

Strengthening Coordination of West Virginia's Obesity Prevention Efforts

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Abstract – The purpose of this project was to facilitate the implementation of a collaborative network of public and private organizations in West Virginia to coordinate obesity prevention resources and strategies. Because the problems associated with obesity and physical inactivity are so monumental and because there is so much attention to the issues, there is a lot at stake in this work. Attempting to coordinate and collaborate without hindering on-going initiatives is a challenge, but a worthy cause. The overriding principle is not to require or force any one organization or effort to change to a specific model. Rather, the concept is to look for natural synergy and forge common goals and performance benchmarks (outcomes) that will increase everyone's results.

The project was conceived in early January, 2005 and built upon work already underway, but which was largely conceptual. My role, as Director of the Office of Epidemiology and Health Promotion, was seen as pivotal in facilitating this collaboration. As such, it afforded me an excellent opportunity to apply a variety of leadership skills throughout the duration of the project. Additionally, during the course of the project, a number of unanticipated opportunities occurred (e.g., passage of major state legislation, gubernatorial attention, a joint WV-CDC Epi-Aid initiative, etc.) that gave even greater potential significance to the possible outcomes of the project and to my role as the principal facilitator.

Introduction / Background

West Virginia ranks 3rd in the nation in the prevalence of obesity at 27.6% and 42nd highest in the prevalence of overweight at 36.1%. (BRFSS - 2003). At 28.4%, WV ranks 10th highest in the nation in physical inactivity. The cost of obesity and related comorbidities to West Virginia's health care system and in project lost productivity was estimated to be in excess of \$2 billion in 2003 (Attachment 1 provides additional data on the prevalence and problems associated with obesity in WV).

A variety of state and local public and private (including nonprofit) organizations are addressing obesity through a multiple approaches and interventions aimed at specific groups or in targeted settings (e.g., youth, minority populations, schools, worksites, communities, etc.) WV's Physical Activity and Nutrition (PAN) Program (administered through OEHP) has been funded at the CDC "capacity-building" level for two years. As such, we have attempted (with moderate success) to create partnerships, both statewide and locally, to build a framework for a multi-year state plan which, if approved by CDC,

could result in increased funding to implement new initiatives and support existing proven programs.

In recent years, there has been a dramatic increase in the number of groups and organizations attempting to “carve out” a role to address West Virginia’s obesity problem. Indeed, there has also been the entry of non-traditional partners in the process. In 2002, the WV Council for Community and Economic Development’s comprehensive economic development plan, *WV – A Vision Shared*, boldly recognized that the health of our citizens is a significant factor impacting economic and community growth. It called for the creation of a Healthy Citizens Task Group and served as the foundation for the creation of the *WV Healthy Lifestyles Coalition*. This coalition, led generally by the private sector, has received foundation support to undertake and implement a 3-year strategic plan to address obesity in West Virginia.

On April 1, 2005, the WV State Legislature enacted the *Healthy West Virginia Act of 2005* (H.B. 2816). This legislation (Attachment 2), introduced by the Governor, provides for the creation of the WV Healthy Lifestyles Coalition and the formation of the WV Office of Healthy Lifestyles (OHL) (housed in OEHP). The Coalition began meeting in September, 2005 under the leadership of First Lady, Gayle Manchin. In my capacity as director of the Office of Epidemiology and Health Promotion, I serve as the agency-appointed administrator of the Office of Healthy Lifestyles. Our Division of Health Promotion and Chronic Disease also provides technical and administrative support to the Coalition.

Project Description, Objectives and Methodology

The overall goal of the project was *to enhance collaboration among organizations and programs involved in obesity prevention in West Virginia*. The following were the project objectives :

- To have a better collective understanding of the programs and resources available to address the obesity crisis in West Virginia;
- To test the feasibility and interest in the formation of a statewide collaborative framework to coordinate obesity prevention efforts;
- To forge stronger working relationships among existing organizations and programs working in the field of physical activity and nutrition;
- To achieve greater engagement of partner organizations in the development of West Virginia’s Physical Activity and Nutrition (PAN) state plan to CDC;
- To determine the potential for developing policy and funding strategies that would augment and support innovative state and local physical activity and nutrition initiatives;

Fundamentally, we needed a framework through which to undertake this work. Following is a description and diagram of the preliminary framework that was created for

this initiative. This framework enabled us to “visualize” the possibilities of what would eventually become the *Public-Private Collaborative Planning Compact*.

Planning Compact Model *(see note below)*

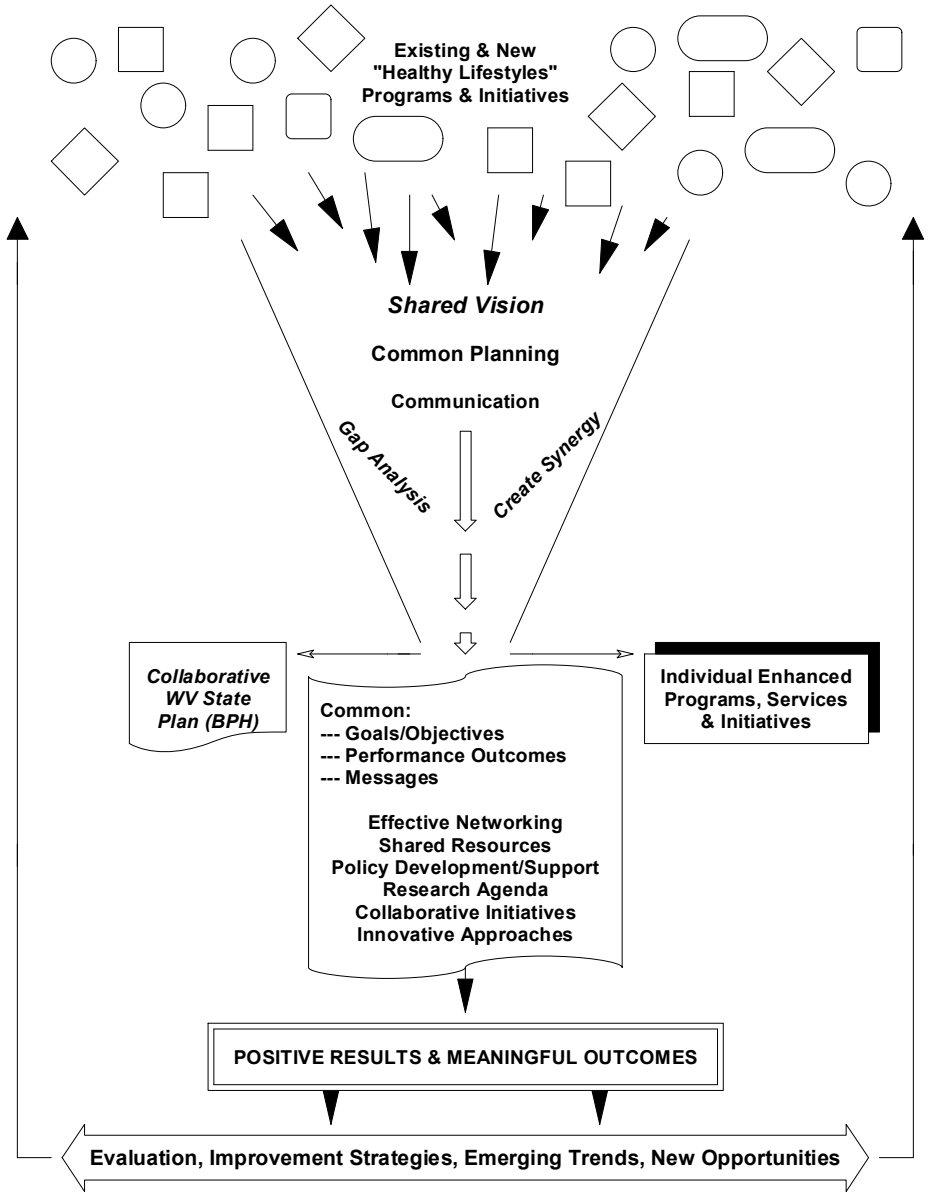
The premise behind the formation of the WV Healthy Lifestyles Collaborative Planning Compact was to bring together representatives from as many of the existing and new “Healthy Lifestyles” programs and initiatives as possible. The following diagram uses a funnel concept to depict how the Planning Compact is designed to work. There are many diverse programs and initiatives currently active at various levels throughout the state of West Virginia addressing increased physical activity and healthy eating. The intent of the Planning Compact is to identify these programs and initiatives and involve them based on their mission in being part of the formal planning compact. The middle of the funnel reflects the key components of the work of the Planning Compact: developing a shared vision (which may not be too much different than each program’s current vision), undertaking common planning activities, and increasing communication among all stakeholders (internal and external).

