

NEW ENGLAND HEALTHY WEIGHT TRENDS REPORT

Health care used to mean taking care of emergencies from accidents and infectious disease. But as medicine has learned to deal with many of these acute problems, we have seen the emergence of chronic illness as an increasingly important issue and cost.

Partly responsible for many of these emerging, long-term diseases is the growing weight of our population. Being overweight or obese causes a host of health problems from diabetes to cancer, from high blood pressure to asthma, from heart disease to poor emotional health. Research has concluded that obesity is associated with increased mortality. Strategies for reducing obesity, however, are less clear. While genetics obviously plays some role, researchers have repeatedly shown that the food people eat and the amount of physical activity they do have a major impact on their weight, overall fitness, and well-being.

While improving individual eating patterns and increasing individual levels of physical activity are the ultimate goal, a public health perspective teaches that the most cost-effective strategies focus on changing the surrounding environment. And shaping that environment is at least partly the responsibility of the public sector. We need to create an environment that makes healthy choices the easy-to-do default, supports empowering efforts that go beyond those first steps, and is structured to prevent disaster for those who are unable to act on their own.

The “New England Healthy Weight Trends Report” describes the current situation in each of the six states on both the weight status of key populations and on the degree to which each state has developed the facilities and programs that make it easier for people to eat well and be physically active. It also highlights disparities between key population subgroups. Future New England Healthy Weight Trends Reports, to be issued every two years, will track each state’s progress on each of the items; this first Report primarily establishes a baseline from which to measure improvement.

The New England Healthy Weight Trends Report was created for the New England Governors Conference by NECON (New England Coalition for Health Promotion and Disease Prevention)* in partnership with the Nutrition Department of the Harvard School of Public Health (HSPH) and in collaboration with teams of public health professionals in each of the six states as well as with a broad network of organizations including the state Medical Associations, the School Nutrition Associations, the American Planners Associations, the Human Resources Management Associations,, Chambers of Commerce, and others.

This Report was written by Healthy Weight Initiative Executive Director Steven E. Miller and HSPH doctoral student Alison El Ayadi under the guidance of Dr. Walter Willett, Chair of the HSPH Department of Nutrition, Associate Professor Karen Peterson PhD of HSPH, and NECON Chair Bertram Yaffe.

* *In 1986, the New England Governors' Conference charged NECON to interact with the states' chief health officers and other health policymakers and to submit recommendations periodically for the improvement of the health status of the region. NECON responds to that charge through annual conferences and interactive Working Groups that address the prevention and control of cancer, heart disease and stroke, obesity, and HIV/AIDS, as well as prevention and health promoting initiatives in mental health, women's health, managed care, and among underserved populations.*

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Goals

The New England Healthy Weight Trends Report has three goals.

1. **Guide Policy:** Help state policy-makers evaluate existing efforts to make it easier for individuals to select “healthy choices” and focus any available additional public resources on effective, research-based strategies.
2. **Increase Awareness:** Help focus the public discussion about the growing epidemic of overweight and obesity from diet or exercise fads to the enabling factors that shape individual actions.
3. **Update the HSPH/NECON “Strategic Plan for the Prevention and Control of Overweight and Obesity in New England”:** In 2003, the New England Governors Conference responded positively to the Strategic Plan created by NECON in partnership with the Nutrition Department of HSPH. The Strategic Plan has also been adopted as a national model by the Public Health Service of the federal Health and Human Services Department. While the Strategic Plan’s recommendations remain valid, continuing research has led to additional insights which are summarized as part of this Report.

What The Trends Report Contains

The Healthy Weight Trends Report contains twelve Trend Indicators of each state’s status and, over time, level of improvement in eight areas of concern drawn from the HSPH/NECON “Strategic Plan for the Prevention and Control of Overweight and Obesity in New England”. For this initial version of the Report, each Indicator provides the current situation in each state, the current national status if known, and the national goal if one has been set. It also includes a quick note about the source of the data and the source of the goal such as the benchmarks set by the CDC’s Healthy People 2010 program or some other appropriate national body. The areas of concern, following a social-ecological framework, include **Population Outcomes and Behaviors, Health Care/Insurance, Schools & Youth, Worksites and Employers, Built Environment, Food Industry, Social & Cultural Environment, and Economics.**

Following the Trend Indicators are a series of Disparity Measurements showing the degree of difference between two population subgroups: white versus non-white, female versus male, high-income versus low-income, and large versus small companies, among others.

