health education course in high school.
- Nutrition and fitness education is provided in numerous high school elective courses.
- Mental and emotional health unit provides instruction on physical well-being.
- Mental and emotional health unit provides students with opportunities to develop personal health goals and track progress towards achievement.

Extracurricular physical activity in elementary, middle, and high schools provides students with additional opportunities to increase or maintain their levels of physical activity and fitness. Examples of extracurricular activities may include, but are not limited to the following:

- Morning workout programs
- Recess fitness programs for elementary school students (i.e., Mileage Club and Student Strides Walking Club)
- After-school programs (i.e., Girls on the Run and Excel Beyond the Bell)
- Middle school physical education intramural program
- Middle school athletics program (cross country, basketball, softball, and soccer)
- Corollary sports for high school students (track and field, bocce, and softball)
- Interscholastic sports for high school students

The *Operating Budget and Personnel Complement FY 2012* provides information about costs for instructional materials, equipment, and staffing allocated to schools. Elementary schools are addressed in Chapter 1–9 and 1–10, middle schools in Chapter 1–19 and 1–20, and high schools in Chapter 1–27 and 1–28. Chapters 4–38 through 4–40 detail the mission, functions, accomplishments, and strategies of the Department of Curriculum and Instruction, which develops curriculum, instruction, assessment, and professional development resources for content areas including health and physical education. The program description for elementary physical education from the *Program Budget FY 2013* provides additional information. For FY 2013, the cost of this program is $10,993,119, not including related employee benefits, and includes 145.9 full-time equivalent positions.

2. Please explain how MCPS would respond to the proposed $50,000 reduction to its Alternative Education contract with DHHS. Will MCPS make up for the reduction and provide the same level of social worker support services as currently provided? How would MCPS respond to a complete elimination of the Alternative Education contract?

DHHS has provided support for many years to the MCPS Office of Special Education and Student Services for social work services for approximately 80 students at middle school alternative programs, including the Fleet Street, Glenmont, and Hadley Farms programs. These programs serve students who have difficulty in succeeding in a traditional school environment and require an alternative setting. For FY 2012, DHHS and MCPS have executed a contract totaling $114,000. Since 2001, MCPS has arranged a subcontract with Family Support Center, Inc., to provide needed social work services.

Services provided by licensed clinical social workers include small group counseling; drug use prevention and intervention; individual counseling for eating disorders, grief, and suicide prevention; emergency referrals to outside agencies; parent outreach; and family advocacy services. The credentials and training of a licensed clinical social worker are significantly different from a school counselor. Licensed clinical social workers are certified to provide

mental health therapy. Their role is critical in supporting and guiding parents, administrators, teachers, counselors, and, most importantly, students who require mental health services. The goals of the social work services are to help improve student academic performance and enable students to return to their home schools as quickly as possible. Some of the students participating in these services are special education students, for whom mental health services are determined by the Individualized Education Program (IEP) team.

DHHS has informed MCPS that it intends to reduce its support for social work services from $114,000 to $64,000. The continued support guarantees that all special education students will continue to receive services required by their IEPs and that the alternative programs staff can prioritize services for remaining students to continue the most critical support. MCPS currently has one current full-time, 12-month social worker assigned to the programs. Continued county support will provide MCPS staff with an opportunity to review the needs of all the middle school students in these programs, identify available resources, and determine the appropriate funding amount for FY 2014 and future years. Budget planning will take into account the possibility that all county funding may be discontinued.

MCPS staff is available to answer any additional questions. If you have any questions, please contact me at 301-279-3547.

Sincerely,

Marshall C. Spatz
Director

MCS:jp

Copy to:
Mr. Bowers
Mrs. Caplon
Mrs. Lazor
Ms. Garvey

Montgomery County Commission on Health

Commission on Health recommendations on obesity prevention

Presentation to Joint Education
and
Health and Human Services Committee
July 30, 2012

Addressing the Problem

- Montgomery County is at increasing risk for poor health due to high levels of obesity
- Obesity leads to higher costs and lower productivity
- The Commission on Health determined a need to focus its attention on preventing obesity
  - Conducted an extensive literature search
  - Identified evidence to focus Commission's efforts
- Decided to focus on the CDC Community Strategies Guide
- Queried County agencies about current policies and recommended specific CDC strategies.

The CDC Community Strategies Guide specifically addresses local government's role in reversing the obesity epidemic:

"Many aspects of our physical environment that influence our health are created, managed, and maintained by local governments…Clearly, local governments and public school systems can make a real difference in creating healthy food and activity environments that benefit all people living in their communities." (Community Strategies Page 2)

What Can County Government Do?

- Revise policies to integrate CDC recommended strategies
- Serve as a model for the private sector
- Create an environment within the County that promotes strategies that can prevent or reduce obesity
- Take policy action without increasing expenditures

The CDC Guide recommends 24 strategies, the Commission selected the following for its work:

- CDC Strategy 2: Communities should improve the availability of affordable food and beverage choices in public service venues.
- CDC Strategy 6/4: Communities should provide incentives for the production, distribution, and procurement of foods from local farms./Communities should provide incentives to food retailers to locate in and/or offer healthier food and beverage choices in underserved areas.
- CDC Strategy 11: Communities should increase support for breastfeeding.
- CDC Strategy 14: Communities should increase opportunities for extracurricular physical activity.

Strategy 2 – Improve the availability of healthier food and beverages in public service venues

The Commission wrote to the County and bi-County agencies asking about their policy for food in vending machines. Questions were asked about nutrition standards, adjusting prices to encourage the purchase of healthy foods, using icons to identify healthy foods, offering incentives, and education.

The Commission recommends the following guidelines for vending machine offerings in government buildings:

Product: Adopt healthy-choice nutritional standards for vending machines. A list of healthy products that meet nutritional standards should be developed and maintained.

Pricing: The pricing of healthy items can be a strong determinant when choosing from a vending machine, and may well be a key to changing behavior. Cost can positively or negatively impact purchasing decisions.

Placement: Proper placement of the healthy vending machine items can assist employees in identifying healthy choices and makes it easier to purchase a healthy item.

Promotion: Promotion or publicizing the availability of healthy food products is critical to success.

Implementation: Current procurement contracts should be revised to reflect the adopted nutritional guidelines for vending machines and all new contracts should comply with county guidelines.

Enforcement: Vending machines should be inspected quarterly and vendors that do not comply should be removed from service.

The Commission did not receive written responses from the agencies. Our liaison to the Obesity Strategies Work Group has informed us that County Government expects to implement a pilot program to improve healthy choices in County Government vending machines.

Strategies 6/4 – Provide incentives for the production, distribution, and procurement of foods from local farms. Provide incentives to food retailers to locate in and/or offer healthier food and beverage choices in underserved areas.

Commission members met with the Department of Economic Development's Agricultural Services Division:

- explored agricultural strategies/incentives and business processes.
- discussed potential barriers to accessing healthy foods for the elderly, disabled, and lower income families.

The Commission believes Montgomery County should adopt policies that encourage the procurement of food from local farms, promote and increase the viability of local farms, and increase the availability, security, and consumption of healthful, locally-produced foods. Incentives may include farmland preservation, marketing of local crops, zoning variances, subsidies, and streamlined licensing.

The Commission recommends that the County Council and Executive review proposals from DED on horticultural and agricultural uses in the Rural Density Transfer zone. (The response from Council President Berliner indicated that no proposal has been received by the Council at this time.)

Strategy 11 – Increase support for breastfeeding

The Commission wrote to the County and bi-County agencies asking about their policies to allow and encourage mothers to breastfeed. The letter noted the health advantages of breastfeeding as well as information on federal law supporting breastfeeding in the workplace. Employers are required to provide reasonable break time and a private, non-bathroom place for nursing mothers to express milk during the workday for one year after a child's birth.

The Commission recommends:

- Montgomery County agencies have clear policies requiring facilities to provide breastfeeding accommodations that include both time and a clean space for expressing milk during work hours. The facilities should be a private, enclosed area with an electrical outlet and must not be a bathroom. A refrigerator should be available.

- State and local governments can offer incentives to private businesses to accommodate breastfeeding by employees; they can also set policies requiring government agencies to support breastfeeding by female employees.

- Any policy referring to breastfeeding practices should include a communication strategy to improve awareness and clearly state consequences of non-compliance.

The Commission received a response from M-NCPPC (attached) that provides information on its "Nursing Mother Program" that has been in place since 1995. It notes that, while not required, past practice has been that a private area with or near clean water and a refrigerator has been available. M-NCPPC health plans do not cover lactation assistance.

The Commission received a response from Montgomery College that they do provide break time for nursing mothers and that a supervisor will arrange for a room that is not a bathroom and is shielded and free from intrusions. Health plans do not cover lactation assistance.

The Commission did not receive responses from the other agencies.

Strategy 14 – Increase opportunities for extracurricular physical activity

The Commission wrote to MCPS, M-NCPPC, and the Recreation Department noting the benefits of physical activity in decreasing obesity, cardiovascular disease, Type 2 Diabetes, and some cancers and in improving mental health and mood. The Commission cited after-school pilot programs in Palo Alto and Oakland that showed significant impact on activity and highlighted significant barriers to access and participation, including transportation. We asked MCPS, M-NCPPC, and the Recreation Department what programs they had in place, criteria for participation, and what they view as major barriers to participation.

The Commission recommends:

1. MCPS develop programs that encourage their students not currently involved in sports to increase physical activity as a part of a healthy lifestyle.

2. MCPS measure weight and height from students and provide anonymous BMI data to DHHS to track obesity rates and set a baseline for future obesity prevention programs.

3. MCPS add Field Day as a part of the Elementary School K-5 physical education program. An event that celebrates physical education sends a strong message of the importance of physical activity and a healthy lifestyle.

- The Commission received a response from MCPS (attached) saying that MCPS middle schools offer opportunity to participate in 7 interscholastic athletic teams and that the high school program includes 40 interscholastic teams per each high school. The $30 activity fee is contingent on income. Barriers to offering additional activities include limited facilities, funds, interest, and personnel to supervise activities.

- MCPS does not measure BMI and responded that it provides few medical tests for students. This information is not required to participate in athletic teams.

- The Commission is concerned that unless BMI data is collected, the county will not accurately understand trends in childhood obesity. The 2008 Maryland Task Force on Student Physical Fitness called for investigating BMI assessment in schools for the purpose of surveillance and to determine the efficacy of obesity prevention and intervention programs. It noted that there must be consideration of privacy issues, measurement techniques, training, parental notification, and linking families to community resources.

- The Commission has recently been made aware of Harford County Public Schools use of the FitnessGram program that includes measuring BMI (attached). We hope to look into this effort to see if it might be a model for MCPS.

Summary of Commission's Recommendations

- Focus on policy and practices of county agencies
- Require an investment in education within and action by county agencies, not new resources
- Assess feasibility to implement throughout the county
- Improve health within the county

The Commission's goal in providing these recommendations is to improve the health status of our community in a responsible and responsive manner.

It is our vision that the healthy choice is the easy choice for all Montgomery County residents.

Attached Information:

March 22, 2012 letter to Montgomery County Council with recommendations on CDC Obesity Prevention Strategies 2, 11, and 14.

April 19, 2012 letter to Montgomery County Council with recommendations on CDC Obesity Prevention Strategies 4 and 6.

November 2010 literature search on strategies to reduce obesity.

Excerpt from introduction in CDC's Community Strategy Guide – Local Government's Role

List of CDC's 24 recommended strategies for Obesity Prevention.

Excerpt from CDC Community Strategy Guide – Strategy 2 – improve availability of healthy food.

Excerpt from CDC Community Strategy Guide – Strategy 4 – incentives to retailers to offer healthier foods in underserved areas.

Excerpt from CDC Community Strategy Guide – Strategy 6 – Incentives for the production and procurement of food from local farms.

Excerpt from CDC Community Strategy Guide – Strategy 11 – Increase support for breastfeeding.

Excerpt from CDC Community Strategy Guide – Strategy 14 – Increase opportunities for extracurricular physical activity.

Letter to Department of General Services re: policy on food in vending machines (similar letter was sent to each county and bi-county agency.

Letter to Montgomery College re: breastfeeding policies (similar letter was sent to each county and bi-county agency).

Response from M-NCPPC re: breastfeeding policies. Response from College was by e-mail.

Letter to MCPS re: physical activity (similar letter was sent to M-NCPPC and Recreation Department).

Response from MCPS re: extracurricular physical activity.

Harford County Public School's information on Fitnessgram assessment.

Excerpt from 2008 Task Force on Student Physical Fitness in Maryland Public Schools.

HHS

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Isiah Leggett
County Executive

Uma S. Ahluwalia
Director

March 22, 2012

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Roger Berliner, President
Montgomery County Council
100 Maryland Avenue
Rockville, Maryland 20850

Dear Council President Berliner:

The Montgomery County Commission on Health (COH) is supporting the Montgomery County Department of Health and Human Services' (DHHS) effort to reduce adult and childhood obesity in the County. As a commission, we reviewed 24 strategies to prevent obesity in children and adults recommended by the Centers for Disease Control and Prevention (CDC) and identified four as our focus. http://www.cdc.gov/obesity/downloads/community_strategies_guide.pdf

- Strategy 2: Communities should improve availability of affordable healthier food and beverage choices in public service venues.
- Strategy 6/4: Communities should provide incentives for the production, distribution, and procurement of foods from local farms/Communities should provide incentives to food retailers to locate in and/or offer healthier food and beverage choices in underserved areas.
- Strategy 11: Communities should increase support for breastfeeding.
- Strategy 14: Communities should increase opportunities for extracurricular physical activity.

This letter addresses Strategies 2, 11, and 14. A letter regarding Strategy 6/4 will be finalized later this spring and thus is not addressed in this letter.