A high hope outcome of these activities is the potential synergy that will be greater than the “sum of the parts”. That is, using this approach those natural collaborations and synergies would be present as well as new found synergistic opportunities in a variety of combinations. Also, as more entities/efforts are identified and brought through some common collaborative work, a gap analysis can be performed to see where needs existed as well as where there was duplication of effort.

As shown outside the bottom of the funnel, several distinct outcomes can be expected. On the left, the box shows a collaborative WV State Plan that would address some of the gaps and help foster some of the synergy discovered in the Planning Compact work. On the right, there can be an expectation that many of the existing programs can be enhanced based on the work. Some of this will be solely internal while others will be reflected in collaborative activities.

As shown in the middle, those involved regarding the “Healthy Lifestyles” efforts in West Virginia would also disseminate common messages. Internally, those programs and initiatives involved in the Planning Compact work would benefit from effective networking, shared resources, shared policy development and support, common research agendas, collaborative initiatives, and innovative approaches. As a result of the work of the Planning Compact, the key outcome would be positive results and meaningful outcomes for all involved including the citizens of West Virginia. As follow-up to the work, evaluation would be conducted, improvement strategies would be identified, emerging trends would be followed and new opportunities would be identified for the “Healthy Lifestyles” programs and initiatives.

Building a West Virginia Healthy Lifestyles Planning Compact



Note: The diagram above was largely developed by staff at CESD, with my input and that from others on the core planning team.

Methodology

1. Given that there have been so many coalitions, partnerships and new programs that have sprung up in recent years to address the obesity issue, it was critical to “connect the dots” in ways that minimize inefficiency and duplication in the system. One of the initial steps of the project was to **develop a partner assessment and involvement profile** to determine the organizations that are either coordinating and/or delivering services or programs. A description of the methodology is attached (Attachment 3).
2. It was necessary to **construct a “collaborative model” that would provide a framework** for understanding the various organizational and programmatic relationships and which would provide a means through which future work could be (see Attachment 4).
3. Although not contemplated at the time of the initial project design, the passage of the *Healthy West Virginia Act of 2005* created a major organizing and collaboration challenge in that it was important to **strategically relate existing efforts** (including the new “framework”) to the goals of the new legislation and implementation of the “new” Healthy Lifestyles Coalition and to **brief the newly appointed Coalition members on the work that preceded the Coalition.**

Project Results

The results of this project can best be described as short-term, intermediate, evolving and unanticipated. Much of what will hopefully be realized from this project will occur in the future in terms of stronger working relationships, collaborative decision-making, enhanced communications, more effective and strategic programming, better coordinated and more efficient funding decisions. Results achieved during the project period (January - November, 2005) are described below.

1. **The completion of an organizational “involvement profile”.** In the design of the involvement profile, we attempted to classify levels of involvement by organizational partners based upon: mission focus, scope of work (the degree to which the organization’s work was directly or indirectly related to “healthy lifestyle” programs), West Virginia presence (statewide, regional or local), and type of organization (profit, nonprofit, governmental, etc.). A summary of the initial profile is attached.

Our initial data confirmed that organizational partners are active at varying levels of intensity. Sixty-nine organizations completed the questionnaire. Of these, 49% (n=34) indicated that 50% or more of their programs were directly related to physical activity and/or nutrition on a regular basis. 46% (n=32) of those surveyed

dedicated less than 50% to this work. The remaining 3 organizations (a foundation, a public policy group and a major statewide insurer) indicated support of healthy lifestyles efforts, but no direct activities or programs.

2. **An organizing meeting of West Virginia Healthy Lifestyles Collaborative Planning Network core partners was convened on June 13, 2005 following with a larger “roll-out” meeting in August 24, 2005.** As director of the Office of Epidemiology and Health Promotion (which is the principal recipient of CDC funding in WV and lead entity for the state’s Physical Activity and Nutrition Program), I served as the initial convener for these sessions. Initial “buy-in” to the concept and principles of the planning compact was achieved at the August meeting. At the initial meeting, compact participants categorized potential challenges into three areas: *overarching concerns about keeping the collaboration alive, potential turf issues and research needs*. They also identified three broad potential areas of benefit by having the compact: *strength in unity, communication (internal & external), and gap identification*.

The development stages of the planning compact framework and subsequent efforts has been led by a core planning team consisting of: myself, the Physical Activity and Nutrition (PAN) program manager, the executive director of the WV Healthy Lifestyles Coalition (#1), with technical support from the WVU Center for Entrepreneurial Studies and Development (CESD), under a contract from the West Virginia Physical Activity and Nutrition Program. It has been particularly important to also involve First Lady Gayle Manchin and representatives of the Benedum Foundation (a major investor in the first Healthy Lifestyles Coalition and a potential investor in the newly established Office of Healthy Lifestyles) in all aspects of this work as it moves forward.