In addition to an Executive Summary, the complete New England Healthy Weight Trends Report (available online at www.neconinfo.org) contains over 50 additional “Supporting Statistics” that broaden and validate the picture painted by the Indicators. For each Indicator and Supporting Statistic the complete report also describes the source of the data used in this report, the formulas used to calculate the numbers, and any caveats or limitations to the data analysis process. Finally, the complete Report also contains an appendix with the text and results of the surveys used to collect some of the data, citations of relevant research, sources of additional information, and action guidance.

Future Trend Reports, to be issued every two years, will track progress on each of the items. The current edition establishes a baseline from which to measure each state’s improvement over time.

Social Ecological Model

The framework adopted by NECON for both the Strategic Report for the Prevention and Control of Obesity and Overweight in New England and the Trends Report is the Social Ecological model. This model is currently utilized by the CDC for its state based programs in overweight and obesity interventions as well as for other subject areas [7]. The Social Ecological model addresses the

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interdependencies between socioeconomic, cultural, political, environmental, organizational, psychological, and biological determinants of health and illness[8]. It acknowledges the contextual influences on health and explicitly requires investigation and intervention at multiple levels for effective health promotion.

Report Development Process

A series of conference calls with leading public health officials and professionals across New England were held in 2006 to discuss what indicators the Trends Report should contain. These were summarized and expanded upon by Professors Peterson and Willett and by Mr. Miller, and then circulated to the state partners for additional comment and suggestions about which items on the list would be most useful for each state.

The HSPH team, joined by PhD student Alison El Ayadi, divided the suggested indicators into seven major groups, based on the HSPH/NECON Strategic Plan's "areas of concern." They then consulted with over a hundred national experts to determine:

- Which indicators were linked by solid research to population incidence of overweight or obesity?
- For which indicators was there a widely accepted benchmark to aim for?
- What might be a meaningful population disparity measurement in that category?
- Were relevant statistics already being reliably and regularly collected by someone at a state-by-state level?
- If the data wasn't being collected was there a feasible method of getting it and were there potential partners who were interested in working with us to do so?
- Was the indicator dealing with something that was "actionable," meaning that the information could inform policy and practice and, in turn, be impacted by changes in policy and practice?
- Did the indicator add value, insight, a new slant, or access to new types of data sources to what was already easily available to state decision-makers and program leaders?

The Trends Report team then reached out to a wide variety of groups who might partner with us for innovative data collection efforts including the state chapters of the Society for Human Resource Management, Chambers of Commerce, American Planning Association, School Nutrition Associations, Medical Associations and Societies, and many more. They were asked for help both with the Indicators and with the survey questions that would be used to gather some of the data.

Finally, an "almost final draft" version of the Trends Report was resent to the public health partners in each state who were given several more opportunities to suggest improvements.

With the indicators selected, Mr. Miller and Ms. El Ayadi reached out to numerous other organizations around the region to create new data sharing partnerships. These groups helped design their online surveys and promoted participation by their members. All collected data was shared with these organizational partners.

The resulting data were then analyzed by the Trends Report staff and a presentation design was created. Numerous policy suggestions were collected, evaluated, and included. The final report was both published online and a smaller hardcopy version was created for distribution.

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TREND DATA TABLES

POPULATION OUTCOMES AND BEHAVIORS

1. Percent of adult population that is obese (BMI≥30).							
Target	USA	CT	MA	ME	NH	RI	VT
15%	26.2% (27.2%)	21.7% (26.6%)	21.7% (26.3%)	25.2% (30.2%)	25.1% (30.2%)	21.7% (27.0%)	21.9% (26.3%)

Data Sources: BRFSS, 2007; Healthy People 2010.
Notes: Adults age 18 and over. While BRFSS data is available by state and allows trend-over-time comparisons, it is self-reported. When individuals are measured, the rates of adult obesity are actually higher as shown above in parentheses and calculated by age and sex standardizing NHANES data. BRFSS 95% confidence intervals: USA (26.0-26.5), CT (20.6-22.9), MA (21.0-22.5), ME (24.1-26.4), NH (24.0-26.3), RI (20.4-23.1), VT (20.9-22.9).