To assess current county practices around the four obesity prevention strategies we sent fact finding letters to the following county agencies: Montgomery County Government (Office of Human Resources and General Services), MCPS, Park and Planning, Montgomery College and WSSC. We received responses from two of the five agencies. However, after reviewing the literature and other sources of information, the Commission is prepared to submit recommendations to the County Executive and County Council for your consideration.

In conducting our work, we organized in four workgroups. Each group was assigned one strategy to research and outline recommendations. What follows is the final report of each workgroup by Strategy.

Strategy 2 Workgroup: "Communities should improve availability of affordable healthier food and beverage choices in public service venues"

Literature reviews conducted by a number of science-based organizations have found evidence to support environmental strategies such as increasing availability and variety of healthy food options, reducing the price of healthy food in work site cafeterias and vending machines, and tailored nutrition education to help people make better food choices.

In an effort to understand County policies to support healthy foods in county facilities, a letter to the Director of General Services was sent on November 18, 2011 requesting information on such policies. Specifically, information was requested on policies for nutritional standards for food products sold in County cafeterias and vending machines (non-MCPS facilities) and policies regarding the promotion, placement, and pricing of foods. A response to that letter has not been received. COH research on county websites and communications with the County Obesity Prevention Strategy Group did not reveal relevant existing nutritional policies or guidelines for vending machines.

A healthy Montgomery County population is a high priority. Implementing healthy vending machine policies in worksites and County facilities can be an effective strategy for increasing access to healthy foods for employees and visitors to Montgomery County facilities. The COH recommends that the County Executive establish ***Nutritional Guidelines for Vending Machines*** in County facilities. These guidelines should apply to all vending machines located on property owned or leased by the County. Guidelines should include provisions that address: characteristics of the products to be sold such as pricing, placement, and promotion.

Product: Adopt healthy-choice nutritional standards for vending machines. A list of healthy products that meet nutritional standards should be developed and maintained.

Examples:

- Standards for food should consider calories, fats, sugar, sodium and fiber content and portion size. Products should not contain trans-fats.
- Standards for beverages should consider calories, fat, and sugar or high-fructose corn syrup content and size. Water should be included among choices.

Pricing: The pricing of healthy items can be a strong determinant when choosing from a vending machine, and may well be a key to changing behavior. Cost can positively or negatively impact purchasing decisions.

Examples:

- Healthy items should not cost more than the regular version.
- The price of the healthy items should either be set lower than the regular version of the items, or a comparable level. For example, water should cost less than soda.

Placement: Proper placement of the healthy vending machine items can assist employees in identifying the healthy choices and makes it easier to purchase a healthy item.

Examples:

- Fifty percent of products will be healthy food and drink choices.
- Healthy items should be placed in center rows or in the far left rows of machines for easy viewing and selection.
- Healthy choices should be inventoried and filled by contractors/vendors at all times.

Promotion: Promotion or publicizing the availability of healthy food products is critical to success.

Examples:

- Promotional materials may include front of package good choice symbols (i.e. Heart Healthy) or labeling, posters, bill boards, table tents.
- Information to employees through websites, newsletters, or emails.

Implementation: Current procurement contracts with vending machine providers should be reviewed immediately and revised accordingly to reflect the *Nutritional Guidelines for Vending Machines*. For new contracts, new Requests for Proposals should include in the solicitation a statement that all vending machines must comply with the nutritional guidelines.

Enforcement: Vending machines should be inspected periodically (quarterly) for adherence. Contractors/vendors that do not comply should be removed from service.

Strategy 11 Workgroup: Communities should increase support for breastfeeding

Research has shown that breastfeeding provides a significant degree of protection against childhood obesity (IOM, http://www.iom.edu/Reports/2011/Updating-the-USDA-National-Breastfeeding-Campaign-Workshop-Summary.aspx). Despite the advantages of breastfeeding, many women who work outside the home must bottle-feed their babies because their work setting does not provide time or private space to breastfeed or to pump breast milk. Further, federal law supports breastfeeding in the workplace. Section 4207 of the Patient Protection and Affordable Care Act (also known as Health Care Reform), signed into law on March 23, 2010, amended the Fair Labor Standards Act (FLSA) or federal wage and hour law regarding breastfeeding. The amendment requires employers to provide reasonable break time and a private, non-bathroom place for nursing mothers to express breast milk during the workday, for one year after the child's birth. Current applicable laws related to breastfeeding in the U.S. can be found at: http://www.usbreastfeeding.org/LegislationPolicy/ExistingLegislation/tabid/233/Default.aspx

The COH offers the following recommendations:

1. Montgomery County Government needs a clear policy requiring government agencies/facilities to provide breastfeeding accommodations for employees that include both time and designated clean space for breastfeeding and expressing breast milk during working hours. These facilities should be private, enclosed areas with an electrical outlet and equipped with a refrigerator for storage. This area cannot be a bathroom.

2. State and local governments can offer incentives to private businesses to accommodate breastfeeding among employees; they can also set policies that require government facilities to support breastfeeding among female employees.

3. Any policy referring to breastfeeding practices should include a communication strategy to improve awareness and clearly state consequences for non-compliance with the policy.

Strategy 14 Workgroup: Communities should increase opportunities for extracurricular physical activity

The COH offers the following recommendations:

1. MCPS should develop programs that encourage their students not currently involved in interscholastic sports to increase physical activity as part of a healthy lifestyle.

2. MCPS should measure weight and height from students and provide anonymous Body Mass Index (BMI) data to the Montgomery County DHHS to track obesity rates, and set a baseline for future obesity prevention programs.

3. MCPS should add Field Day as part of the Elementary School K-5 Physical Education Program. With pressure to increase time in other subjects, an event that celebrates physical education sends a strong message of the importance of physical activity to a healthy lifestyle.

The Commission takes these recommendations very seriously. While the four obesity prevention strategies and recommendations appear to be simple in nature, some will require policy and programmatic changes. Our ultimate goal, which we believe is also shared by the County Executive and County Council, is to improve the health status of our community in a responsible and responsive manner.

It is our vision that the healthy choice is the easy choice for all Montgomery County residents.

As always, the Commission on Health appreciates the opportunity to serve the residents of Montgomery County. We look forward to working with the County Executive and County Council to improve the health and wellness of our residents.

Thank you for your consideration of these recommendations.

Sincerely,

Marcos Pesquera, R.Ph., MPH
Chair, Montgomery County Commission on Health

CC:
Uma Ahluwalia, Director, Department of Health and Human Services
Dr. Ulder J. Tillman, County Health Officer

References

Timmings, Caitlyn, Steven Savvaidis, Manager, Matt Drennan-Scace. Addressing healthy eating and active living: a community level policy scan. 2011. Second Edition Report prepared by: Media Network Media Network Expansion Project, Program Training and Consultation Centre, University of Toronto

Gemmill E, Cotugna N. Vending machine policies and practices in Delaware. J Sch Nurs. 2005 Apr;21(2):94-9. Source Department of Health, Nutrition and Exercise Sciences, University of Delaware, Newark, DE, USA.

Kim, Daniel and Ichiro Kawachi. 2006. Food Taxation and Pricing Strategies to Thin Out the Obesity Epidemic. American Journal of Preventive Medicine 30(5): 430-437.

San Diego and Imperial Regional Nutrition Network. Literature review on strategies for healthy vending, Funded by the USDA Food Stamp Program, an equal opportunity employer and provider, through the California Nutrition Network.

Healthy Vending Guide, Nemours
http://www.nemours.org/content/dam/nemours/www/filebox/service/preventive/nhps/resource/healthyvending.pdf

Kelly B, Baur LA, Bauman AE, King L, Chapman K, Smith BJ. Examining opportunities for promotion of healthy eating at children's sports clubs. Aust N Z J Public Health. 2010 Dec;34(6):583-8. Prevention Research Collaboration, School of Public Health, University of Sydney, New South Wales.

Healthy Vending Policy, Monterey, CA
http://www.co.monterey.ca.us/admin/pdfs/HealthyVendingPolicy.pdf

Developing Policies that Support Healthy Options in Vending Machines, the Healthy Maine Partnership.
http://www.healthymainepartnerships.org/panp/site/226-008-04_kit.pdf\

Vending Machines. Developed in partnership between the NC Division of Public Health, NC Department of Public Instruction, NC Cooperative Extension and NC Action for Healthy Kids.
http://www.eatsmartmovemorenc.com/EatSmartSchoolStds/Texts/vending.pdf

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Isiah Leggett
County Executive

Uma S. Ahluwalia
Director

RECEIVED
COUNTY

April 19, 2012

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Roger Berliner, President
Montgomery County Council
100 Maryland Avenue
Rockville, Maryland 20850

Dear Council President Berliner:

The Montgomery County Commission on Health continues to make the obesity problem and approaches to appropriate interventions in Montgomery County a priority.

Scientific evidence has demonstrated that successful approaches to the reduction of the leading causes of death and disability in the United States – heart disease, cancer, and diabetes - are related to dietary patterns and physical activity, particularly in young populations. **Ref 1.** In combating the obesity epidemic, it is well established that good nutrition is vital to good health, disease prevention, and essential for healthy growth and development of children and adolescents. **Ref 2.**

In this effort, the Commission has participated with several groups and pursued a variety of strategies, including support of the Healthy Montgomery, the Montgomery County Community Health Improvement Process (MCCHIP); Maryland's State Health Improvement Process (SHIP) and the County Obesity Prevention Strategy Group (OPSG) to improve the health and well-being of Montgomery County residents. These collaborative efforts are designed to address the nutrition-related health status, food access and disparity problems in Montgomery County and have developed obesity-related objectives and measures which are tracked for status and improvement. **Ref 3.**

The U.S. Centers for Disease Control and Prevention (CDCP) has identified several strategies for creating and maintaining a healthy food environment in local areas. These strategies involve rethinking local zoning, land use planning, urban/peri-urban agriculture, farmland protection, local food distribution, food access, and more. **Refs. 4,5.** The Commission has reviewed these approaches for applicability to Montgomery County.

To learn more about current obstacles to combat the obesity epidemic in Montgomery County, the Commission has met with the Montgomery County Department of Economic Development (DED) and it's Agricultural Services Division. In these discussions, the Commission has learned that the County's current land use and permitting regulations impose barriers to agricultural and horticultural businesses in Montgomery County. The DED has developed approaches that are designed to foster an environment to permit agricultural processing operations in the agricultural zone where agriculture is the preferred use, and identifies land uses that are needed to achieve the goals of more agricultural processing operations and farms similar to other jurisdictions where residents can more readily purchase locally grown and processed foods.

Based upon its studies, the Commission believes that Montgomery County should adopt policies that encourage the procurement of food from local farms. County policies should promote and increase the viability of local farms, and thus the availability, security and consumption of healthful locally-produced foods. Thus, the Commission supports incentives such as farmland preservation, marketing of local crops, zoning variances, subsidies, and streamlined licensing.

The Commission supports efforts at all levels of government to reduce obesity and improve community health, employing a wide variety of related strategies. Based on our recent studies, the Commission recommends that the County Council and the County Executive review the forthcoming DED proposal for *Zoning Text Amendments on Horticultural and Agricultural Uses in the Rural Density Transfer Zone*. We encourage the Council to hold hearings on these and other DED proposals in the near future.

The Commission has explored many strategies and opportunities to reduce obesity in Montgomery County and looks forward to working with you on these proposals for enhancing the nutritional and overall health status of our residents.

Sincerely,

Marcos Pesquera, R.Ph., MPH
Chair, Montgomery County Commission on Health

CC:
Uma Ahluwalia, Director, Department of Health and Human Services
Dr. Ulder J. Tillman, County Health Officer

References

Reference 1:
Centers for Disease Control and prevention: *Overweight and Obesity* CDC Division of Nutrition, Physical Activity, and Obesity (DNPAO)
http://www.cdc.gov/obesity/

Reference 2:
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Glanz, et al. *Healthy nutrition environments: concepts and measures*. Am J Health Promotion. 2005; 19(5):330-3, ii.

Horowitz CR, Colson KA, Hebert PL, Lancaster K. *Barriers to buying healthy foods for people with diabetes: evidence of environmental disparities*. Am J Pub Health. 2004; 94:1549-54.

Reference 3:
Healthy Montgomery: *The Community Health Improvement Process for Montgomery County, MD* :see for example: Community Dashboard (exercise, nutrition & weight; diabetes; heart disease & stroke, etc.)
http://www.healthymontgomery.org/

Maryland Department of Health and Mental Hygiene: *Maryland State health Improvement Process* (SHIP): Nutrition Measures (diabetes; hypertension; obesity & healthy weight)
http://dhmh.maryland.gov/ship/SitePages/Home.aspx

Reference 4:
Centers for Disease Control and Prevention: *Healthy Food Environment*
http://www.cdc.gov/healthyplaces/healthtopics/healthyfood_environment.htm

Reference 5:
Centers for Disease Control and Prevention: *Recommended Community Strategies and Measurements to Prevent Obesity in the United States. Khan et.al.,* Division of Nutrition, Physical Activity, and Obesity, National Center for Chronic Disease Prevention and Health Promotion, CDC
http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5807a1.htm

Strategies for Reducing Obesity

Recommendations/Strategies

1. **Recommended Community Strategies and Measurements to Prevent Obesity in the United States** – CDC; 2009; http://www.cdc.gov/mmwr/pdf/rr/rr5807.pdf
&
2. **Recommended Community Strategies and Measurements to Prevent Obesity in the United States: Implementation and Measurement Guide** – CDC; 2009; http://www.cdc.gov/obesity/downloads/community_strategies_guide.pdf

Reports containing policy-level obesity prevention strategies and guidance for implementing the strategies. Recommended strategies are based on a literature review and expert opinion (experts identified the most promising strategies of those found in the literature).