3. The *Collaborative Planning Network* will meet again on December 12, 2005 to begin more formal discussions in the areas of member roles, decision criteria and the establishment of an initial leadership structure. Specifically, we plan to: a) update the Compact members (including levels) to ensure the right members have been identified, b) continue to build the official compact member database and invite new members, c) identify the next work items desired from the compact to include, but not be limited to:
 - Gap analysis (what is missing as to target populations, in approach, etc.)
 - Synergy opportunities (possible strategies that make sense)
 - Common work plan document (agreed upon strategies all will support)
 - Explore the potential common performance benchmarks (e.g., HP 2010)

4. With the passage of the *Healthy West Virginia Act of 2005*, the project took on a new and challenging dimension. Governor Joe Manchin III appointed 13 members to the WV Healthy Lifestyles Coalition. These individuals represent a wide variety of public, private and academic interests. Additionally, the Office of Epidemiology and Health Promotion (OEHP) was designated by the Secretary of the WV Dept. of Health and Human Resources (WV DHHR) to assume the responsibilities of the newly formed Office of Healthy Lifestyles (OHL). This decision was based upon the fact that the staff and CDC funding infrastructure was already in place in OEHP. With program support from the Program Manager of the PAN program and other key OEHP staff as needed, I am serving as the lead for the OHL. The convening meeting of the Coalition was held on September 21, 2005. Meetings will be held monthly at least through December, 2005.

As this was the first time many of the appointees had met, a good deal of time was devoted to providing background information and data on West Virginia's health status related to obesity, physical activity and nutrition. A comprehensive compendium of materials was also provided to each member. Preliminary operating and decision-making parameters were reviewed and discussed. An overview of the Healthy Lifestyles Collaborative Planning Network and Compact was also shared. The second meeting, held on October 24, 2005, was dedicated to a review of specific components of the legislation.

The Coalition has no regulatory administrative authority, but needs to play a greater role than simply serving in an advisory capacity. The group recognizes the need to establish its own "personality". As such, we are paying particular attention to building the coalition as a team. An offsite two-day retreat is being planned for early 2006.

5. An unanticipated result during the project period (April - May) was a three-week Epi-Aid "obesity" investigation conducted through a partnership between CDC and OEHP. A description of the initiative is attached. The investigation, the first ever of its type for CDC, was intended to perform an environmental assessment of obstacles to physical activity and good nutrition in Gilmer County and Clarksburg (Harrison County), West Virginia. A second objective was to develop and refine the environmental assessment methods used in Gilmer County and Clarksburg to formulate an environmental assessment "kit" that could be used then by other counties in West Virginia and nationally. Assessments were conducted in schools, worksites, grocery stores and restaurants. Additionally, walkability audits of over 800 ¼ mile segments were conducted in both communities.

This project was cited by Julie Gerberding, CDC Chief, during a press conference on June 2, 2005 focusing on the efficacy of controversial CDC obesity studies and related data. As a result, our office and key staff became the focus of major national

and international media inquiries. (More detail will be given about this and the communications lessons learned in the “leadership” section that follows.)

Conclusion

This project, even in its conception, was potentially a very difficult project to grasp. The subject matter (i.e., obesity, physical activity, nutrition) is highly visible, often controversial and is complicated by such forces as culture, urbanization and many other influences. In West Virginia, as in every other state, policymakers, program managers and private interests are all positioning for a place in the mix, in terms of solutions, approaches and innovation.

Had nothing else occurred during the course of this project, it would have remained a daunting, albeit laudable, goal to achieve a marginal degree of collaboration beyond what has been present (or absent) in the past. With, however, the introduction of major new legislation and the formation of a brand new coalition charged with advising and leading the state’s healthy lifestyles efforts, the project and the implications for future actions became more timely and necessary.

It is my belief that the mere process of conducting this project, coupled with the many other “tools” and learning from the SEPHLI experience enhanced my ability to better understand the dynamics of collaborative structures and processes. Likewise, I believe that the framework that we developed and have laid out to our partners has the potential to adaptation to many other disciplines. Indeed, it has been shared with a network of WV community development practitioners and the WV Leadership Network.

The results of this project and corollary efforts can be a significant step forward in advancing a high-performing network of collaborative partners committed to reducing the impact of obesity and its associated health problems for West Virginia.

Leadership Development

At the outset of the project, I was hopeful that I would be in a position to adapt my skills in leading collaborative efforts to this work. For many years prior to my current position in the WV Bureau for Public Health, I was fortunate to be in a position to facilitate collaborative teams in areas of entrepreneurship, telecommunications, welfare reform, rural capital investment among others. The arena of public health was relatively untested territory for me. Given that I have only been in my current position for a little over two years, I am still learning much about the players, the organizations, the prior relationships and history of those involved in the field of health promotion and, specifically obesity prevention. As a result, I have used the experience of this project to periodically “check” my leadership skills as I have worked through this challenging, but rewarding process.

I have learned, through this experience, the importance of understanding and respecting historical organizational relationships. In this specific project, it was clear that an understanding or resolution of agreement would be needed between the earlier established WV Healthy Lifestyles Coalition and the newly created WV Healthy Lifestyles Coalition. Coalition # 1 formed as a very legitimate and creative outgrowth of the state's Community and Economic Development plan. It attracted non-traditional partners (i.e., businesses, economic development professionals, etc.) to the importance of healthy people and healthy communities to the "business" of development. This coalition also benefited from a major investment from the Benedum Foundation.

With the passage of the Healthy West Virginia Act of 2005 and the legal creation of a new WV Healthy Lifestyles Coalition (placed under the direction of my office), it has been a delicate task to honor and build upon the work of the first coalition, without usurping the viability of the new coalition. This requires me to "crosswalk" between both entities, while keeping the message intact and alive. The compact should be a useful process tool to accomplish this.

My SEPHLI experience also prepared me well for the rather unexpected media response to the Epi-Aid initiative. Once Dr. Gerberding made reference to the West Virginia project in her national press conference, it became immediately clear that the communications techniques provided by Bob Howard would come to be extremely valuable. I discussed communications objectives in terms of messages and the importance of the Single Overriding Communications Objective (SOCO) with our key staff.

Throughout the project I also learned that public agencies must live in a balance that responds to the needs and demands of the citizens, while recognizing the need to engage private partners in the process. Issues of ownership and public agency control frequently emerge. It is difficult, but necessary, to not only convey a spirit of collaboration, but to model the actions of true collaborative leadership. It is frequently seen with skepticism, but it is essential to push ahead.