2. Percent of adult population participating in the recommended levels of moderate or vigorous physical activity.							
Target	USA	CT	MA	ME	NH	RI	VT
30%	48.6%	52.4%	51.4%	56.0%	54.0%	49.9%	57.6%

Data Sources: BRFSS, 2007; Healthy People 2010.
Note: Adults age 18 and over. BRFSS 95% confidence intervals: USA (48.3-48.9), CT (51.0-53.8), MA (50.5-52.3), ME (54.6-57.2), NH (52.6-55.4), RI (48.1-51.7), VT (56.3-58.9). Recommended activity levels: moderate is 30 minutes per day on 5 or more days per week, vigorous is 20 minutes per day on 3 or more days per week.

3. Percent of adolescents in grades 9 – 12 who are obese (BMI≥95th percentile)							
Target	USA	CT	MA	ME	NH	RI	VT
5%	13.0%	12.3%	11.1%	12.8%	11.7%	10.7%	11.8%

Data Sources: YRBSS, 2007; Healthy People 2010.
Note: YRBSS 95% confidence intervals: USA (11.9-14.1), CT (10.8-13.9), MA (9.5-12.7), ME (10.1-15.4), NH (9.7-13.7), RI (8.5-12.9), VT (8.5-15.5). BMI percentiles are age and sex specific.

4. Percent of adolescents in grades 9 – 12 who consumed soda or pop less than one time per day.							
Target	USA	CT	MA	ME	NH	RI	VT
-	66.2%	NA	75.1%	80.1%	75.8%	74.8%	76.0%

Data Source: YRBSS, 2007.
Notes: Target not established. One serving of soda is defined as “a can, bottle, or glass.” YRBSS 95% confidence intervals: USA (63.3-69.1), MA (72.3-77.9), ME (75.9-84.2), NH (72.7-79.0), RI (71.2-78.4), VT (71.0-80.9). CT YRBSS did not include a soda consumption question.

HEALTH CARE AND INSURANCE

5. Percent of responding health care providers that regularly calculate patient’s BMI.
The Healthy Weight Trends Indicator Project joined with all six New England state medical societies to survey their physician members on their professional practices around healthy weight issues. While 54% of the overall sample reported calculating BMI regularly among their patients, the convenience nature of the sample and low survey response [CT (n=81), MA (n=30), ME (n=116), NH (n=30), RI (n=28), VT (n=42)] prohibited meaningful interpretation of the data. Future versions of the Trends Report will utilize an alternate data source for this indicator.

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SCHOOLS AND YOUTH

6. Percent of state policy adherence to school nutrition guidelines for foods outside of meals.							
Target	USA	CT	MA	ME	NH	RI	VT
-	-	56.3%	1.6%	32.8%	1.6%	55.3%	1.6%

Data Source: Center for Science in the Public Interest (CSPI), 2007[1].
Notes: Implicit target is 100%. Guidelines are based on National Association for Nutrition and Activity standards. MA, NH, and VT do not have statewide required standards. Other states lost points for having recommended, rather than mandatory, standards for a la carte, allowing 2% milk rather than only low fat or fat free, not banning trans fats or setting sodium limits for snacks, among other criteria.