Recommended Community Strategies includes 24 strategies, the evidence on which they were recommended, and suggested measurements.

The *Implementation and Measurement Guide* (which may be more useful) presents those same 24 strategies along with examples of how communities have implemented the strategies; links to resources (some of which contain additional specific strategies to support the general strategies); suggested measures to demonstrate progress; and measurement "tips." I printed a portion of the *Guide* containing the Table of Contents, Introduction, the full list of recommended strategies, and the description of the first strategy so you could see what type of information is included.

There is also a PowerPoint to accompany these resources called *Health Communities: What Local Governments Can Do to Reduce and Prevent Obesity.* It is the first resource in the "New!" box on the CDC's Overweight and Obesity Recommendations page (http://www.cdc.gov/obesity/recommendations.html).

3. **Public Health Strategies for Preventing and Controlling Overweight and Obesity in School and Worksite Settings** – CDC; 2005; http://www.cdc.gov/mmwr/pdf/rr/rr5410.pdf

A systematic review developed for the Community Guide. Concludes that there is insufficient evidence to determine the effectiveness of school-based nutrition and physical fitness interventions due to a limited number of qualifying studies reporting comparable outcomes. Worksite interventions that combine nutrition and physical fitness are recommended, but there is insufficient evidence to determine the effectiveness of physical activity, nutrition, or behavioral interventions used separately.

4. **School-Based Obesity Prevention Strategies for State Policymakers** – CDC; http://www.cdc.gov/healthyYouth/policy/pdf/obesity_prevention_strategies.pdf

"Strategies that states have used and that have shown promise in helping schools address childhood obesity."

5. **The Role of Schools in Preventing Childhood Obesity** – The State Education Standard; 2004; http://www.cdc.gov/HealthyYouth/physicalactivity/pdf/roleofschools_obesity.pdf

Presents 10 key strategies for schools to use in improving nutrition and increasing physical activity among students. Summarizes CDC guidelines that were based on literature review and expert opinion. Includes examples of what schools have done.

CDC Materials that relate to these strategies are presented in *Make a Difference at Your School! CDC Resources Can Help You Implement Strategies to Prevent Obesity among Children and Adolescents* (http://www.cdc.gov/HealthyYouth/keystrategies/pdf/make-a-difference.pdf). Both resources are available at http://www.cdc.gov/HealthyYouth/keystrategies/index.htm.

6. **Community Guide – Obesity Control and Prevention: Interventions in Community Settings** – (http://www.thecommunityguide.org/obesity/communitysettings.html)

Contains community-level recommendations. Behavioral interventions to reduce screen time; technology-supported, multicomponent coaching or counseling interventions; and worksite

programs are recommended. There is insufficient evidence to determine the effectiveness of mass media interventions to reduce screen time or school-based programs.

Literature

7. **Interventions for Preventing Obesity in Children** – Cochrane Review; 2009; http://onlinelibrary.wiley.com/o/cochrane/clsysrev/articles/CD001871/pdf_abstract_fs.html

"The current evidence suggests that many diet and exercise interventions to prevent obesity in children are not effective in preventing weight gain, but can be effective in promoting a healthy diet and increased physical activity levels.... There is not enough evidence from trials to prove that any one particular programme can prevent obesity in children, although comprehensive strategies to address dietary and physical activity change, together with psycho-social support and environmental change may help."

8. **Studies on which the Community Guide recommendations are based**:

A. Literature related to behavioral interventions to reduce screen time (http://www.thecommunityguide.org/obesity/supportingmaterials/ISscreentime_behavioral.html). Most of these studies involve school-based programs/curricula.

B. Literature related to worksite programs (http://www.thecommunityguide.org/obesity/supportingmaterials/IS-worksite.html). Mainly programs focused on nutrition and exercise using counseling, education, activities.

C. Evidence summary table for worksite programs (http://www.thecommunityguide.org/obesity/supportingmaterials/SETWorksiteobesity.pdf).

I've emailed the Community Guide people to ask about the literature for the rest of the interventions, but haven't heard anything yet. I can let you know if/when I do, but the other resources above might be a more efficient starting place.

9. **PubMed Literature Searches** (I've highlighted relevant conclusions where abstracts were available and starred a few papers that seem like the most promising.):

A. Effectiveness of Obesity Prevention and Control Strategies – Some of these will be irrelevant, but this gives a flavor of what has been published. If there are any specific articles you would like, just let me know.

B. Health Education and Obesity Prevention and Control – Determining the efficacy of health education in relation to obesity appears difficult to do.

C. Health Fairs and Obesity Prevention and Control – There appears to be little evaluation of health fairs targeting obesity.

D. Effectiveness of Health Fairs – I pulled out articles which appear to evaluate health fairs in general rather than those for a specific condition, with the exception of a couple related to nutrition and fitness that might be relevant. My impression is that health fairs may or may not work. Many of these articles don't have abstracts in PubMed so it's hard to know. They may be effective for information dissemination and increasing knowledge level.

10. **Challenges and Failures of Health Fairs and Community Screenings** – Unite for Sight; http://www.uniteforsight.org/health-screenings/health-screenings

Reports that there are few quality studies assessing the effectiveness of health fairs, especially with respect to health outcomes. Focused mainly on health fairs used to conduct health screenings. Not sure how good this material is, but it's the best I found online.

11. As a bonus! **Possible Lessons from the Tobacco Experience for Obesity Control** – Am J Clin Nutr; 2003

I haven't really read this, but it sounds kind of neat....

Local Governments' Role in Reversing the Obesity Epidemic

Many aspects of our physical environment that influence our health are created, managed, and maintained by local governments. For example, local policies and incentives can affect the presence and absence of parks, sidewalks, bike lanes, mixed-use development, healthy food retailers, and farmers markets. Public schools—although not under the authority of local governments—also have a vital role in ensuring that children have access to healthy food and sufficient opportunities for physical activity during the school day. Clearly, local governments and public school systems can make a real difference in creating healthy food and activity environments that benefit all people living in their communities.

Aside from the health benefits, there are also economic benefits to local governments for creating walkable, safe, and food-secure environments. For example, home values are expected to rise faster in "smart communities" that are made pedestrian-friendly by employing mixed-use development, sidewalks, and traffic-calming features (Local Government Commission Center for Livable Communities, n.d.).

How Local Governments Can Use Strategies and Measures of Environmental and Policy-Level Change

In order for local governments to target strategic investments that promote healthy eating and active living in their communities, they need information about the current conditions in their community that could be improved to better facilitate the health of their citizens. In addition, communities need tools to track their progress over time and to compare themselves to other similar communities on measures of environmental and policy change for obesity prevention. Accordingly, the 24 strategies and measures presented in this manual are designed to meet these needs. More specifically, the strategies and measures can be used by local governments and communities in three ways:

1. **For baseline assessment**
   - Do the policies and environmental conditions in our community currently promote active living and healthy eating?
   - How do our policies and environmental conditions compare to other communities of similar size, type, and population?

2. **To identify priorities for action**
   - What aspects of our environment are in greatest need of improvement to promote the health of our citizens?
   - Which strategies should we choose to implement to become a healthier community?

3. **To measure change over time**
   - Are we making progress from year to year in changing policies and environmental conditions to promote active living and healthy eating?

How the Strategies and Measures Were Identified and Developed

The strategies described in this manual are the product of an intensive collaborative process involving a cadre of nutrition and active living experts. A literature search was conducted to identify a broad range of environmental and policy-level strategies for obesity prevention. The results of the search were reviewed and narrowed by a select panel of nutrition and active living experts who were asked to prioritize the strategies based on their potential for extended reach, mutability, transferability, effectiveness, and sustainability.

After the strategies were identified, nutrition and active living experts and local government representatives were asked to nominate measures for each strategy while considering the criteria of utility, construct validity, and feasibility of each measure. Next, experts discussed the merits and limitations of each nominated measure during a series of teleconferences. Based on these discussions, experts selected a preferred measure for each strategy, which were then vetted by measurement experts and pilot tested by 20 local government representatives recruited by the Center for Performance Measurement of the International City/County Management Association. The measures were then further revised to ensure that they were feasible and useful to local governments. A complete description of the methodology used to identify and select the recommended strategies and measures is available at <http://www.cdc.gov/NCCDPHP/DNPAO/Publications/index.html>.

Limitations of the Strategies and Measures

The strategies and measures presented in this manual represent an early step in our understanding of how the environment and policies influence behavior. We are still accumulating evidence to support each strategy and the measures are not yet validated and their reliability has yet to be determined. The strategies do not represent an exhaustive list of the types of changes that need to occur and some may prove to be more important than others in relation to desired behavioral changes that affect health. Even with these limitations, these strategies and measures are an important starting point for addressing the obesity epidemic in the United States.

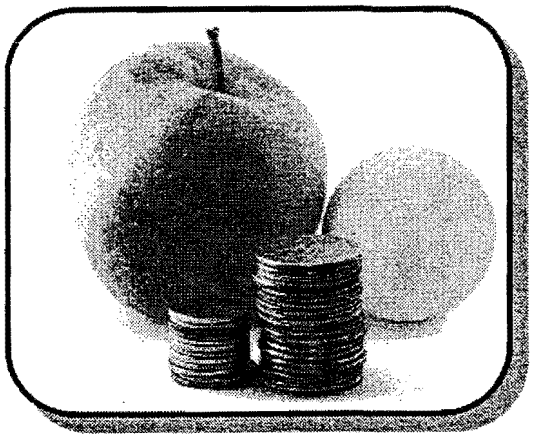
CDC's Recommended Strategies for Obesity Prevention

Communities should do the following:

1. Increase availability of healthier food and beverage choices in public service venues
2. Improve availability of affordable healthier food and beverage choices in public service venues
3. Improve geographic availability of supermarkets in underserved areas
4. Provide incentives to food retailers to locate in and/or offer healthier food and beverage choices in underserved areas
5. Improve availability of mechanisms for purchasing foods from farms
6. Provide incentives for the production, distribution, and procurement of foods from local farms
7. Restrict availability of less healthy foods and beverages in public service venues
8. Institute smaller portion size options in public service venues
9. Limit advertisements of less healthy foods and beverages
10. Discourage consumption of sugar-sweetened beverages
11. Increase support for breastfeeding
12. Require physical education in schools
13. Increase the amount of physical activity in physical education programs in schools
14. Increase opportunities for extracurricular physical activity
15. Reduce screen time in public service venues
16. Improve access to outdoor recreational facilities
17. Enhance infrastructure supporting bicycling
18. Enhance infrastructure supporting walking
19. Support locating schools within easy walking distance of residential areas
20. Improve access to public transportation
21. Zone for mixed-use development
22. Enhance personal safety in areas where persons are or could be physically active
23. Enhance traffic safety in areas where persons are or could be physically active
24. Participate in community coalitions or partnerships to address obesity

Strategy 2: Improve Availability of Affordable Healthier Food and Beverage Choices in Public Service Venues

Healthier foods are generally more expensive than less healthy foods, posing an economic barrier to healthier eating, particularly among low-income populations (Drewnowski, 2004). Public schools and local governments can improve the affordability of healthier foods and beverages sold in public service venues by establishing policies that lower prices of healthier foods and beverages relative to the cost of less healthy foods sold in vending machines, cafeterias, and concession stands in schools and local government facilities. Other strategies to make healthy food more affordable include offering coupons or vouchers redeemable for healthier foods and incentives or bonuses for the purchase of healthier foods.



Community Examples

- The New York City Department of Health operates the Health Bucks Program to make fruits and vegetables more affordable to residents who receive food stamps. For every five dollars' worth of food stamps spent at farmers' markets, individuals receive a $2 Health Bucks coupon which can be redeemed year round at more than 30 farmers' markets citywide. In 2007, the City Health Department reported that New Yorkers used more than 40% of the 9,000 Health Bucks distributed in 2006 (New York City Department of Health and Mental Hygiene, 2007).

- In 2004, the Seattle School Board unanimously approved nutrition-related policies designed to provide healthy and affordable food and beverage options to students. As a result, all campus vending machines and student stores are now required to sell beverages such as soda, juice, and sports drinks at a higher price than bottled water. The policy was implemented in all elementary, middle, and high schools throughout the Seattle School District (Seattle Public Schools, 2004).

Resources

- California Project LEAN and the Center for Weight and Health. (2006). *Policy in action: A guide to implementing your local school wellness policy*. Sacramento: California Project LEAN. Available online at: <http://www.californiaprojectlean.org/Assets/1019/files/Policy%20in%20Action%20Guide%20FINAL.pdf>

- Flourney, R., & Treuhaft, S. (2005). *Healthy food, healthy communities: Improving access and opportunities through food retailing*. Oakland, CA: PolicyLink. Available online at: <http://www.policylink.org/pdfs/HealthyFoodHealthyCommunities.pdf>

- U.S. Department of Agriculture. (2005). *Making it happen! School nutrition success stories*. Alexandria, VA: Author. Available online at: <http://www.fns.usda.gov/TN/Resources/makingithappen.html>

MEASURE 2:

A policy exists to affect the cost of healthier foods and beverages relative to the cost of less healthy foods and beverages sold within local government facilities in a local jurisdiction or on public school campuses during the school day within the largest school district in a local jurisdiction.

Data Collection Questions

1. Does your local government have a policy to affect the cost of healthier foods and beverages relative to the cost of less healthy foods and beverages sold in local government facilities?

   1a. If you answered yes to question 1, to which of the following types of foods does your local government's policy regarding pricing of healthier food apply?

   - Entrees/main courses/sandwiches
   - Dairy
   - Fruits
   - Vegetables
   - Beverages
   - Snacks
   - Other (please specify)

   1b. If you answered yes to question 1, to which of the following types of facilities does your local government's policy regarding pricing of healthier food apply?