Attachment 1

Fast Facts: The Need for a Healthier West Virginia

- In 2002, West Virginia ranked 1st in the nation in the prevalence of obesity (27.6%) and 42nd highest in the prevalence of overweight (36.1%). More than 63% of West Virginians are considered overweight or obese. (Source: BRFSS)
- West Virginia leads the country in unhealthy conditions despite spending more than \$10 billion on health care in 2003. These costs could exceed \$20 billion by 2010. The state faced a \$168 million shortfall in Medicaid funding during the last budget cycle and a recent legislative report indicates that future state budget shortfalls, fueled in large measure by health care spending, are projected to grow to \$1.4 billion over the next few years. (Source: Kaiser Foundation, *Health Affairs*, Legislative Report)
- One of the drivers of these health care costs is the prevalence of chronic conditions. Chronic diseases such as cardiovascular disease, diabetes and arthritis account for roughly 78% of health care costs annually. More than 800,000 (over 40%) West Virginians have one or more chronic conditions. These conditions account for:
 - 70 % of hospital admissions and 80% of all days spent in a hospital;
 - 72% of physician visits and 88% of prescriptions filled; nearly 60% of emergency room visits; and
 - 70 cents of every dollar spent for health insurance by employers and workers.(Source: Robert Wood Johnson, *Partnership for Prevention*, *Health Affairs*)
- One in every five dollars billed for hospital care in West Virginia is related to diabetes. Eight of every ten hospital discharges is related to cardiovascular disease. (Source: Bureau for Public Health, *Burden of Cardiovascular Disease in West Virginia*)
- Over 31% of West Virginia adults reported suffering from hypertension (high blood pressure); 37% of the adult population is living with an unhealthy level of cholesterol. (Source: Bureau for Public Health, *Burden of Cardiovascular Disease in West Virginia*)
- 64% of West Virginians do not maintain a healthy weight and one in four West Virginians is obese. There is a strong correlation (67%) between an unhealthy weight and diabetes, high blood pressure, hypertension, heart disease, asthma and/or cancer). (Source: Bureau for Public Health, *Obesity in West Virginia*)
- Based upon national studies and using formulas and ratios used in these national studies, the total cost of obesity and overweight conditions in West Virginia is estimated within a range of \$1.5 to 2.0 billion. (Source: CDC, *Obesity Research*, Bureau for Public Health, *Obesity in West Virginia*)
- The estimated amount of state tax dollars spent for medical conditions associated with poor weight control and physical inactivity is estimated to exceed \$250 million. (Source: Projections based upon 2001 information set forth in *Obesity in West Virginia*)

- Using formulas and percentages from a national study, the estimated impact on West Virginia businesses and citizens annually for conditions associated with poor weight control and physical inactivity is:
 - 400,000 lost work days due to obesity-related causes;
 - 2.4 million restricted-activity days;
 - 900,000 bed-days;
 - 600,000 physician visits; and
 - more than 2 million related prescriptions.
 (Source: Bureau for Public Health, *Obesity in West Virginia*)

- Obese individuals spend 36% on health services and 77% more on medications than individuals that maintain a healthy weight. (Source: Bureau for Public Health, *Obesity in West Virginia*)

- According to a recent study, obesity is responsible for 61% of type 2 diabetes in this country. Obese individuals have a 27 times higher risk of developing diabetes than individuals that maintain a healthy weight (Source: Bureau for Public Health, *Obesity in West Virginia*)

- Alarmingly, nearly 85,000 of our K-12 students are overweight or at risk of becoming overweight. Overweight adolescents have a 70% chance of becoming overweight or obese adults. One in three children born in 2000 is at risk of developing diabetes due to physical inactivity and diet if current trends continue. (Source: Bureau for Public Health, *Burden of Diabetes in West Virginia*)

- In 2000, more than 35% of West Virginia adults reported getting no physical activity within the last month and nearly 70% of West Virginians are classified as sedentary. (Source: Bureau for Public Health, *Physical Activity Facts*)

- Studies indicate the risk of developing arthritis increases by 9-11% for each pound above a healthy weight. (Source: Bureau for Public Health, *Obesity in West Virginia*)

Attachment 2

ENROLLED

COMMITTEE SUBSTITUTE

FOR

H. B. 2816

(By Mr. Speaker, Mr. Kiss, and Delegate Trump)

[Passed April 9, 2005, in effect ninety days from passage]

AN ACT to amend the Code of West Virginia, 1931, as amended, by adding thereto a new article, designated §5-1E-1, §5-1E-2, §5-1E-3, §5-1E-4 and §5-1E-5; and to amend and reenact §18-2-6a, §18-2-7a and §18-2-9 of said code, all relating to promoting healthy lifestyles; creating a Healthy Lifestyles Office in the Department of Health and Human Resources; establishing the functions of the Office; creating a special revenue account; establishing a voluntary private sector partnership program to encourage healthy lifestyles; establishing physical activity requirements in the schools; using body mass index as an indicator of progress; encouraging the use of healthy beverages in schools; and adding requirements for health education.

Be it enacted by the Legislature of West Virginia:

That the Code of West Virginia, 1931, as amended, be amended by adding thereto a new article, designated §5-1E-1, §5-1E-2, §5-1E-3, §5-1E-4 and §5-1E-5; and that §18-2-6a, §18-2-7a and §18-2-9 of said code be amended and reenacted, all to read as follows:

CHAPTER 5. GENERAL POWERS AND AUTHORITY OF THE GOVERNOR,

**SECRETARY OF STATE AND ATTORNEY GENERAL; BOARD OF PUBLIC WORKS;
MISCELLANEOUS AGENCIES, COMMISSIONS, OFFICES, PROGRAMS, ETC.**

ARTICLE 1E. HEALTHY WEST VIRGINIA PROGRAM.

§5-1E-1. Findings and purposes.

The Legislature finds and declares that the rise in obesity and related weight problems accompanied by the resulting incidence of chronic disease has created a health care crisis that burdens the health care infrastructure of the state. The Legislature also finds that the State of West Virginia must take an informed, sensitive approach to communicate and educate the citizens of the state about health issues related to obesity and inappropriate weight gain. The Legislature further finds that the state must take action to assist West Virginia citizens in engaging in healthful eating and regular physical activity. The Legislature further finds that the state must invest in research that improves understanding of inappropriate weight gain and obesity. These efforts are needed to coordinate the state's interest in improving the health of its citizens and in reducing the cost of health care. Therefore, it is the purpose of this article to create, as an integral part of the Department of Health

and Human Resources, an entity to coordinate the efforts of all agencies to prevent and remedy obesity and related weight problems and to ensure that all citizens are being educated on this serious health risk that is affecting the state.

§5-1E-2. Creation of the Office of Healthy Lifestyles.

There is hereby created the Office of Healthy Lifestyles within the Department of Health and Human Resources. The management of this office shall be provided in the manner determined by the Secretary of the Department of Health and Human Resources to be in the best interest of the state and its citizens.

§5-1E-3. Powers and duties of the Office.