7. Percent of adolescents in grades 9 thru 12 who participate in daily school-based physical education.							
Target	USA	CT	MA	ME	NH	RI	VT
50%	30.3%	12.9%	18.2%	6.7%	17.2%	23.1%	18.2%

Data Sources: YRBSS 2005 & 2007; Healthy People 2010.
Notes: CT data is from 2005, all other states' data from 2007. YRBSS 95% confidence intervals: USA (25.4-35.8), CT (7.6-18.3), MA (13.3-23.2), ME (1.8-11.7), NH (13.4-21.1), RI (14.1-32.1), VT (11.5-25.0)

8. Percent of adolescents in grades 9 – 12 who participate in 60 minutes of physical activity on 5 or more days per week, AND watch 2 or fewer hours of TV per day.							
Target	USA	CT	MA	ME	NH	RI	VT
-	23.9%	32.7%	29.5%	33.3%	35.4%	30.5%	32.7%

Data Source: YRBS, 2007.
Notes: Target not established. Vermont combined TV and computer games into the same question. YRBSS 95% confidence intervals: USA (21.5-26.2), CT (28.9-36.4), MA (26.8-32.1), ME (28.5-38.1), NH (32.7-38.2), RI (27.0-34.0), VT (29.3-36.1)

BUILT ENVIRONMENT

9. Per capita amount of federal Transportation Enhancement (TE) funds spent on pedestrian and bicycle projects.							
Target	USA	CT	MA	ME	NH	RI	VT
-	\$3.98	\$2.83	\$0.84	\$4.12	\$11.51	\$22.28	\$17.66

Data Source: Federal Transportation Enhancement Database, 2004-2006.
Note: Target not established.

SOCIAL AND CULTURAL ENVIRONMENT

10. Percentage of middle/junior and senior high schools where students cannot purchase foods of low nutritional value from vending machines or at the school store, canteen, or snack bar.							
Target	USA	CT	MA	ME	NH	RI	VT
-	-	31.4%	27.8%	27.8%	13.7%	31.4%	29.4%

Data Source: School Health Profiles, 2006
Note: General categories comprising 'foods of low nutritional value' were chocolate candy, other kinds of candy, salty snacks that are not low in fat, soda pop or fruit drinks that are not 100% juice, sports drinks, 2% or whole milk.

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ECONOMICS

11. Estimated adult obesity-attributable medical expenditures per capita.							
Target	USA	CT	MA	ME	NH	RI	VT
-	\$267	\$257	\$287	\$280	\$244	\$291	\$236

Data Source: Finkelstein, et al, 2004 [2]. U.S. Census 2000.
Note: Target not established. Data provides measure of scale; within state uncertainty margins were larger than some between state differences.

PUBLIC POLICIES TO FACILITY HEALTHY WEIGHT CHOICES

Since the HSPH/NECON Strategic Plan was issued in 2003, both research and policy have advanced. About one third of the nation’s 50 states have taken action of one kind or another as reported by the Robert Wood Johnson Foundation [3]. In 2007, for example –

- Twenty-five states launched a pilot project or created a task force, council or commission to improve the nutrition and physical activity environments for children or prevent obesity.
- Lawmakers in 16 states enacted legislation to increase farm-to-school programs or to improve the nutritional quality of school breakfasts, lunches, á la carte selections or vending machine offerings.
- Seven states enacted legislation to promote farmers' markets—and a growing number of states also are working to increase access to fresh or frozen affordable foods through grocery stores.
- Some states are considering policies that would require restaurants to provide nutritional information for the foods they offer, and nine states or localities enacted legislation to regulate the use of trans fat.
- Policy-makers in 20 states considered legislation to promote safe physical activity, pedestrian and bicycle transportation and/or efforts to design communities that support physical activity.
- Sixteen states supported policies to strengthen physical education classes or physical activity programs in schools.
- Eleven states enacted laws concerning student BMI measures and/or physical fitness assessments.

Health Care and Insurance

States need to define BMI as a “vital sign” and require all state-funded or regulated medical services and health insurance programs, including Medicare and Medicaid and all insurance options given to public employees, to include collection and reporting of BMI as part of annual visits. State regulators need to ensure that healthy weight counseling is a reimbursable activity and require that all primary care health professionals receive counseling on healthy weight issues and multi-cultural communication.