   - Administrative office facilities
   - 24-hour "dormitory-type" facilities
   - Health care facilities
   - Recreation/community center facilities
   - Detention facilities
   - Other facilities

   1c. If you answered yes to question 1, please describe your local government's food pricing policy.

   1d. Is there a State policy or requirement regarding food pricing that applies to your local jurisdiction?

2. Does the largest school district within your local jurisdiction have a policy to affect the cost of healthier foods and beverages relative to the cost of less healthy foods and beverages sold on public school campuses during the school day within the district?

   2a. If you answered yes to question 2, to which of the following types of foods does your school district's policy regarding pricing of healthier food apply?

   - Entrees/main courses/sandwiches
   - Dairy
   - Fruits
   - Vegetables
   - Beverages
   - Snacks
   - Other (please specify)

   2b. If you answered yes to question 2, please describe the school district's food pricing policy.

Data Sources

- School district administrative offices
- Facilities managers and/or parks and recreation staff
- Local government office that maintains government policies

Strategy 4: Provide Incentives to Food Retailers to Locate in and/or Offer Healthier Food and Beverage Choices in Underserved Areas

Limited availability of healthier food and beverage choices in underserved communities poses a significant barrier to improving nutrition and preventing obesity (Morland, Wing, & Diez Roux, 2002). Local governments can offer financial and nonfinancial incentives to food retailers (e.g., grocery stores) to open new stores and/or to offer healthier food and beverage choices in areas with few healthy food options. Financial incentives include, but are not limited to, tax breaks, tax credits, loans, loan guarantees, and grants to cover start-up and investment costs. Nonfinancial incentives include supportive zoning, negotiation assistance, and capacity building for small businesses that want to initiate sales of healthier foods and beverages.

Community Examples

- The city of Richmond, California, attracted a national discount grocery store to an urban retail center with adjacent affordable housing by offering an attractive incentive package, which included land sold at a reduced cost to the developer; a Federal Urban Development Action Grant of $3.5 million for commercial development; a zoning designation that provided tax incentives; assistance in negotiations with State regulatory agencies; improvements to surrounding sidewalks, streetscape, and traffic signals; and concessions on design standards (PolicyLink & Bay Area Local Initiatives Support Corporation, 2008).
- New York City's FRESH Program provides zoning and financial incentives to property owners, developers, and grocery store operators in areas of the city currently underserved by grocery stores. Although other cities have restricted unhealthy food outlets or provided funding for supermarkets on individual sites, FRESH is the first program in the nation to combine zoning and financial incentives and to offer them in multiple neighborhoods. FRESH will help create an estimated 15 new grocery stores and upgrade 10 existing stores, creating 1,100 new jobs and retaining 400 others (City of New York, 2009).

Resources

- Flourney, R., & Treuhaft, S. (2005). *Healthy food, healthy communities: Improving access and opportunities through food retailing.* Oakland, CA: PolicyLink. Available online at: <http://www.policylink.org/pdfs/HealthyFoodHealthyCommunities.pdf>
- PolicyLink and Bay Area LISC. (2007). *Grocery store attraction strategies: A resource for community activists and local governments.* Oakland, CA: Authors. Available online at: <http://www.policylink.org/mailings/publications/store_attraction.pdf>
- PolicyLink. (n.d.). *Equitable development toolkit: Healthy food retailing.* Retrieved April 13, 2009, from: <http://www.policylink.org/EDTK/HealthyFoodRetailing/default.html>
- Strategic Alliance ENACT. (n.d.). *Provide training and incentives to small store owners underserved areas to carry healthier food items, such as fresh produce.* Retrieved April 13, 2009, from: <http://www.preventioninstitute.org/sa/enact/neighborhood/shopkeepers.php>

MEASURE 4:

Local government offers at least one incentive to new and/or existing food retailers to offer healthier food and beverage choices in underserved areas.

Data Collection Questions

1. Does your local government offer at least one incentive (financial or nonfinancial) to new and/or existing food retailers to offer healthier food and beverage choices in underserved areas?

   1a. If you answered yes to question 1, which of the following incentive(s) are offered to local retailers?

   - Tax benefits, tax credits, or tax breaks
   - Loans
   - Technical assistance/negotiation assistance
   - Waivers for local ordinance requirements
   - Other

Data Sources

- City/county manager's office
- Economic development office
- Chamber of Commerce

Strategy 6: Provide Incentives for the Production, Distribution, and Procurement of Foods From Local Farms

Currently, the United States does not produce enough fruits, vegetables, whole grains, and dairy products for all U.S. citizens to eat the quantities of these foods recommended by the USDA Dietary Guidelines for Americans (Buzby, Wells, & Vocke, 2006). Increasing the production, distribution, and procurement of food from local farms might expand the capacity of the food system to produce sufficient quantities of healthier foods and to improve food security within local communities.

Community Examples

- The Hartford Food System (HFS) in Connecticut is a nonprofit organization working to create an equitable and sustainable food system that addresses the underlying causes of hunger and poor nutrition facing low-income and elderly residents. In addition to developing innovative projects and initiatives that tackle food cost, access, and nutrition, the organization actively participates in public policy initiatives aimed at increasing production, distribution, and procurement of foods from local farms at the local, State, and Federal Government levels (Feenstra, 1997).

- The New North Florida Cooperative (NNFC) serves as a regional lead agency for the National Farm to School Network and is the hub for farm-to-school activities in the southern region of the United States. The mission of NNFC is to facilitate the sale of locally grown produce to local school districts for school lunch and breakfast programs by acting as an intermediary between local farmers and school districts. The cooperative markets, handles, processes, and delivers fresh produce on behalf of participating local farmers at competitive prices so schools are not paying more to buy local. To date, the cooperative has served fresh fruits and vegetables to over one million students in 72 school districts (Holmes, 2009).

Resources

- Buck, M. (2007). *A guide to developing a sustainable food purchasing policy.* Portland, OR: The Food Alliance. Available online at: <www.sustainablefoodpolicy.org/SustainableFoodPolicyGuide.pdf>

- Herrera, H. (2006). *Building local food systems: A planning guide*. Rochester, NY: Center for Popular Research, Education and Policy and New York Sustainable Agriculture Working Group. Available online at: <http://www.nysawg.org/pdf/Local_Food_Planning_Guide_v2.pdf>

- Pothukuchi, K. (2007). *Building community food security: Lessons from Community Food Projects 1999–2003*. Venice, CA: Community Food Security Coalition. Available online at: <www.foodsecurity.org/BuildingCommunityFoodSecurity.pdf>

- Strategic Alliance ENACT. (n.d.). *Connect locally grown food to local food retail establishments.* Retrieved April 13, 2009, from: <http://www.preventioninstitute.org/sa/enact/neighborhood/localfood.php>

MEASURE 6:

Local government has a policy that encourages the production, distribution, or procurement of food from local farms in the local jurisdiction.

Data Collection Questions

1. Does your local government have a policy that encourages the production, distribution, or procurement of food from local farms?

   1a. If you answered yes to question 1, which of the following incentive(s) are offered to local farmers?

   - Purchasing electronic bank transfer (EBT) machines for farmers' markets
   - Farm-to-school programs
   - Farmland preservation
   - Marketing of local crops within the jurisdiction
   - Allowing farm stands
   - Support for grower cooperatives for smaller farms
   - Other

   1b. Is there a State policy or requirement that encourages the production, distribution, or procurement of food from local farms that applies to your local jurisdiction?

Data Sources

- Office that maintains government-wide policies (e.g., city/county manager's office, mayor's office)
- Central budget office or budget director
- County extension service: <http://www.csrees.usda.gov/qlinks/partners/state_partners.html>

Strategy 11: Increase Support for Breastfeeding

Research has shown that breastfeeding provides a significant degree of protection against childhood obesity (IOM, 2005). Despite the advantages of breastfeeding, many women who work outside the home must bottle-feed their babies because their work setting does not provide time or private space to breastfeed or to pump breast milk. State and local governments can offer incentives to private businesses to accommodate breastfeeding among employees; they can also set policies that require government facilities to support breastfeeding among female employees.

Community Examples

- In 1998, California passed the *Breastfeeding at Work* law, which requires all employers to ensure that employees are provided with adequate facilities for breastfeeding or expressing milk. In 2002, the State passed *Lactation Accommodation*, which expands prior workplace provisions to require adequate break time and space for breastfeeding or milk expression, with a violation penalty of $100 (Shealy, Li, Benton-Davis, & Grummer-Strawn, 2005).

- In 2008, Navajo Nation lawmakers passed a bill that requires employers on the reservation to provide a place for working mothers to breastfeed. The Navajo Nation Healthy Start Act allows mothers unpaid time during work hours to breastfeed their children or to use a breast pump (Fonseca, 2008).

Resources

- Centers for Disease Control and Prevention. (2007). *Does breastfeeding reduce the risk of pediatric overweight? Research to Practice Series* (No. 4). Atlanta, GA: Author. Available online at: <http://www.cdc.gov/nccdphp/dnpa/nutrition/pdf/breastfeeding_r2p.pdf>

- Shealy, K., Li, R., Benton-Davis, S., & Grummer-Strawn, L. (2005). *The CDC guide to breastfeeding interventions.* Atlanta, GA: Centers for Disease Control and Prevention. Available online at: <http://www.cdc.gov/breastfeeding/pdf/breastfeeding_interventions.pdf>

MEASURE 11:

Local government has a policy requiring local government facilities to provide breastfeeding accommodations for employees that include both time and designated space for breastfeeding and expressing breast milk during working hours.

Data Collection Questions

1. Does your local government have a policy requiring local government facilities to provide breastfeeding accommodations for employees, including both time and designated space for breastfeeding during working hours?

   1a. If you answered yes to question 1, to which of the following types of facilities does your local government's policy regarding breastfeeding accommodations apply?

   - Administrative office facilities
   - 24-hour "dormitory-type" facilities
   - Health care facilities
   - Recreation/community center facilities
   - Detention facilities
   - Other facilities

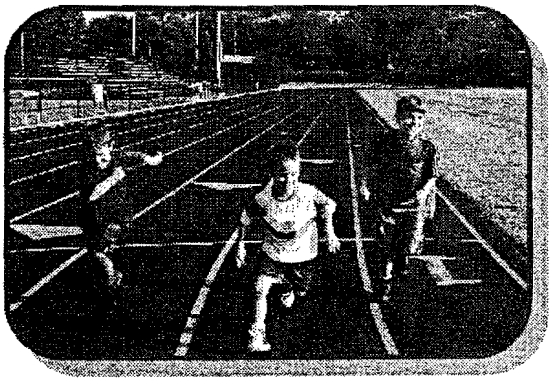
   1b. Is there a State policy or requirement regarding breastfeeding accommodations for government employees that applies to your local jurisdiction?

Data Sources

- Office that maintains government-wide policies (e.g., city/county manager's office, mayor's office)
- Facilities Management Department

Strategy 14: Increase Opportunities for Extracurricular Physical Activity

Children and families need places and opportunities to be physically active outside of school hours as part of a healthy lifestyle. One way to increase opportunities for physical activity is to ensure that existing recreational facilities, such as school gyms and playgrounds, are open to the public. In addition, more communities and school districts are entering joint use agreements to develop new recreational facilities that can be shared by schools and the general public.



Community Examples

- The city of Eugene, Oregon, and the Bethel School District pooled their resources to purchase and develop a 70-acre parcel of land. The property now includes a 35-acre site for Meadow View School and 35 acres for Bethel Community Park, which includes wetlands, a running path, ball fields, and a skate/community park. Many students can walk through the park to get to school (Oregon Transportation and Growth Management Program, 2005).

- Pitt County, North Carolina, formed the Community Schools and Recreation Program (CSR) in 1978 to provide recreation and physical activity opportunities for all citizens. As a result of ongoing collaboration between the CSR and the Pitt County School District, all school facilities are available for free or a small service charge to community organizations, civic groups, private nonprofit agencies, commercial businesses, faith organizations, private or commercial sport leagues, and individuals (Active Living by Design, 2006).

Resources

- National Coalition for Promoting Physical Activity. (2002). *Physical activity for youth policy initiative.* Washington, DC: Author. Available online at: <http://www.ncppa.org/Physical%20Activity%20For%20Youth%20Policy%20Initiative.pdf>

- National Policy & Legal Analysis Network to Prevent Childhood Obesity. (n.d.). *Joint use agreement 1: Opening outdoor school facilities for use during non-school hours.* Available online at: <http://nplanonline.org/files/JU1_OutdoorAreasAgrmt_FINAL_090318.pdf>

- Statewide Afterschool Networks. (n.d.). *Afterschool as a vehicle for youth obesity prevention.* Retrieved April 13, 2009 from: <http://www.statewideafterschoolnetworks.net/resources/wellness_and_youth_obesity_prevention.html>

MEASURE 14:

The percentage of public schools within the largest school district in a local jurisdiction that allows the use of their athletic facilities by the public during nonschool hours on a regular basis.

Data Collection Questions

1. What is the total number of public elementary, middle, and high schools within the largest school district in your local jurisdiction?
2. Of the schools reported in question 1, how many schools allow the use of their athletic facilities by the public or for extracurricular physical activity programs during nonschool hours?
3. Divide the answer to question 2 by the answer to question 1 to calculate the percentage.

Data Sources

- School district administrative offices: <http://nces.ed.gov/ccd/districtsearch/index.asp?start=0&ID2=1301740>
- School district's Department of Physical Education
- Parks and Recreation Department (for list of schools that are designated parks)

November 18, 2011

David Dise, Director
Montgomery County Department of General Services
9th Floor, 101 Monroe Street
Rockville, MD 20850

Dear Mr. Dise:

I am writing on behalf of Montgomery County's Commission on Health requesting information on your offices policies and practices that support access to healthy nutrition in county facilities.