The Office of Healthy Lifestyles shall:

- (1) Establish a Healthy Lifestyle Coalition to assure consistency of the public health and private sector approach to dealing with programs that address the problems that affect overweight and obese individuals; to provide a forum for discussing the issues that affect healthy lifestyles and to identify best practices that can be replicated. By the first day of July, two thousand five, the Governor shall appoint thirteen members of the Coalition whose terms shall be for a period of four years, and the members may be reappointed to a second term. The terms may be staggered by the Governor to assure continuity of experience on the coalition. Members shall represent state agencies, community organizations and other entities which have an interest and expertise in obesity. Members may not be compensated but shall receive reimbursement for expenses incurred while performing the business of the coalition. The Coalition shall meet monthly for at least the first eighteen months of the Coalition to develop and implement an action plan to meet the goals established by the Coalition;
- (2) Establish a clinical advisory committee to assure a unified approach using the latest research to assure consistency in program development;
- (3) Establish a statewide voluntary private sector partnership and recognition program for employers, merchants, restaurants and other private sector businesses to encourage the development or further advance current programs that encourage healthy lifestyles;
- (4) Coordinate higher education training programs for dietary and exercise physiology students with rural health care providers;
- (5) Coordinate existing health promotion initiatives to assure clear, concise and consistent communication;
- (6) Solicit, accept and expend grants, gifts, bequests, donations and other funds from any source for programs that will enable the state to accomplish the goals of this program;
- (7) Develop a cross-agency series of goals to ensure consistency throughout the system of providers and agencies working in the area of improving lifestyles;
- (8) Establish as a goal to increase the prevalence of healthy weight among all people in the state because obesity leads to diabetes, heart disease, strokes and kidney failure. These diseases, often arising in older age as a result of unhealthy lifestyles that began during a person's youth, place an undue financial burden on individuals, the health care industry and state health care programs;
- (9) Consider the resources of the local health departments and recommend ongoing relationships, as appropriate, between local health departments, family resource networks, faith-based organizations, cooperative extension services, farm bureaus and other health care providers;
- (10) Encourage the development of incentives for participation in employee wellness programs. Incentives may be based upon, but should not be limited to, the employee's completion of health questionnaires or participating in healthy lifestyles initiatives, and may use experiences of successful initiatives that have occurred in this state. The action plan should include among its

- targets, state government employees in this incentive program;
- (11) Build upon existing initiatives that focus on any of the coalition's goals, soliciting input from these initiatives and eliminating duplication of efforts;
- (12) Report its progress annually by the first of December to the Legislative Oversight Commission on Health and Human Resource Accountability.

§5-1E-4. Partnership to encourage healthy lifestyles by children and families.

- (a) The West Virginia Healthy Lifestyles program will develop a statewide voluntary private sector partnership program to work with businesses throughout the State that encourage and promote healthy lifestyles among their employees and communities.
- (b) Beginning the first day of July, two thousand five, those businesses voluntarily choosing to participate in the Healthy Lifestyles program shall submit their own detailed programs to the Office of Healthy Lifestyles for review. The programs should be creative and unique, highlighting the efforts of the business to promote healthy lifestyles to West Virginians through sensible diet and physical fitness.
- (c) The West Virginia Healthy Lifestyles program will develop a recognition program for private sector enterprises that develop or advance programs that address the problems affecting overweight and obese individuals and that promote a healthy lifestyle.
- (d) Any business program promoting healthy lifestyles that is recognized by the Office of Healthy Lifestyles will be issued a universally recognized logo, suitable for public display by the business.
- (e) Marketing of programs recognized by the Office of Healthy Lifestyles shall take place through all state agencies. The West Virginia Public Employees Insurance Agency, the Bureau for Medical Services and the West Virginia Workers' Compensation Commission shall aggressively market this program to their members for the purposes of health promotion among their members.
- (f) The Office of Healthy Lifestyles shall market recognized programs to other businesses, as models, to help create additional programs promoting healthy lifestyles.
- (g) The Office of Healthy Lifestyles shall report annually by the first day of December to the Legislative Oversight Commission on Health and Human Resources Accountability: (1) The number of participants; (2) the impact on businesses as established by a survey of participating businesses; and (3) the results of consumer satisfaction surveys all designed by the Office of Healthy Lifestyles.

§5-1E-5. Creation of a Healthy Lifestyles Fund.

There is hereby created in the State Treasury a separate special revenue account, which shall be an interest bearing account, to be known as the "Healthy Lifestyles Fund". The special revenue account shall consist of all appropriations made by the Legislature, income from the investment of moneys held in the special revenue account and all other sums available for deposit to the special revenue account from any source, public or private. No expenditures for purposes of this section are authorized from collections except in accordance with the provisions of article three, chapter twelve of this code and upon fulfillment of the provisions set forth in article two, chapter eleven-b of this code. Any balance remaining in the special revenue account at the end of any state fiscal year does not revert to the general revenue fund but remains in the special revenue account and shall be used solely in a manner consistent with this article. No expenses incurred under this section shall be a charge against the general funds of the state.

CHAPTER 18. EDUCATION.

ARTICLE 2. STATE BOARD OF EDUCATION.

§18-2-6a. Sale of healthy beverages and soft drinks in schools.

(a) In order to generate funding for necessary programs and supplies, county boards may permit the sale of healthy beverages and soft drinks in county schools except during breakfast and lunch periods as follows:

(1) During a school day, soft drinks may not be sold in areas accessible to students in an elementary school, middle school or junior high school through vending machines on the premises, in school stores or in school canteens or through fund raisers by students, teachers, groups or by any other means. In elementary, middle school or junior high school, only healthy beverages may be sold in vending machines on the premises, in school canteens or through fundraisers by students, teachers, groups or by any other means. Nothing in this section shall be construed to prohibit or limit sale or distribution of any food or beverage item through fund-raising activities of students, teachers or educational groups when the items are intended for sale off the school grounds. (2) Those high schools which permit the sale of soft drinks through vending machines also shall offer for sale healthy beverages. Of the total beverages offered for sale, at least fifty percent shall be healthy beverages. Vending machines containing healthy beverages shall be in the same location or substantially similar location as vending machines containing soft drinks.

(3) The sale of healthy beverages and soft drinks shall be in compliance with the rules of the National School Lunch Program and the School Breakfast Program of the State Board and the Nutrition Service of the United States Department of Agriculture, which became effective on the seventeenth day of June, one thousand nine hundred eighty-five. Seventy-five percent of the profits from the sale of healthy beverages and soft drinks shall be allocated by a majority vote of the faculty senate of each school and twenty-five percent of the profits from the sale of healthy beverages and soft drinks shall be allocated to the purchase of necessary supplies by the principal of the school.

(b) For the purposes of this section:

(1) "School day" means the period of time between the arrival of the first student at the school building and the end of the last instructional period; and

(2) "Healthy beverage" means water, one hundred percent fruit and vegetable juice, low-fat milk and other juice beverages with a minimum of twenty percent real juice.

§18-2-7a. Legislative findings; required physical education; program in physical fitness.

(a) The Legislature hereby finds that obesity is a problem of epidemic proportions in this state. There is increasing evidence that all segments of the population, beginning with children, are becoming more sedentary, more overweight, and more likely to develop health risks and diseases including Type II Diabetes, high blood cholesterol and high blood pressure. The Legislature further finds that the promotion of physical activity during the school day for school children is a crucial step in combating this growing epidemic and in changing the attitudes and behavior of the residents of this state toward health promoting physical activity.