Food Industry: Food Access and Land Use

In addition to state level changes, notable municipal level initiatives have also been implemented. Findings from a food availability assessment of low-income African American and Latino neighborhoods in Austin, Texas, prompted the creation of new bus routes to take residents to supermarkets, legislation that allocated land for community gardens and farmers’ markets, establishment of a food policy council, and renovation of a local grocery store. City Council members of Oakland, CA raised \$1.2 million to build the Mandela Co-Op in the underserved West Oakland area which sells

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fresh, affordable produce grown by African American farmers, hires local workers, and reserves 33 percent of its profits for employees.

While zoning is usually a municipal responsibility, local action exists within the context of state enabling laws that explicitly authorize or facilitate specific public health purposes including banning fast food outlets, drive-throughs or “formula restaurants” in certain sections of a city; and setting quotas on fast food restaurants based on a per capita limit or on their proximity to each other, or on the distance of fast food restaurants from specified locations (i.e., schools, hospitals, or churches) because of noise, pollution, odor, litter, and traffic. For example, Los Angeles has imposed a one-year moratorium on fast food restaurant establishment in South and Southeast LA to create time for the development of a grocery store and sit-down restaurant incentive strategy to encourage new businesses investment in South Los Angeles. The proposed incentives range from discounts on electric bills to assistance from the redevelopment agency. New York City is also considering a similar effort. However, this is still a controversial strategy and while there is evidence-based support for the value of this approach, it is only likely to spread if state governments provide support.

Other strategies to improve local food access, particularly in low-income areas, require state level leadership. These strategies include overall zoning and land use reform, facilitating the use of food stamps and other EBT in farmers’ markets, expanding public transportation, stepping up public safety, creating programs that help small grocery stores install proper equipment for fresh or frozen foods, facilitating direct farm-to-local-store connections, establishing local food policy councils, and setting minimal nutritional guidelines for school lunches and a la carte foods.

States can learn from New York City’s pioneering work in requiring nutritional information on fast-food restaurant menus and order boards, and banning trans-fats from all restaurant foods. They can expand their Farmer’s Market programs, perhaps using public buildings as a location, and expand access by making it easier to buy food at those markets using Food Stamps or other EBT services. States can also set an example by requiring all cafeterias and food vendors working in state buildings to give consumers choice of selecting a full range of healthy food options.

Social and Cultural Environment: Marketing Controls

TV and radio broadcasting is under federal control and anti-regulatory beliefs have rebuffed efforts to limit advertising, even advertising directed at children. However, states can play a role in encouraging municipalities to limit other marketing channels. For example, it is possible to ban the use of TV or radio stations that advertise unhealthy products in school classrooms and on school buses; to forbid the posting of ads for unhealthy products in schools, on school buses or scoreboards; to void incentive programs that tie school revenue with the sale or consumption of unhealthy products; or to stop the use of commercially sponsored “educational materials” that are designed to build brand awareness and loyalty. To kick off a “grass roots” social marketing campaign, states can work with civic groups (e.g., churches, etc.) to set up a “Healthy Food Pledge” campaign in which community organizations commit to serving healthy food.

Schools and Youth: Improving Nutrition

State agencies should monitor the quality and implementation of school and district Wellness Policies, using the NANA (National Alliance for Nutrition and Activity) guidelines as baseline requirements. If funds permit, states can set up implementation mini-grants, with an emphasis on low-income, urban areas.

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Schools and Youth: Facilitating Physical Activity

While programs for facilitating increased physical activity is primarily a local responsibility, state-level leadership can make a huge difference in the degree of implementation. Safe Routes to School and participation in active physical education classes has been positively associated with school achievement. Reviews have found school-based physical activity to be effective at increasing levels of physical activity among youth [4, 5] The American Academy of Pediatrics has issued a policy statement calling for the “reinstatement of compulsory, quality, daily PE classes in all schools (kindergarten through grade 12) taught by qualified, trained educators, [where the] curricula should emphasize enjoyable participation in physical activity that helps students develop the knowledge, attitudes, motor skills, behavioral skills, and confidence required to adopt and maintain healthy active lifestyles.”[6].