The Commission on Health is comprised of 19 representatives of the general public, health care professionals, health care organizations and institutions, the County Health Officer and the County Council that are charged with advising the County Executive and County Council on health planning needs and gaps in County public health programs.

The Commission is undertaking an effort to review several strategies established by the Center for Disease Control and Prevention (CDC) to reduce obesity. The Commission views obesity, and especially childhood obesity, as one of the most critical health problems facing Montgomery County. The CDC notes that about two-thirds of U.S. adults and one out of five of U.S. children are obese or overweight and that from 1980-2004, obesity prevalence among U.S. adults doubled. The CDC has adopted 24 strategies to combat obesity. (http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5807a1.htm).

Among CDC's 24 Community Strategies to Prevent Obesity is the recommendation that: **"Communities Should Improve Availability of Affordable Healthier Food and Beverage Choices in Public Service Venues."** The CDC further suggests that public service venues are well positioned to influence the availability of healthier foods including those offered in after-school programs, child care centers, community recreational facilities (e.g., parks, playgrounds, and swimming pools), city and county buildings, prisons, and juvenile detention centers. Improving the availability of healthier food and beverage choices (e.g., fruits, vegetables, and water) in such venues might increase the access to and consumption of healthier foods.

Literature reviews conducted by a number of science-based organizations have found evidence to support implementing environmental strategies such as increasing the availability and variety of healthful food options, reducing the price of healthful food in work site cafeterias and vending

machines, and tailored nutrition education to be beneficial in helping individuals make better food choices.

In the interest of understanding how the County and its subcontractors support healthy nutrition in county facilities, please provide us with a written response to the following questions:

1. **Does the County have a policy to apply nutrition standards that are consistent with the Dietary Guidelines for Americans to all food sold (e.g., meal menus and vending machines) within local government facilities in the jurisdiction? If such a policy exits, we would appreciate receiving a copy of the policy.**
    a. Is adherence to the policy monitored? How?
    b. Does the County work with vendors (contractors) to modify food and beverage specifications to adhere to Dietary Guidelines for Americans? If so, how?
    c. Has the nutritional content of cafeteria and vending machine food and beverages been analyzed? How is the information used?
    d. If different nutrition guidelines or standards are applied, please provide a copy.

2. **Does the County have a policy for adjusting pricing to encourage the purchase of healthy foods?**
    a. Are healthy foods and beverages sold at a lower cost?
    b. Are the costs of healthy foods and beverages subsidized?

3. **Does the County have a policy for promoting healthy foods and beverages by:**
    a. Using icons used to identify healthy foods and beverages?
    b. Providing nutrition information at point of purchase (displaying signage or information on nutritional content)
    c. Placing healthy foods and beverages where they will be most visible?

4. **Does the County have a policy for offering incentives to encourage healthy eating?**
    a. Provide samples, coupons, has a frequent buyer program for healthy food and beverage purchases (e.g. buy 5 fruit get the 6th one free)

5. **Does the County have a policy for providing nutrition education to its employees?**
    a. Displays, cooking demonstrations, classes, nutrition resources (e.g. literature)

6. **How and with what periodicity are these policies monitored?**

Thank you in advance for assisting the Commission with this request. We hope to discuss your response at our December 15, 2011 meeting. We are making similar requests regarding policies and practices that support reducing obesity of all five County and bi-County agencies and will be forwarding the information we compile to the County Executive and County Council for their consideration.

Sincerely,

Marcos Pesquera, R.Ph., M.P.H.
Chair, Montgomery County Commission on Health

CC:
Uma Ahluwalia, Director, Department of Health and Human Services
Ulder J. Tillman, M.D., County

July 29, 2011

Vivian M. Lawyer, Chief Human Resources Officer
Montgomery College
900 Hungerford Drive, Suite 130
Rockville, Maryland 20850

Dear Ms. Lawyer:

The Montgomery County Commission on Health (COH) is supporting the Montgomery County Department of Health and Human Services' (DHHS) effort to reduce adult and childhood obesity in the County. As a commission, we are exploring four strategies from the Centers for Disease Control and Prevention (CDC) as follows:

- Strategy 2: Communities should improve availability of affordable healthier food and beverage choices in public service venues.

- Strategy 6: Communities should provide incentives for the production, distribution, and procurement of foods from local farms.

- Strategy 11: Communities should increase support for breastfeeding.

- Strategy 14: Communities should increase opportunities for extracurricular physical activity.

In an effort to make realistic recommendations to the County Executive and County Council, we would like to enlist your assistance in responding to questions about policies in your organization relative to the CDC's recommended strategies to reduce obesity. We anticipate four letters of correspondence over the next few months.

Your assistance is greatly appreciated. We also welcome any thoughts you may have on how to improve the health of our residents by reducing obesity in Montgomery County.

Thank you for your assistance.

Sincerely,

Marcos Pesquera, R.Ph., M.P.H.
Chair, Montgomery County Commission on Health

July 29, 2011

Vivian M. Lawyer, Chief Human Resources Officer
Montgomery College
900 Hungerford Drive, Suite 130
Rockville, Maryland 20850

Dear Ms. Lawyer:

I am writing on behalf of Montgomery County's Commission on Health requesting information on your agency's policies and practices that support breastfeeding.

The Commission on Health is comprised of 21 representatives of the general public, health care professionals, health care organizations and institutions, the County Health Officer and the County Council that are charged with advising the County Executive and County Council on health planning needs and gaps in County public health programs.

The Commission is undertaking an effort to review several strategies established by the Center for Disease Control (CDC) to combat obesity. The Commission views obesity, and especially childhood obesity, and one of the most critical health problems facing Montgomery County. The CDC notes that about 2/3 of U.S. adults and 1/5 of U.S. children are obese or overweight and that from 1980-2004 obesity prevalence among U.S. adults doubled. The CDC (http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5807a1.htm) has adopted 24 strategies to combat obesity. Strategy #11 is **"Communities Should Increase Support for Breastfeeding." The CDC further suggests that, local government should have a "policy requiring local government facilities to provide breastfeeding accommodations for employees that include both time and private space for breastfeeding during working hours."**

Breastfeeding is shown to have many benefits:

- Breastfeeding protects infants and children from a variety of acute and chronic diseases.
- Breastfed infants have a reduced risk of obesity throughout their life span. One study showed that for each month of breastfeeding up to age 9 months, the odds of being overweight decreased by 4% when compared to a child who was never breastfed.
- Women who breastfeed have a reduced risk of breast cancer, ovarian cancer, Type 2 Diabetes, and postpartum depression.

One evidenced-based practice that is shown to increase the likelihood that a mother will continue to breast feed her baby is support for breastfeeding in the workplace. Working outside the home is associated with lower rates of initial breastfeeding and reduced total time for breastfeeding. In 2004, only 35% of mothers aged 20-29 breastfed their baby for the first six months.

In addition to health benefits, the United States Breastfeeding Committee reports that corporate lactation programs have demonstrated a decrease in absenteeism and a reduction in sick child health care claims. Employers including Aetna, Cigna, and Home Depot have documented savings. In 2002, the Arizona Department of Health Services adopted a breastfeeding policy for all its employees that allows new mothers to bring their child to work until age 4 months. This period can be extended in 1 month increments depending on job performance and the infant's activity level. Texas adopted the following as the components for a mother-friendly workplace that supports breastfeeding.

- Flexible work schedules to provide time for milk expression.
- Access to a private location for milk expression.
- Access to a nearby clean and safe water source and sink for washing hands and rinsing out any breast-pump equipment.
- Access to hygienic storage options for the mother to store her milk.

The Federal Patient Protection and Affordable Care Act that was signed into law on March 23, 2010 amended the Fair Labor Standards Act to require an employer to provide a covered employee with reasonable break time for a mother to express milk for 1 year after the child is born. The Act also requires that the employer provide a place, other than a bathroom, that is shielded from view and free from intrusion from co-workers and the public.

In the interest of accessing what our County agencies provide, please provide us with a written response to the following questions:

1. Does your agency have a policy in place to support breastfeeding and, if so, what is that policy?

2. Are you able to provide employees who are nursing mothers with adequate time to express milk?

3. Does your agency allow a nursing mother to have her child at the workplace in order to encourage breastfeeding?

4. Do you have a room, other than a bathroom, which can be used as a lactation room? If so, is there access to clean water and to a refrigerator that could be used for milk storage?

5. Do your employee health plans cover lactation assistance programs that would help a nursing mother to begin breastfeeding and/or lengthen the duration of breastfeeding? Do these plans cover the cost of breast pumps?

6. Are their issues that prevent your agency from implementing this obesity prevention strategy?

Thank you in advance for assisting the Commission with this request. We are making the same request of all five County and bi-County agencies and will be forwarding the information we compile to the County Executive and County Council for their consideration.

Sincerely,

Marcos Pesquera, R.Ph., M.P.H.
Chair, Montgomery County Commission on Health

CC:
Uma Ahluwalia, Director, Department of Health and Human Services
Ulder J. Tillman, M.D., County Health Officer

MONTGOMERY COUNTY PLANNING BOARD
THE MARYLAND-NATIONAL CAPITAL PARK AND PLANNING COMMISSION

OFFICE OF THE CHAIRMAN

August 16, 2011

Mr. Marcos Pesquera, R.Ph., M.P.H.
Chair, Montgomery County Commission on Health
Department of Health and Human Services—Public Health Services
1335 Piccard Drive, Suite 236
Rockville, Maryland 20850

RE: Montgomery County Commission on Health Information Request

Dear Mr. Pesquera:

This letter is in response to your July 29, 2011 inquiry concerning the Maryland-National Capital Parks and Planning Commission's ("MNCPPC) policies and practices concerning breastfeeding. In your letter, a written response was requested to six (6) specific questions concerning the Commission's administrative procedure on breastfeeding. The Commission's responses are outlined in detail below.

In response to Question # 1, the Commission's administrative procedure referencing breastfeeding is entitled "The Nursing Mother Program" (See Attached). The procedure has been in effect since September 1995.

In response to Question # 2, pursuant to the administrative procedure, an employee wishing to utilize the nursing mother program must first complete an application requesting space and additionally schedule a time in which to use the space to express breast milk.

In response to Question # 3, although not specifically addressed by the administrative procedure, a nursing mother is permitted, with the approval of the employee's Department Head, to bring her child to the workplace to express breast milk.

In response to Question # 4, the administrative procedure does not specifically address the designation of a "lactation room." However, the past practice utilized by the divisions and/or departments has been to designate a private room or available office space for utilization by a nursing mother. Additionally, the administrative procedure does not address that clean water and refrigeration facilities are to be provided. However, based on past practice, the specifically designated areas have been either outfitted with or closely accessible to clean water and a refrigerator for milk storage.

8787 Georgia Avenue, Silver Spring, Maryland 20910 Phone: 301.495.4605 Fax: 301.495.1320
www.MCParkandPlanning.org E-Mail: mcp-chairman@mncppc.org

In response to Question # 5, the Commission's health plans do not cover lactation assistance programs and the costs of breast pumps.

In response to Question # 6, there are no issues which exist to prevent the Commission from implementing this obesity prevention strategy, since the Commission currently has an administrative procedure in place covering nursing mothers.

I hope that this information fully responds to your questions. Should you wish to ask any follow-up questions, please contact our Director of Human Resources, William Spencer, at 301-454-1706.

Sincerely,

Françoise M. Carrier, Chair
Montgomery County Planning Board

cc: William Spencer, M-NCPPC Human Resources Director

Attachments: Administrative Procedure # 95-05
Application for Nursing Mother Program

Administrative Procedures

WORK LIFE PROGRAM

No. 95-05

Effective Date September 20, 1995

Authorized by

Trudye Morgan Johnson, Executive Director

NURSING MOTHER PROGRAM

The Nursing Mother Program provides for a clean, private space for nursing mothers to express milk, as space allows.

ELIGIBLE EMPLOYEES:

All employees are eligible to apply for the Nursing Mother Program.

RESPONSIBILITIES/PROCEDURES:

Employee	Submits to supervisor a completed "Application For Nursing Mother Program" (attached) requesting private space to express milk.
Supervisor	Reviews request and identifies available clean, private space for nursing mothers. If space is not available, the supervisor will advise the employee in writing that there is not adequate space at the facility to accommodate the requests. If the supervisor denies the employee's request, the supervisor must forward the employee's request along with the reason for denial.
Department Head	A Department Head shall review all requests which are forwarded by the supervisor and will approve or deny the employee's request. In all cases, the Department Head's decision is final and is not grievable.

APPLICATION FOR
NURSING MOTHER PROGRAM

EMPLOYEE:

Name: _____

Work Location/Department: _____

Work Phone: _____

I request space under the Nursing Mother Program. I propose the following space and, if necessary, the scheduling time(s) the space will be needed.

_____

_____

_____

Signature: _____ **Date:** _____

SUPERVISOR:

☐ Approve Employee's Request ☐ Deny Employee's Request

If employee's request is denied, please explain:

_____

_____

_____

Supervisor may also recommend available alternate space below:

_____

Signature: _____ **Date:** _____

DEPARTMENT HEAD:

☐ Approve Employee's Request ☐ Deny Employee's Request

Signature: _____ **Date:** _____

November 30, 2011

Dr. Joshua Starr
Superintendent of Schools
850 Hungerford Drive
Room 122
Rockville, Maryland 20850

Dear Dr. Starr:

I am writing on behalf of Montgomery County's Commission on Health requesting information on your agency's efforts to promote extracurricular physical activity for children.

The Commission on Health is comprised of 19 representatives from the general public and the health care profession. The Commission is charged with advising the County Executive and County Council on public health issues, programs, services and facilities.