(b) As a result of these findings, the State Department of Education shall establish the requirement that each child enrolled in the public schools of this state actively participates in physical education classes during the school year to the level of his or her ability as follows:

(1) *Kindergarten to and including grade five.* -- Not less than thirty minutes of physical education,

including physical exercise and age appropriate physical activities, for not less than three days a week.

(2) *Grade six to and including grade eight.* -- Not less than one full period of physical education, including physical exercise and age appropriate physical activities, each school day of one semester of the school year.

(3) *Grade nine to and including grade twelve.* -- Not less than one full course credit of physical education, including physical exercise and age appropriate physical activities which shall be required for graduation and the opportunity to enroll in an elective lifetime physical education course.

(c) Enrollment in physical education classes and activities required by the provisions of this section shall not exceed, and shall be consistent with, state guidelines for enrollment in all other subjects and classes: *Provided*, That schools which do not currently have the number of certified physical education teachers or required physical setting may develop alternate programs that will enable current staff and physical settings to be used to meet the physical education requirements established herein. These alternate programs shall be submitted to the State Department of Education and the Healthy Lifestyle Council for approval. Those schools needing to develop alternate programs shall not be required to implement this program until the school year commencing two thousand six.

(d) The State Board shall prescribe a program within the existing health and physical education program which incorporates fitness testing, reporting, recognition, fitness events and incentive programs which requires the participation in grades four through eight and the required high school course. The program shall be selected from nationally accepted fitness testing programs designed for school-aged children that test cardiovascular fitness, muscular strength and endurance, flexibility and body composition: *Provided*, That nothing in this subsection shall be construed to prohibit the use of programs designed under the auspices of the President's Council on Physical Fitness and Sports. The program shall include modified tests for exceptional students. Each school in the state shall participate in National Physical Fitness and Sports Month in May of each year and shall make every effort to involve the community it serves in the related events.

(e) Body mass index measures shall be used as an indicator of progress toward promoting healthy lifestyles among school-aged children. The body mass index measures shall be determined using student height and weight data and reported to the State Department of Education via the West Virginia Education Information System. Body mass index measures shall be included in kindergarten screening procedures. Students in grades four through eight and students enrolled in high school physical education courses shall have their body mass index measured through required fitness testing procedures. All school personnel responsible for conducting and reporting body mass index measures shall receive training or written documentation on the appropriate methodology for assessing the body mass index and reporting data in a manner that protects student confidentiality. All body mass index data shall be reported in aggregate to the Governor, the State Board of Education, the Healthy Lifestyles Coalition and the Legislative Oversight Commission on Health and Human Resource Accountability.

§18-2-9. Required courses of instruction; violation and penalty.

(a) In all public, private, parochial and denominational schools located within this state there shall be given prior to the completion of the eighth grade at least one year of instruction in the history of the state of West Virginia. The schools shall require regular courses of instruction by the completion of the twelfth grade in the history of the United States, in civics, in the constitution of

the United States, and in the government of the state of West Virginia for the purpose of teaching, fostering and perpetuating the ideals, principles and spirit of political and economic democracy in America and increasing the knowledge of the organization and machinery of the government of the United States and of the state of West Virginia. The State Board shall, with the advice of the State Superintendent, prescribe the courses of study covering these subjects for the public schools. It shall be the duty of the officials or boards having authority over the respective private, parochial and denominational schools to prescribe courses of study for the schools under their control and supervision similar to those required for the public schools. To further such study, every high school student eligible by age for voter registration shall be afforded the opportunity to register to vote pursuant to section twenty-two, article two, chapter three of this code.

(b) The State Board shall cause to be taught in all of the public schools of this state the subject of health education, including instruction in any of the grades six through twelve as considered appropriate by the county board, on (1) the prevention, transmission and spread of acquired immune deficiency syndrome and other sexually transmitted diseases, (2) substance abuse, including the nature of alcoholic drinks and narcotics, tobacco products, and other potentially harmful drugs, with special instruction as to their effect upon the human system and upon society in general and (3) the importance of healthy eating and physical activity to maintaining healthy weight. The course curriculum requirements and materials for the instruction shall be adopted by the State Board by rule in consultation with the Department of Health and Human Resources. The State Board shall prescribe a standardized health education assessment to be administered within health education classes to measure student health knowledge and program effectiveness.

An opportunity shall be afforded to the parent or guardian of a child subject to instruction in the prevention, transmission and spread of acquired immune deficiency syndrome and other sexually transmitted diseases to examine the course curriculum requirements and materials to be used in the instruction. The parent or guardian may exempt the child from participation in the instruction by giving notice to that effect in writing to the school principal.

(c) Any person violating the provisions of this section shall be guilty of a misdemeanor, and, upon conviction thereof, shall be fined not exceeding ten dollars for each violation, and each week during which there is a violation shall constitute a separate offense. If the person so convicted occupy a position in connection with the public schools, that person shall automatically be removed from that position and shall be ineligible for reappointment to that or a similar position for the period of one year.

Attachment 3

Involvement Profile

By definition, some entities are more engaged in these aspects of healthy lifestyles work as part of their mission. Yet, there can be others who incorporate this type work as one or more strategies within their overall scope work (e.g., operations, mission, programs, and services).

In seeking active participation for the Healthy Lifestyles Planning Compact, suggested classification attributes were identified to assist in profiling organizations based on different levels of potential involvement in the effort. This would be both in planning work and for on-going support of the effort. In addition, it appears that this may also be helpful in setting expectations of the participant’s engagement level. The initial ways to classify participation or membership include Mission Focus, Scope of Work, West Virginia Presence, and Type of Organization. The following information, in table format, details the specifics for these classifications. A background survey, sent out to potential compact members solicited this information from the various programs and initiatives.

Mission Focus

<i>HLPC Tier</i>	<i>Mission</i>	<i>Comments</i>
1	90 % to 100% or more of this organization/group/individual is focused on healthy lifestyle work	Those organizations most engaged directly in “healthy lifestyles” type work on a regular basis in the areas of obesity, physical activity and nutrition. Clearly the primary mission of this participant.
2	50% to 90% or more of this organization/group/individual is focused on healthy lifestyle work	Those organizations who have at least ½ of work activities directly engaged in healthy lifestyles type work on a regular basis in the areas of obesity, physical activity and nutrition. This work would be a significant part of the participant’s mission.
3	Less than 50%, but some level of this organization/group/individual is focused on healthy lifestyle work	Those organizations where some part of their overall work (mission) involves healthy lifestyles type work, but there is some level of this work on a regular basis in the areas of obesity, physical activity and nutrition
4	Not directly involved in this area as part of its work and/or provides support in some manner to those that are engaged in healthy lifestyles type of work.	May have interest, but perhaps no direct expertise or active role in delivery of programs or services in the “healthy Lifestyles” arena.