Built Environment: Facilitating Physical Activity

Adults are also more likely to be physically active on a daily basis when in a supportive built environment. These are typically municipal responsibilities, but state-level support can be vital in prompting location action. Some possible improvements include:

- good condition sidewalks kept clear of snow, leaves, and trash;
- crossing signals timed to increase pedestrian (and cyclist) visibility by letting them start across intersections before turning cars begin to move;
- well-lit and safe streets full of attractive destinations and street life;
- networks of separated pedestrian and bike paths or bike lanes, with sufficient and secure bike parking facilities at destination points; and
- accessible and safe parks and playgrounds.

Creating policies to accomplish these and other infrastructure changes is facilitated by a variety of reforms to state-level policy-making bodies, such as:

- Placing representatives of the state public health agency on key transportation boards and advisory groups;
- Making improving public health one of the explicit goals of all transportation related public agencies and requiring that a health impact assessment be conducted prior to final approval of all transportation projects;
- Requiring that all transportation and parking projects receiving state funds include routine accommodations for non-motorized modes (“complete streets”);
- Requiring that all municipalities receiving state transportation funds must have a pedestrian/bicycle citizens’ advisory committee, with the power to comment on all local road proposals, and with the understanding that small towns can assign to another public board the responsibility of regularly considering bicycle/pedestrian needs;
- Use a high proportion of federal Transportation Enhancement funds, as well as tapping into Highway Safety Funds, for pedestrian and bicycle infrastructure projects; and
- Create new programs that promote parks and playgrounds and other “green areas” in areas presenting lacking them, particularly those in low-income neighborhoods.

Workplaces

States need to both set an example and motivate the private sector to improve work environments. A first step might be to appoint a Commission to make suggestions for changes in government offices and public buildings to encourage improved access to healthy food and increased physical activity. Creating incentives, or just social pressure, for other employers to set up “Wellness Programs” could also make a significant difference.

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DATA FOR ACTION

The 2003 HSPH/NECON Strategic Plan identified numerous data collection needs. The creation of this Healthy Weight Trends Report revealed that few of those needs have been met and revealed an absence of credible, regularly collected, state-level (much less municipal-level or school district-level) data about the types of environmental factors that facilitate or hinder individual choices about eating healthy food or being physically active. As has been often noted, “what is counted, counts” -- we need data to more effectively and strategically track our progress in creating an environment that makes healthy choices the easy-to-do default, supports empowering efforts that go beyond those first steps, and is structured to prevent disaster for those who are unable to act on their own. Questions that we were unable to answer with existing data include:

Outcomes & Behaviors: What percentage of non-WIC participant income children ages 2 to 5 are overweight or obese? What percentage of children of all income levels ages 5 to 14 are overweight or obese? What percentage of people with various types of disabilities are overweight or obese?

Healthcare & Insurance: What percentage of primary care doctors and other health professionals in each state measure and report BMI, effectively counsel clients about healthy weight issues, provide relevant referrals for meaningful behavioral changes, or follow-up to reinforce the original suggestions; and how does that vary according to the income level, race/ethnicity, language ability, or other characteristics of the client? How many people have insurance plans that cover healthy weight counseling by their health care providers; and how does that vary by demographic categories?

Schools: What percentage of youth in each school district by state regularly walk or ride their bikes to school? How many schools or school districts have established effective Safe Routes to School programs? How many schools and school districts in each state have eliminated unhealthy foods from their vending machines, lunch programs, and events? Compared to best practice models, how many schools or school districts have adopted quality Wellness Policies? What percentage of schools or school districts in each state require the recommended amounts of active physical education per week? What percentage of schools or school districts in each state has implemented a significant amount of their Wellness Policy recommendations? How do all of these results differ by the demographic characteristics of the school or district?

Worksites: What percentage of employers or employees in a state have health insurance plans that cover healthy weight counseling by their health care providers; and how does that vary by size of firm, type of job, industry, salary, level of unionization, or demographic categories?

Social & Cultural Environment: What proportion of adults feel safe exercising in their neighborhoods, or allowing their children to play outside, and how does this vary by demographic characteristics?

Built Environment: What percentage of municipalities in each state have adopted “complete streets” policies; and how does that vary by demographic characteristics?

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