The Commission is undertaking an effort to review several strategies established by the Center for Disease Control (CDC) to combat obesity. The Commission views obesity, particularly childhood obesity, as one of the most critical health problems facing Montgomery County. The CDC notes that about 2/3 of U.S. adults and 1/5 of U.S. children are obese or overweight and that from 1980 to 2004 the obesity rate among U.S. adults doubled. The CDC has adopted 24 strategies[1] to combat obesity. Strategy 14 proposes that *Communities Should Increase Opportunities for Extracurricular Physical Activity.*

Physical activity is shown to have many benefits including:

- Decreased obesity
- Reduced risk of cardiovascular disease
- Reduced risk of type 2 diabetes
- Reduced risk of some cancers
- Improved mental health and mood

Research has demonstrated that non-competitive after-school programs increase children's levels of physical activity. Pilot after-school programs in Palo Alto and Oakland showed significant impact in physical activity and decreased sedentary behavior.

[1] http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5807a1.htm

Access to the programs, including transportation, was a significant barrier to participation.

Please provide us with a response to the following questions to help the Commission evaluate opportunities available to Montgomery County youths.

1. What extracurricular programs does your agency/organization have in place to encourage physical activity? What are the eligibility criteria for these programs? Are fees charged to participate in these programs? If so, are the fees contingent on income?
2. What do you and your staff view as the major barriers to promoting extracurricular activities among young people? What advice can the Commission provide to the County Executive to help remove these barriers?
3. Do you measure body mass index (BMI) (or height and weight) in children? If so, when and how often? If BMI is not measured, why not?
4. Would you be able to release aggregated, non-identifying student BMI data maintained by your organization to the Montgomery County Department of Health and Human Services for research purposes?

Thank you in advance for assisting the Commission with this request. Please feel free to provide any additional information or suggestions that would help further encourage and improve access to extracurricular activities and enhance our collaboration. Your input is critical to our review and will form the basis of the recommendations to be forwarded to the County Executive and County Council for their consideration.

Sincerely,

Marcos Pesquera, R.Ph., M.P.H
Chair, Montgomery County Commission on Health

CC:
Larry Bowers, MCPS Chief Operating Officer
Uma Ahluwalia, Director, Department of Health and Human Services
Ulder J. Tillman, M.D., County Health Officer

MCPS MONTGOMERY COUNTY PUBLIC SCHOOLS
www.montgomeryschoolsmd.org MARYLAND

December 9, 2011

Mr. Marcos Pesquera, R.Ph., M.P.H.
Chair, Montgomery County Commission on Health
Department of Health and Human Services
1335 Piccard Drive, Suite 236
Rockville, Maryland 20850

Dear Mr. Pesquera:

I am responding on behalf of Dr. Joshua P. Starr, superintendent of schools, Montgomery County Public Schools (MCPS), to questions that you have concerning MCPS extracurricular interscholastic activities for students.

Ori> the middle school level, each of the 38 MCPS middle schools offers opportunities to participate on seven interscholastic athletic teams: boys' and girls' soccer (spring), boys' and gitls' basketball (winter), boys' and girls' softball (fall), and coed cross country (fall). Approximately 4;700 MCPS middle school stUdents. paiticfpate annually in middle school interscholastic athletics.

On the high school level, approximately 21,500 MCPS students participate annually in the high school interscholastic athletics program. The program includes 40 interscholastic teams per each of the 25 high schools.

Regarding eligibility criteria, students at both the middle school level and the high school level are required to maintain a minimum of a 2.0 grade point average with no more than one failing grade for the most recently completed grading period. At the high school level, students also must satisfy state athletic association eligibility criteria including age, residence, and years of participation.

In addition to the interscholastic athletics program, schools offer many other after-school participation opportunities of a physical nature, some of which are associated with specific classes such as marching band. Others are on the club level, including the physical development club, ski club, sports club, drill team, step club, and majorettes. Most middle schools have active intramural programs.

Sfudents are required to pay an extracurricular activity fee of $30 annually in order to participate in:itn after-school activity in which there is a'paid activity coach or sponsor. The $30 fee covers all activities for the year-it is not a separate fee. for separate activities. The fee is contingent on income.

Some barriers associated with offering additional after-school physical activities include limited facilities, limited funds, limited interest, and limited personnel to supervise the activities.

Regarding your question on body mass index, the school system does not measure body mass index for students. The school system provides relatively few medical tests and procedures for students. This information also is not requested on health inventories required for participation on interscholastic athletics teams.

I hope that this information will assist you. If you have any further questions, please contact me at 301-279-3144.

Sincerely,

William G. Beattie, Ph.D.
Director of Systemwide Athletics

WGB:dlw

Copy to: Dr.
Starr Mr.
Bowers
Dr. Lacey
Ms. Ahluwalia
:tvlr. Tillman

Board of Education of Harford County
Informational Report
Body Mass Index as a Part of Fitnessgram Assessment
November 10, 2008

Background Information

In June of 2005, the General Curriculum Committee approved the implementation of the Fitnessgram assessment in grades 4, 5, 6, 7, 8, and 9. Fitnessgram is a computerized tool created by the Cooper Institute for the purpose of criterion referenced fitness assessment. This fitness assessment is nationally endorsed by the American Association for Health, Physical Education, Recreation and Dance (AAHPERD), and utilizes Health Fitness Zones that have been carefully established for each age and gender by the Cooper Institute Scientific Board.

In the fall of 2006, annual system-wide Fitnessgram testing was completed with the exception of the body mass index component. This particular test required additional testing protocols to be established and therefore was removed until additional issues could be resolved. The physical education teacher expectation for the Fitnessgram assessment requires that all students complete the assessment with a comparable assessment available for students with disabilities, the Brockport. A student reflection component including goal setting is completed by all students. All parents and/or guardians receive a Parent Report Form including test results, wellness information, and recommendations.

Discussion

According to the 2006 Shape of the Nation report, 16 percent of children and teens aged 6 to 19 years (over 9 million young people), are overweight. Obese and overweight children are at a much greater risk to develop diabetes, high blood pressure, and heart disease than children of normal weight. The Surgeon General has stated that this will be the first generation of children to have a shorter life expectancy than the previous generation. In light of this national data, it is prudent to take a more proactive position by collecting data regarding obesity of children in Harford County Public Schools as well as to educate students regarding body composition.

The justification of the collection of body mass is related to the voluntary state curriculum and Standard 5 – Physical Activity. This standard investigates the developing of personal fitness goals based on fitness assessment and specifically body composition. Clearly, the inclusion of the body mass index as the final component of the Fitnessgram assessment will provide specific grade and gender related data, assist with personal goal setting, and communicate a comprehensive wellness assessment for parent information regarding their child.

The protocol for this assessment will include an opt -out form for those parents who do not wish body mass index information of their child. Student weight data will be collected in a private environment and all fitness data follows the HIPA regulations. Fitness data is not a part of a physical education grade.

Superintendent's Recommendation's

The Superintendent recommends supporting the collection of body mass index using a student's height and weight as a part of the Fitnessgram assessment in grades 4-9 using a phased implementation plan.

Thinkport Member Web Site

Thinkport Home

Welcome to the web site of **Ali Hunsinger**

Pages

- Your Physical Education Teachers
- Class Expectations
- Report Card Standards by Grade Level
- Yearly Schedule
- Explanation of Tests on the FitnessGram
- BMI Waiver

BMI Waiver

HARFORD COUNTY PUBLIC SCHOOLS
102 South Hickory Avenue Bel Air, MD 21014
Office 410-588-5249 ? Fax 410-588-5370

Office of Physical Education, Health Education and Athletics

Dear Parent or Guardian,

Body composition is one of the health related components of fitness that your child will be studying this year. Students will be assessed in the areas of health related fitness including: aerobic capacity, muscular strength, endurance and flexibility. The results of these assessments will help students to develop their own fitness plans. These plans are a required part of the physical education program and provide the knowledge necessary for practicing lifelong wellness. Results for all assessments are provided to the students to be shared with their parent or guardian. The objectives and activities for this unit include:

- Developing and understanding the relationship between body mass index and wellness
- Examining the concept of caloric intake and caloric expenditure
- Identifying the health risks associated with being overweight or obese
- Understanding and developing personal fitness plans

In order to obtain the most accurate information for the personal fitness plan, your child will have his or her body composition assessed using body mass index. A physical education teacher will measure your child for his or her current height and weight. The results of this assessment are personal and will not be shared with anyone other than your child. The information obtained will be utilized by your child to set personal fitness goals using the Fitnessgram program. We hope that the personal fitness goals set by your child will assist him or her in maintaining a fit and healthy lifestyle.

If you have further questions about the body composition unit and objectives taught or if you would like more specific details regarding the Body Mass Index Assessment, please feel free to contact your child's physical education teacher.

If after reading the above information, you **DO NOT** wish your child to participate in the body mass index assessment, please complete and sign the attached form and return it to your child's physical education teacher. Denying permission for this assessment will in no way lower your child's grade in his or her physical education class.

Sincerely,
Virginia M. Popiolek

Supervisor of Elementary/Middle School
Physical Education and Health Education

Please cut and return bottom portion of form:

I have read the above statement and I **DO NOT WISH** for my child to participate in the assessment of their body composition.

Child's Name (print)

_____
(First) (Last)

135

Parent/Guardian's Signature

_____

Physical Education Teacher _____

Date of Signature _____

Please return this form to your child's Physical Education teacher by: January 1st 2010

Note: Please expect a call from your PE teacher Verifying this!

Attachments:

 This site has been visited **3231** times.

The Cooper Institute
Healthy Living...Down to a Science

HUMAN KINETICS
The Information Leader in Physical Activity

FITNESSGRAM® Tests

Six Recommended Tests Are Bolded

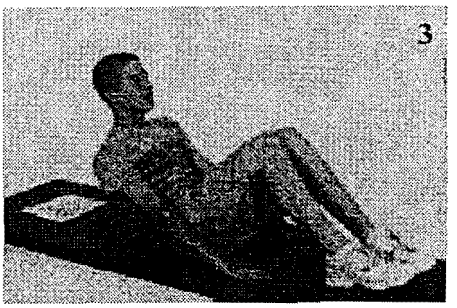

2

AEROBIC CAPACITY

1) **PACER** (Progressive Aerobic Cardiovascular Endurance Run) – Set to music, a paced, 20-meter shuttle run increasing in intensity as time progresses

Or:

- One-Mile Run – Students run (or walk if needed) one mile as fast as they can
- Walk Test – Students walk one mile as fast as they can (for ages 13 or above since the test has only been validated for this age group)


3

BODY COMPOSITION

2) **Skin Fold Test** – Measuring percent body fat by testing the tricep and calf areas

Or:

- Body Mass Index – Calculated from height and weight


4

MUSCULAR STRENGTH AND ENDURANCE

3) **Curl Up** – Measuring abdominal strength and endurance, students lie down with knees bent and feet unanchored. Set to a specified pace, students complete as many repetitions as possible to a maximum of 75

4) **Trunk Lift** – Measuring trunk extensor strength, students lie face down and slowly raise their upper body long enough for the tester to measure the distance between the floor and the student's chin


5

5) **Push-Up** – Measuring upper body strength and endurance, students lower body to a 90-degree elbow angle and push up. Set to a specified pace, students complete as many repetitions as possible

Or:

- Modified Pull-Up (proper equipment required) – With hands on a low bar, legs straight and feet touching the ground, students pull up as many repetitions as possible
- Flexed Arm Hang – Students hang their chin above a bar as long as possible


6

FLEXIBILITY

6) **Back-Saver Sit and Reach** – Testing one leg at a time, students sit with one knee bent and one leg straight against a box and reach forward

Or:

- Shoulder Stretch – With one arm over the shoulder and one arm tucked under behind the back, students try to touch their fingers and then alternate arms

Thinkport Member Web Site

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Explanation of Tests on the FitnessGram

Explanation of Each Test

Curl-ups-The students will complete as many curl ups as possible up to a maximum of 75 at a specified pace.
Push ups-The students will perform as many 90 degree push ups as possible at a rhythmic pace.
Sit and Reach-The students will reach the specified distance on the right and left sides of the body while performing the sit and reach test.
Shoulder Stretch- The students will attempt to touch the fingertips together behind the back by reaching over the shoulder and under the elbow.
Mile Run-The students will run a mile at the fastest pace possible.
PACER-The students will run as long as possible back and forth across a 20 meter space at a specified pace that gets faster

Attachments:

138

How Do You Spend Your Time?

The Physical Activity Pyramid gives you an easy way to group the different physical activities that help you maintain good health. To be your best, you should try to do the following:

- ➢ Get at least 60 minutes of physical activity on most days of the week.
- ➢ Do activities from each level of the Physical Activity Pyramid each week.
- ➢ Limit your TV time, computer time, and Internet surfing to no more than 2 hours each day.

During the week . . .

- In the box for each day, record the number of minutes that you are physically active.
- In the box for each day, record the number of minutes that you watch TV or work on the computer.

At the end of each week . . .

- Add up and record your total minutes of activity and minutes of TV or computer time.
- Put a check in the "minutes of activity" box for each day that you were active for at least 60 minutes.
- Put a check in the "minutes of TV or computer time" box for each day that you spent less than 2 hours (120 minutes) in front of the TV or computer.