Primary Scope of Work

<i>Coding</i>	<i>Definition</i>
D = Direct	Direct programs and services targeted to physical activity or nutrition.
I = Indirect	Indirectly involved in assisting to have programs and services in place. Examples might be coordinating, policy development, coalitions, and research.
F = Funder/Supporters	Funders or supporters of some nature – Specific activity is funding organizations/initiatives in the healthy lifestyles area or providing some form of support.

West Virginia Presence

<i>Coding</i>	<i>Definition</i>
S - Statewide	Statewide coverage (could be a national effort with statewide presence in West Virginia)
R = Regional	Regional programs and services, may be in more than one defined region
L = Local	Local – Only local effort somewhere in West Virginia, may be in more than one location
N = Not applicable	Does not provide programs or services directly

Type of Organization

<i>Coding</i>	<i>Definition</i>
N = Non-profit entity	Non-profit organization
P = For profit entity	For profit organization
S = State government agency	Primarily agency within state government
E = Educational Institution	Includes public and private education in West Virginia
L = Local government entity	Primary operated by local or regional governmental unit

Attachment 4

West Virginia Healthy Lifestyles Collaborative Network

Public-Private Collaborative Planning Compact

Networking Effective Working Relationships to Advance Healthy Eating and Active Living throughout West Virginia

Background

There are many, even more so now, efforts, both formal and informal, by a myriad of organizations regarding developing 'healthy lifestyles' for West Virginians. As an umbrella term, *healthy lifestyles* serves as a primary focal point on addressing obesity issues primarily through improved eating habits (nutrition) and active living (physical activity).

Presently, there are several significant activities in this arena. One is the requirement for West Virginia to submit a state plan to the Center for Disease Control (CDC) on how, through the Bureau of Public Health's Office of Epidemiology and Health Promotion (OEHP), the state will address obesity issues. Secondly, the recently released work plan of the West Virginia Healthy Lifestyles Coalition signals a commitment to truly address the obesity issue. The Coalition has actively promoted a strong comprehensive emphasis on addressing many different aspects of the obesity problem. The Healthy Lifestyles Coalition has suggested four key focus areas: Healthy Kids/Schools, Healthy Employees, Healthy Communities, and Healthy Supports.

Recent legislation (2005), at the request of Governor Manchin, created the Office of Healthy Lifestyles (H.B. 2816). This office, housed within the Secretary's Office in the WV Department of Health and Human Resources (DHHR), has a number of responsibilities spelled out in state code. This office is playing an integral part of the public/private collaborative planning compact work.

In a true collaborative approach, OEHP and the WV Healthy Lifestyles Coalition are working together to coordinate initiatives and build a common planning compact that helps all efforts achieve more. With OEHP, within the public sector, and the Coalition representing a number of organizations, primarily outside the public sector, these two are lending resources to do collaborative planning that will establish an informal, virtual West Virginia Healthy Lifestyles Collaborative Network.

As shown in Diagram 1, the first step was to take a simple inventory of what direct organizational activities were currently in place or pending that centered on healthy lifestyles within the scope of the anticipated planning. The next step involved bringing some of the key entities together to map the central themes of the initiatives. From this planning, opportunities have surfaced to strengthen specific working relationships among common causes. Further, through working together, there may be actual leveraging of resources or reduction in duplication.

The diagram depicts levels (local, statewide, state agencies) and the different types of organizations (public, private, associations). In some cases, those noted on the diagram are specifically engaged in aspects of healthy lifestyles, while others have smaller roles. These roles are often just some part of the overall work of the given organization. There are a number of notable programs already in existence providing programs at the community level. Examples are West Virginia Walks and WV on the Move. Further, the local health departments, through funding/work with the state Bureau for Public Health, are in every county addressing issues such as obesity. Notes at the bottom of Diagram 1 provide more details regarding the groups listed.

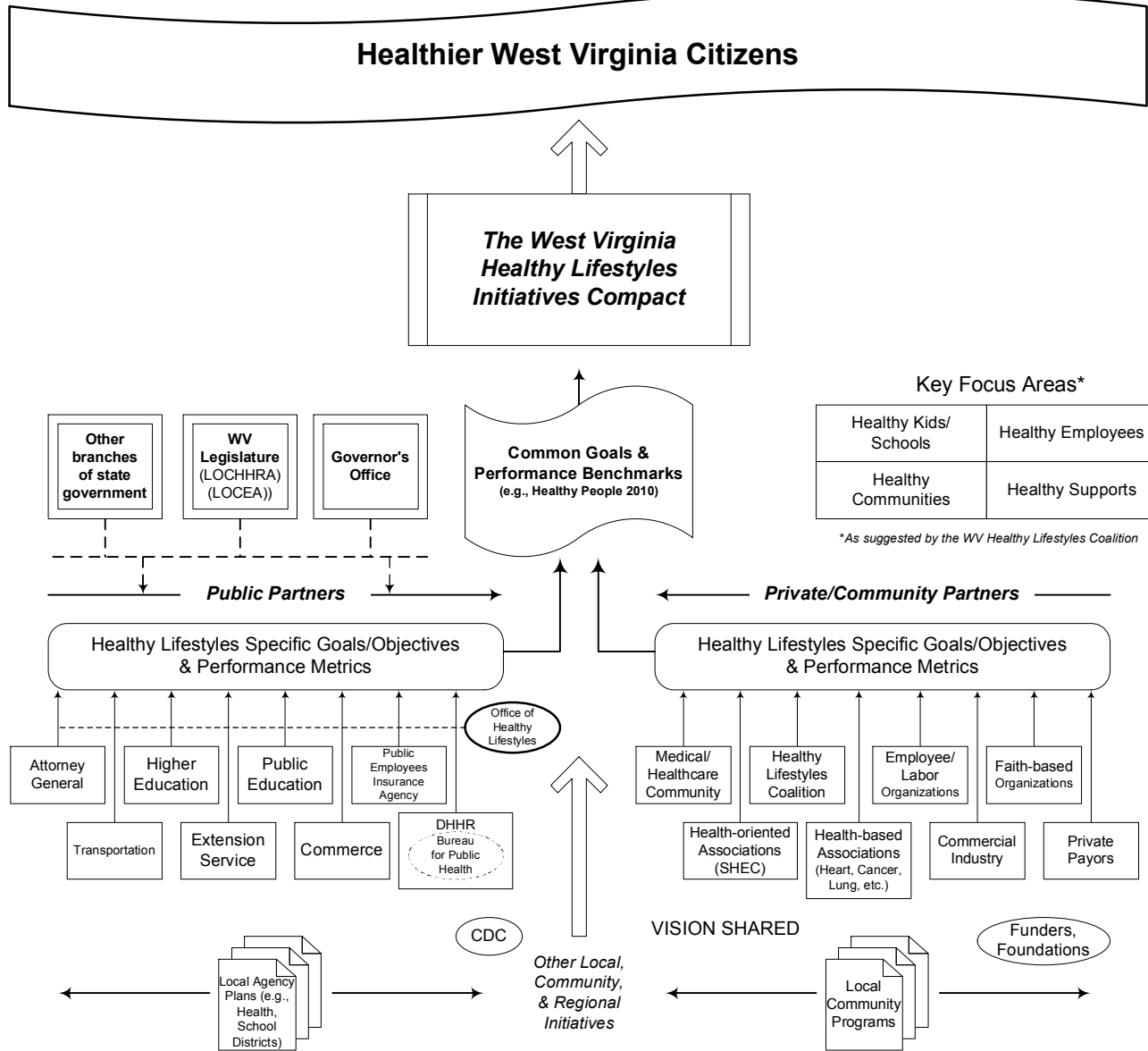
Attempting to coordinate and collaborate without hindering on-going initiatives by a group is a challenge, but a worthy cause. The overriding principle is not to require or force any one organization or effort to change to a specific model. Rather, the concept is to look for natural synergy and forge those common goals and performance benchmarks (outcomes) that will increase everyone's results. Further, this work can help establish consistency in important healthy lifestyle messages to the public.