	Sample Day	SUN	MON	TUES	WED	THURS	FRI	SAT	TOTALS for WEEK
Total minutes of physical activity	✓ 75								
Total minutes of TV or computer time	✓ 103								

Look at the Physical Activity Pyramid and write down the activities that you did during this week in each of these areas:

Lifestyle activities _____

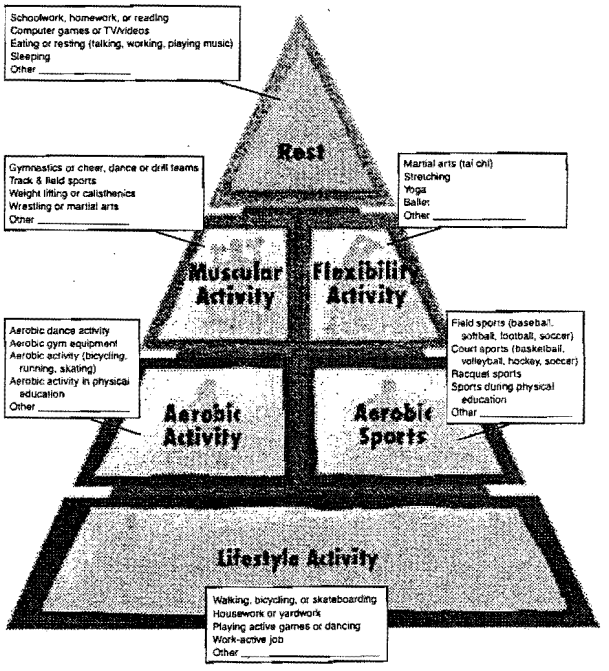
Aerobic activities or sports _____

Muscular activities _____

Flexibility activities _____

_____
Signature of student

_____
Signature of parent



Other Ways to Learn About Activity

The *FITNESSGRAM* software package has several programs that can help you learn about your level of physical activity.

➢ ***ACTIVITYGRAM*** is a computerized measure of physical activity that can help you determine whether you are getting enough physical activity each day.

➢ The ***Activity Log*** is a computerized log of your daily activity levels. You can code steps on a pedometer or the minutes of activity you get each day.

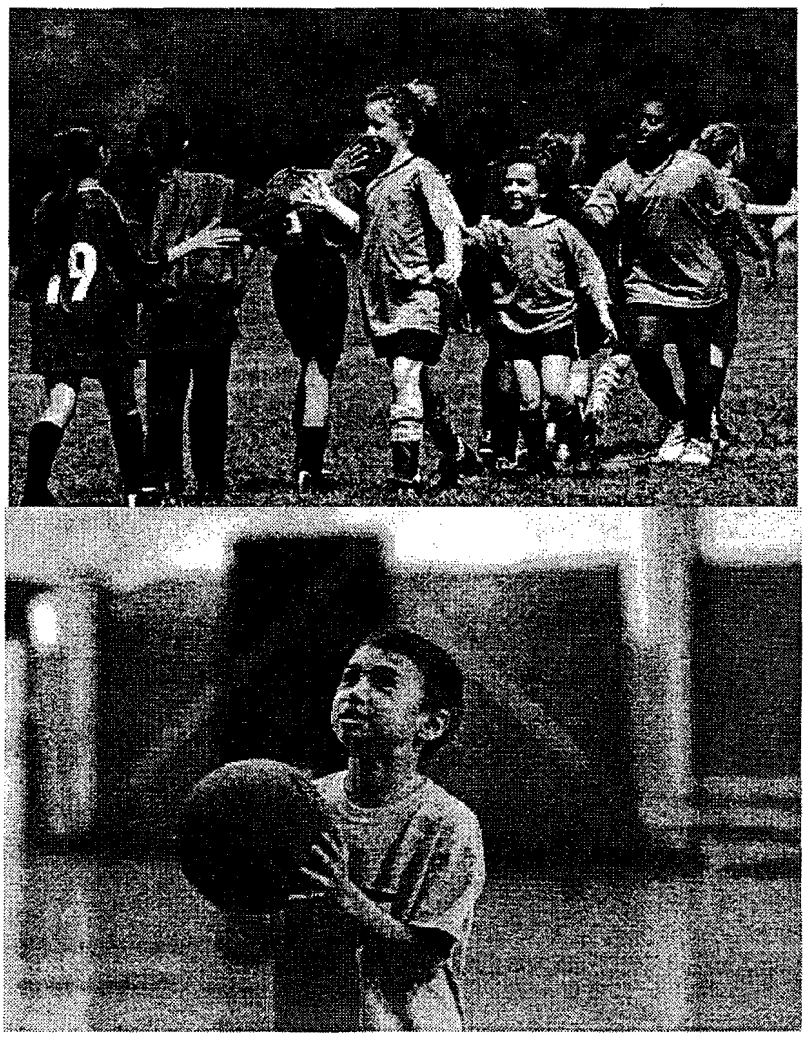
For other information, visit **www.fitnessgram.net**.

FITNESSGRAM was developed by The Cooper Institute and is endorsed by The American Alliance for Health, Physical Education, Recreation and Dance. For information, go to www.fitnessgram.net.

FITNESSGRAM is published by Human Kinetics.

Task Force on Student Physical Fitness in Maryland Public Schools

Final Report of the Task Force to Study Student Fitness in Maryland Public Schools
Submitted to the Maryland General Assembly and Governor
November 20, 2008



Executive Summary

In October 2008, the federal government published the first major review of the science on benefits of physical activity, *2008 Physical Activity Guidelines for Americans*. These guidelines stated that "Children and adolescents aged 6-17 years should accumulate 1 hour or more of physical activity every day. Most of the 1 hour or more a day should be either moderate- or vigorous-intensity aerobic physical activity. As part of their daily physical activity, children and adolescents should do vigorous-intensity activity at least 3 days per week. They also should do muscle-strengthening and bone-strengthening activity at least 3 days per week to improve strength and to enable the body to burn more calories during activity. It is important to encourage young people to participate in physical activities that are appropriate for their age, enjoyable, and offer variety." The Guidelines list a number of examples of each type of activity for children and adolescents. Source: http://www.health.gov/PAGuidelines/guidelines/default.aspx

The Physical Activity Guidelines Advisory Committee concluded there was strong evidence for the following effects of 60 minutes of daily physical activity on children's health:

- Improved cardio respiratory endurance and muscular fitness,
- Favorable body composition,
- Improved bone health, and
- Improved cardiovascular and metabolic health biomarkers.

Instructional time in physical education can provide *part* of the required amount of daily physical activity as recommended in the 2008 Guidelines for Americans. Physical education is an integral part of a child's education and plays a critical role in educating the whole student. It has been suggested that academic theories or concepts have greater meaning for children when they are taught across the three realms of learning, including the cognitive, affective and psychomotor domains. The National Association of Sport and Physical Education states:

> *"Physical education plays a critical role in educating the whole student. Research supports the importance of movement in educating both mind and body. The healthy, physically active student is more likely to be academically motivated, alert, and successful. Throughout the school years, quality physical education can promote social, cooperative, and problem-solving competencies."*

Physical education, like other academic content areas, has national standards that define what students should know and be able to do as a result of participation. Enhanced physical education in schools is an evidence-based solution to increasing physical activity among children and contributing to the management and prevention of childhood overweight and obesity as well as many other serious health problems. The ultimate goal of physical education is participation in health-enhancing physical activity for a lifetime.

At the federal level, there has been an effort to introduce legislation with an emphasis on physical education and physical activity. It has been recommended that when the No Child Left Behind Act is reauthorized or a new education bill is drafted, language similar to legislation that has been proposed in the United States House of Representatives be included in the reauthorization or a new education bill. H.R. 3257, introduced on July 31, 2007, included the following language to improve standards for physical education.

For purposes of section 1111(b)(2) of the Elementary and Secondary Education Act of 1965, each State accountability system shall not only be based on academic assessments, but shall also be based on additional indicators. Such indicators shall include:
(1) demonstrated progress toward meeting the national goal for required physical education that is--
(A) 150 minutes per week for all students in elementary schools; and
(B) 225 minutes per week for all students in middle and high schools; and
(2) attendance rates at required physical education classes
(3) the percentage of elementary and secondary school physical education teachers who are State certified as physical education teachers; and
(4) the amount of square feet of indoor and outdoor facilities that are primarily used for physical education and the amount of square feet of indoor and outdoor facilities that are primarily used for physical activity.

The Action for Healthy Kids Report of 2008, entitled *Progress or Promises*, states that many organizations and agencies have elevated the awareness about the importance of healthy eating and increased physical activity as important steps in combating the childhood obesity crisis. However, the Action for Healthy Kids report points out that schools nationwide continue to scale back or eliminate physical education programs amid funding and staffing constraints. The report recommends that schools refocus their funding and purchasing patterns to emphasize physical education and food service programs and take steps to ensure that budgetary shortfalls do not result in cuts to those programs. In addition, the authors call on schools to engage parents in encouraging healthy student behaviors, particularly in underserved communities. "Real change has begun, and more is within reach..." but warns that, "Progress will be stunted without support from all levels of the education system and a wide range of stakeholders." (UPI, 8/7/08; Action for Healthy Kids report, Fall 2008).

Schools in Maryland must and are playing an active role in addressing the problem of obesity. In 2004, the United States Congress enacted legislation requiring any school system receiving federal school-meal funds to have a wellness policy in place by the 2006–07 school year. Maryland school systems have developed model policies. Future plans include providing a Wellness Policy Implementation and Monitoring Guide to give school systems a framework to follow as they conduct self-assessments of their policies. The guide will provide sample key goals with associated implementation and monitoring strategies which address physical activity and physical education.

Child care centers in Maryland provide opportunities outside the daily structured school environment for additional physical activity. Maryland has more than 72,000 students or approximately 20% of school-aged children enrolled in child care programs. These programs, whether operating out of a home or a center, must adhere to state physical activity guidelines. The Code of Maryland Regulations (COMAR) defines child care centers and includes specific regulations concerning a schedule of daily activities for all children, including physical activity.

Schools are also being encouraged to provide physical activity breaks and to provide opportunities for physical activity across the content areas during daily instruction.
While schools can and must play an integral role in shaping the lives of young people, they are not a panacea for the family, social, environmental, and other societal forces that can impact student's ability to remain healthy. Other stakeholders must help to address the problem of inactivity and the increasing levels of obesity in our youth.

The health care professionals and the medical community must take a leadership role in the fight against inactivity and obesity in our youth. Parents and children must be educated by the medical community on the benefits of exercise and eating health and nutritious meals. Discussions about weight and ways to maintain a proper balance of weight to body type must be provided as part of the educational process for families.

Parks and Recreation programs have been a tremendously important asset in terms of facility usage and establishing partnerships in most local school systems. Some of these partnerships have helped defray the cost of school construction by providing funds for building, expanding, or renovating gyms and playgrounds. Parks and Recreation programs need to continue focusing their efforts on providing children opportunities for physical activity before and after school, and to work with schools on increasing these opportunities.

Parent/teacher organizations (PTA/PTO) are also an important partner in the fight against obesity. PTAs can take a more active role in encouraging parents and children to exercise together. PTAs across the country have held health fairs; encouraged students to walk or ride their bikes to school; introduced families to new, nutritious foods; and launched ongoing fitness programs to celebrate Healthy Lifestyles. The benefits reach far beyond fitness and promote the health and wellness of the entire family unit.

The Problem

Obesity levels in America's elementary and secondary school age children have increased from 14 percent to more than 25 percent. Lack of physical activity at all ages increases risks of heart disease, high blood pressure, and diabetes. The 60 million school-age children and youth have the potential to acquire the knowledge, skills, and values that can lead to a life of physically active and healthy living.

The U.S. Surgeon General, the United States Department of Health and Human Services, the Centers for Disease Control and Prevention, and the National Association for Sport and Physical Education recommend a minimum of 30 minutes of physical education, by accredited professional instructors, every school day for every elementary and secondary school student.

In 2008, the National PTA developed a resolution statement based on the Surgeon General's comments from 2001. The Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity (2001) states physical inactivity is a serious, nationwide epidemic, and physical education classes in American during the past 30 years, have declined in importance and availability. During the same period, technology and nutritional behaviors have provided the population with a less active and more sedentary lifestyle.

This less active and more sedentary lifestyle comes at a cost. Studying the fiscal impact of requiring a certain amount of physical education time was discussed repeatedly in meetings. However, the same phrase came up time and again. Instead of saying we cannot afford to increase the minutes for physical education, the counterpoint argument was raised that, "we cannot afford to not increase the time requirement."

The Net Benefits of Implementing Physical Education

As the medical conditions related to obesity increase in prevalence, so do the related costs. *F as in Fat: How Obesity Policies are Failing in America, 2007* report from the Trust for America's Health (TFAH) stated that the total cost of obesity and physical inactivity in 2000 was estimated to be $117 billion and obesity-related annual costs for children more than tripled between 1979 and 1999.

Advocates who call for increasing the physical activity levels and fitness levels of our children continue to point to the fact that we need to be more proactive in increasing the activity levels of all citizens, including our youth, not only for their health but because of the financial burden it puts on society in general. Without some type of intervention, the cost of obesity will have a significant impact on the health insurance industry and a long term impact on the health and wellness of this generation and future generations. ***If the current trend continues, this new generation may be the first in history to live a shorter life span than their parents.*** Source: New England Journal of Medicine, March 17, 2005.

In Maryland, though the cost for increasing the time for physical education and physical activity is considerable, it is significantly less than the cost for chronic diseases and conditions related to obesity, physical inactivity, and poor nutrition. Chronic diseases and conditions are the primary reason people receive health care, accounting for 75% of health care costs. People with a chronic condition average five times higher health care costs than for those without a chronic condition (Partnership to Fight Chronic Disease, 2008). Obesity costs an estimated $1.5 billion in adult medical expenditures in Maryland (Finkelstein et al, 2004). Diabetes is one example of these costly conditions. For the state of Maryland, the American Diabetes Association estimates the 2007 cost of diabetes at $3.8 billion, including $2.5 billion in excess medical expenditures and $1.3 billion in indirect costs.

This Task Force explored the complexities of increasing the minutes for physical education and physical activity. Fundamental to the issue is recognizing the concerns most often mentioned for not increasing time for physical education and physical activity, which is, the increased cost for staffing and facility improvements. The committee took into account each local school system's current physical education facilities and time allocation without regard for the fact that some geographical areas of a local school system might have more physical education time than others.

New construction costs for gymnasiums were based on current Public School Construction Program budget estimates, calculated at $247 per square foot. The total additional costs for providing staffing and facilities exceed $412 million. The figure for staffing varies in the projected impact on local jurisdictions, from a low of $275,000 in Garrett County to a high of $15 million in Montgomery County, excluding those eight local systems that have already implemented 90 minutes each week of physical education at all elementary schools. Ten school systems already have designated space at each elementary school for physical education instruction. At the remaining fourteen systems, the figure for facilities again varies from a low of $1.9 million in smaller jurisdictions to a high of $159 million in Prince George's County, which has the highest number of schools without designated gymnasiums (81). (For specific district information, see Subcommittee Three report: Estimated Costs to Implement 90 Minutes of Physical Education, pages 47-53 of this report.)

Next Steps

The Task Force considered a number of options beyond increasing student physical activity and physical education time including: 1) the use of wellness policies to evaluate physical activity goals; 2)fitness assessments for collection of data and student goal setting; 3)structured activity during regularly scheduled periods for recess; 4)connecting physical activity to the study of other content during the school day; and 5)the important role of partnerships in providing structured activity in before and after school programs.

This Task Force urges consideration of this report in concert with the work of other groups. There have been a number of federal reports that include recommendations concerning the health and wellness of our students. They include the following:

The Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity 2001, HHS
"Provide all children, from pre-kindergarten through grade 12, with quality daily physical education that helps develop the knowledge, attitudes, skills, behaviors and confidence needed to be physically active for life."

Shape of the Nation Report 2006
National Association for Sport and Physical Education and the American Heart Association
"All elementary school students should participate in at least 150 minutes per week of physical education, and all middle and high schools students should participate in at least 225 minutes of physical education for the entire year."

F as in Fat: How Obesity Policies are Failing in America 2007
Trust for America's Health
"Schools should be encouraged to not only increase the amount of time students spend in physical education classes but ensure that enough time is actually being spent in moderate-to-vigorous physical activity before and after school and between classes."

Recommendations

Childhood obesity has become an urgent and expensive health problem in Maryland and the public schools have a significant role to play in its mitigation along with other partners in the community. The Task Force believes that adherence to the following recommendations, developed by the three subcommittees, will improve the health of Maryland's children and reduce the cost to the state for treating obesity-related illness.

Physical Education

1. **Time:** Require a minimum 90 minutes of physical education per week, of which at least 50% of the time, students should be engaged in moderate to vigorous physical activity.

Other Physical Activity

2. **Recess:** Recess should provide a minimum of 20 minutes of daily physical activity for all elementary students.

    a. This policy should be mandated in each system's Wellness Policy.
    b. The policy requirements should prohibit withholding recess as a punishment.
    c. During inclement weather students should be provided opportunities for physical activity in the classroom.
    d. Ideas for indoor and outdoor physical activities should be developed by a physical activity team, with the physical education teacher as one member of this team.

3. **Classroom:** Physical activity should be provided throughout the school day. Activity ideas should be developed and provided to classroom teachers so that physical activity opportunities can be included across the curriculum.

Fitness and Wellness

4. **Fitness Measurement:** Require schools to perform fitness measurement on students with differentiated instruction provided for students not meeting standards for fitness.

    Fitness measurement is directly referenced in Content Standard 5, Physical Activity, of the Physical Education Voluntary State Curriculum. The indicator designates a fitness measurement of students for the health related components of fitness each year in grade four through high school. These fitness measurements should be used to develop personal fitness goals and select activities for the improvement or maintenance of healthy levels of fitness.

5. **Body Mass Index (BMI):** Investigate BMI assessment in schools for the purpose of surveillance and to determine the efficacy of obesity prevention and intervention programs.

    BMI is the ratio of weight to height squared. It is often used to assess weight status because it is relatively easy to measure and correlates with body fat. The American Academy of Pediatrics (AAP) recommends that BMI should be calculated and plotted

annually on all youth as part of normal health supervision within the child's medical home.

School-based BMI assessment programs used for individual health screening purposes are not recommended unless there is careful consideration of privacy issues, adequate training, measurement techniques, parental notification, adequate evaluation, and the importance of linking families/caregivers with resources in the community.

6. **Local School Wellness Policies**: Wellness policies must be developed, implemented and monitored and must include physical education, physical activity, and recess requirements.

   Wellness Policies are a vehicle for addressing the issue of increasing physical activity and physical education time in the schools through local decision-making. Local school systems shall work through wellness policies to gather base line student fitness data to determine the merit for increased physical education and physical activity. Wellness improvement plans will be a part of local school improvement planning and/or included in local school system master plans with progress and challenges reported out to the local boards of education. Local schools will address physical activity time and develop local school improvement plans.

   MSDE has designed a Wellness Policy implementation and monitoring guide. The guide will provide school systems with a model framework to follow as they implement and monitor Wellness Policies. The guide will provide sample key goals for wellness policies with associated implementation and monitoring strategies. The guide is designed as a template for school systems to insert their specific policy language and support their policy implementation plan.

Support Systems

7. **Health and Physical Education Advisory Council:** Establish a Statewide Advisory Council for Health and Physical Education.

   The State Superintendent of Schools should establish a health and physical education advisory council to assess on going progress on the recommendations of this report, provide direction for improving comprehensive health and physical education programs in the State, and revisit after three and five years the status of these programs. In particular the advisory council needs to examine and recommend policy on the monitoring of student fitness and wellness. This task force has recommended that the membership include parents, health organizations, including a member of the State Department of Health and Mental Hygiene, classroom and supervisory representatives from local school systems, and members of the medical profession who will broaden the perspective of this group and provide links to other legislative and government agencies.

8. **Funding for a Permanent Physical Education Specialist Position:** Create a regular full-time State position and associated funding for a Maryland State Department of Education Physical Education Specialist Position.

   The Maryland State Department of Education should be provided funding and a position identification number (PIN) for a permanent position of Specialist for Physical Education to guide the implementation of these recommendations.

9. **Separate Gymnasium Facilities:** Future legislation on construction should include wording that requires a designated gymnasium for physical education rather than a designated space for physical education.

   A designated space allows for continued construction of a multipurpose room or cafetorium that does not satisfy the spatial and safety needs of children in physical education. The Interagency Committee on School Construction should establish regulations requiring all new elementary schools to include a designated gymnasium for physical education instruction.

Other Funding Sources:

10. **Snack Tax:** Propose legislation that would provide a sustainable revenue source to support increased physical activity and physical education initiatives through the imposition of a tax levy such as a tax on snack foods.

    Seventeen states and D.C. currently have laws that tax foods of low nutritional value. "Some public health officials view the positive impact on taxing tobacco products in reducing smoking as a model for taxing snack foods and sodas to promote healthier behavior." *F as in Fat 2007*

    Slots legislation was passed by popular vote on November 4, 2008. This along with other funding opportunities might provide additional sustainable revenues for physical activity and physical education initiatives. See pages 57-62 in the report for information on additional funding sources and grants.

Montgomery County Obesity Prevention Strategy Group

Make a Move Montgomery: Take Action for a Healthier County

has taken bold action to improve the health of its residents. But much more is needed if we are to successfully combat obesity and its resulting diseases. The recommendations below are consistent with the Maryland Nutrition and Physical Activity Plan and with local priorities for preparing children to live and learn and promoting healthy sustainable communities. Please contact the Obesity Prevention Strategy Group at 240-777-1710 if you want to help us accomplish these actions

Data Collection

Progress: We have Montgomery County body mass index (BMI) data from the Special Supplemental Nutrition Program for Women, Infants and Children (WIC program) and data from the Montgomery County Behavioral Risk Factor Survey for adults.

Call to Action: We need passive consent for participating in Maryland Youth Risk Behavior Survey (YRBS). Not having baseline data for youth on the topics of overweight prevalence, unhealthy dietary behaviors; and physical inactivity limits our ability to compete for grants and measure the impact of program activities.

Progress: We have an Obesity Prevention Strategy Group (OPSG) that meets monthly, facilitated by DHHS staff.

Call to Action: We need funding for staff to develop, print and disseminate key messages and materials to professionals and the public; and secure commitments from County businesses and organizations, including the media, to share responsibility for decreasing obesity in the County.

Food Environment

Progress: The County Council and Board of Health passed a regulation banning artificial trans fats in food establishments.

Call to Action: We need to fund enforcement of the ban; require chain restaurants to post nutritional information; improve nutritional content of County vending machines; and increase enrollment in federal food and nutrition programs.

Progress: We have requirements for developers in high density zones to build sidewalks; local Safe Routes to School grants; and "Heart Smart Trails" in County parks.

Call to Action: We need to link comprehensive infrastructure and health planning; create a community-wide system of walkways and connected bike paths; and expand the Walk to School/Walking School Bus initiative to promote student, parent and community movement.

Target Children/Youth

Progress: We have a Montgomery County Public Schools (MCPS) Wellness Policy; healthier food in MCPS vending machines; Head Start and Linkages to Learning programs promoting physical activity and healthy eating; and physical activity programs offered by Montgomery County Recreation Department (MCRD), city recreation departments, private industry, and the non-profit sector.

Call to Action: We need to promote and enforce the MCPS Wellness Policy; acquire funding to train additional child care providers in the research-based *Color Me Healthy* curriculum; increase physical activity minutes in schools; and promote family meals.

Progress: We have www.activeoptions.org that lists physical activity options close to County zip codes. MCRD is hosting the 2008 Senior Olympics. The African American Health Program, Latino Health Initiative and G.O.S.P.E.L. (Glorifying Our Spiritual and Physical Existence for Life) programs promote physical activity and healthy eating.

Call to Action: We need to target the faith community and other social institutions in order to reach a diverse audience with culturally appropriate nutrition, physical activity and healthy- weight messaging.

Target Disadvantaged Communities

Progress: We have nutrition education and physical activity interventions through Latino outreach programs and walking clubs; 7-3-3-1 Healthy Families Having Fun weight management program targeting families receiving care through Montgomery Cares; and MCRD financial assistance.

Call to Action: We need to expand culturally and linguistically appropriate nutrition and physical activity information and training for low income parents and children

Progress: We have Montgomery Medical Society participation in OPSG; and the Medical Society is surveying physicians re: their comfort addressing obesity with patients.

Call to Action: We need to increase advocacy and professional development by the Medical Society to include obesity prevention, screening, counseling, referrals and toolkits to use in routine clinical practice; promote breastfeeding; and explore medical, educational, and community partnerships and program linkages to ensure families are receiving uniform, specific messaging related to health behaviors.

Worksites

Progress: We have the Montgomery County (MC) Employee Wellness program offering opportunities for physical activities at several work locations; and discounts on selected gym memberships for MC employees.

Call to Action: We need to encourage similar activities at other worksites and recognize exemplary employers.

Progress: We have speed cameras in some school zones and grant funding for a Safe Routes to School Coordinator.

Call to Action: We need to expand the Pedestrian Safety initiative and expand the "Walking School Bus" program.

Media

Progress: We have some media interest in obesity issues.

Call to Action: We need to seek partnerships with multiple media, including minority media outlets, to highlight on an ongoing basis local efforts to combat obesity and communicate messages about healthy nutrition and physical activity behaviors.

Montgomery County
Department of Health and Human Services
Obesity Prevention Strategy Group
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This document is available in alternate formats by calling 240-777-1710, TTY 240-777-1398.

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Make a Move Montgomery: Take Action for a Healthier County

Montgomery County
Obesity Prevention Strategy Group

Make a Move Montgomery:

Take Action for a Healthier County

OBESITY PREVENTION STRATEGY GROUP

MAKING MONTGOMERY COUNTY GOVERNMENT A HEALTHFUL WORKPLACE

RECOMMENDATION

Montgomery County Government should do more to prevent and reduce obesity and promote good health by enhancing the health habits of its employees – by improving food choices available in County facilities and by encouraging increased physical activity.

BACKGROUND

The Montgomery County Obesity Prevention Strategy Group is a public-private coalition dedicated to reversing the obesity trend, in keeping with the County's goal to make Montgomery County the healthiest county in the nation. The Obesity Prevention Strategy Group commends the County Council for its leadership and proactive strategies embracing and prioritizing the importance of health and wellness services provided by Montgomery County Government. The Obesity Prevention Strategy Group actively supports and partners with the Montgomery County Council in their continued efforts to maintain and improve the health of Montgomery County residents. It is represented on and will be working with the Healthy Montgomery Obesity Work Group.

The Obesity Prevention Strategy Group has provided evidenced based testimony and research that identifies the best practices in providing legislation and procedures to implement healthy opportunities and programming for County residents to County Council and Montgomery County Public Schools. It has also provided testimony to the County Council in support of affordable recreation programs and facilities in an effort to maintain or increase the Montgomery County Recreation budget.

CURRENT PROJECT: IMPROVING HEALTHFUL BEHAVIORS IN COUNTY EMPLOYEES

Food: Cafeteria selections in County buildings are reasonably good, but vending machine options are not. At least 50% of offerings in vending machines on County property should meet the guidelines for snacks developed by the Institute of Medicine. Pricing policies should make healthful items no more expensive that those which do not meet IOM criteria. This may require raising prices on less healthful items and perhaps giving up the profit the County makes on the machines.

Activity: Exercise options should be promoted before and after work and during lunch breaks. These can be as simple and cost-free as walking around the neighborhood or walking to and from work. In addition, public (e.g. Department of Recreation) and private (e.g. YMCA) agencies could be offered space in County buildings to offer free or low-cost exercise classes before and after work or during lunch breaks.

Some Maryland counties have initiated competitive healthy living programs for their employees. These have included activities such as team weight loss contests and small prizes for accumulating walking miles. Such programs involve minimal costs and do a great deal to raise awareness of and commitment to healthful lifestyles.