In the end, enhanced communication will be a natural by-product of this work, and the envisioned outcomes will improve overall attention and positive change regarding obesity that fosters healthier West Virginia citizens.

West Virginia Healthy Lifestyles Collaborative Network

Public-Private Collaborative Planning Compact Overview

Networking Effective Working Relationships to Advance Healthy Eating and Active Living throughout West Virginia



Notes:

1. Planning requirements will vary by type of organization and initiatives being undertaken (e.g., mandated compliance plans to ad hoc planning).
2. West Virginia Vision Shared has emphasized the importance of statewide attention to healthy lifestyles/wellness as a vital cornerstone to successful economic development. It has worked closely with the Healthy Lifestyle Coalition.
3. The implementation status of any given 'healthy lifestyles' initiative will vary from new planning to programs that have been in operation for a period of time.
4. WV Dept. of Education specifics: Office of Healthy Schools, Office of School Nutrition, & local county boards of education.
5. Bureau for Public Health: Variety of programs within WV Department of Health and Human Resources; also has Obesity Prevention Plan responsibilities and Healthy People 2010 goals.
6. CDC is the U.S. Center for Disease Control and a major source of funds for physical activity and nutrition education programs.
7. Other state agencies: WV Department of Commerce: (Development Office, Tourism), Parks & Recreation, Dept. of Transportation.
8. LOCHHRA = Legislative Oversight Commission on Health and Human Resource Accountability.
LOCEA = Legislative Oversight Commission on Education Accountability.
9. Employee/Labor Organizations: Chamber of Commerce, Unions, WV Wellness Council.
10. Other branches of state government: Attorney General, Treasurer, Secretary of State, etc.
11. Specific community programs such as West Virginia Walks and West Virginia On the Move are in multiple communities.
12. The Office of Healthy Lifestyles, housed within the Secretary's Office of DHHR, has specific planning and coordinating responsibilities.

What the Planning Compact approach is intended to be at its BEST:

1. An opportunity to share messages, create synergy for existing initiatives and foster new ones.
2. A way to collectively tap and leverage West Virginia's greatest expertise and resources in the areas of healthy lifestyles programs and research.
3. Raising the probability of an effective and comprehensive state plan (to CDC) that is much more collaborative and helps meet needs where most needed.
4. A way to forge a shared vision and common messages regarding efforts with healthy lifestyles in West Virginia.
5. An opportunity to learn of other programs/initiatives and to get a better understanding of the "lay of the land" as it applies to healthy lifestyles work in West Virginia.
6. A way to reach agreement on possible specific focus by an organization(s) so to better leverage the resources and efforts.
7. A planning process that can help find true gaps in addressing healthy lifestyles in West Virginia.
8. A framework for communicating a "unified front" on the seriousness of this issue in West Virginia.
9. Work together to offer and support the development, passage and implementation of policy.

What the Planning Compact is NOT:

1. Not intended to directly change any existing program or initiative.
2. Not about a state agency trying to control all efforts in the healthy lifestyle arena.
3. Not a new coalition or established group.
4. Not a mandated entity or required organization.
5. Not a "closed" or exclusive set of organizations/membership.
6. Not a long strung out commitment by any given organization.
7. Not a control of funding or use of funding.

Attachment 5

West Virginia Chronic Disease Epi-Aid Project Summary

For decades, state health departments have requested and obtained assistance from the Centers for Disease Control and Prevention (CDC) for the investigation and control of infectious disease epidemics (disease rates above expected normal levels). With infectious disease epidemics, there is the expectation that such an investigation will be conducted taking into account the potential factors associated with the unusually high disease rates. It is also expected that specific intervention/control measures would be instituted quickly within the community or population group to curb the outbreak or condition. Prior to this project, such epidemiologic investigations have not been commonly utilized for chronic disease epidemics.

The WV Bureau for Public Health's Office of Epidemiology and Health Promotion in collaboration with the CDC conducted an Epi-Aid investigation that focused on physical activity and good nutrition. This investigation was based on the fact that WV is facing a severe health crisis with hypertension, diabetes, and obesity all at levels greater than the national average. According to the 2003 Behavioral Risk Factor Surveillance System, West Virginia ranks number one (1st) in the nation for hypertension, number four (4th) for diabetes, and number three (3rd) for obesity. Additionally, West Virginia's rate of increase in obesity appears to be exceeding the rate of increase in the rest of the nation.

This investigation took place April 25 – May 13th. The primary objective of the Epi-Aid project was to perform an environmental assessment of barriers to physical activity and good nutrition in Gilmer County and Clarksburg (Harrison County), West Virginia. According to the 2002 BRFSS data, Gilmer County has significantly higher than the U.S. prevalence of hypertension, no leisure-time physical activity, and diabetes. Harrison County, where Clarksburg is located, has significantly higher than the U.S. prevalence of hypertension, no leisure-time physical activity, and obesity. Gilmer County is a small rural county (pop. 7160) and Clarksburg is considered a small town (pop. 16,743); both communities are representative of most counties and small towns in West Virginia in terms of demographics and socio-economic status.

The second objective of the Epi-Aid initiative was to develop and refine the environmental assessment methods used in Gilmer County and Clarksburg to formulate an environmental assessment "kit" that could be used by other communities in West Virginia. Currently, the WV Bureau for Public Health is working on completing the State Physical Activity and Nutrition Plan, and the environmental assessment "kit" will be an important component of the State Physical Activity and Nutrition Plan. The "kit" will provide communities with a structured tool to assess barriers and promote physical activity and good nutrition in their areas. This then promotes the development of priorities with community input and participation. Also, the environmental assessment "kit" will provide communities with a tool for re-assessing their environment following implementation of programs or changes in local policies. The "kit" assesses multiple settings including schools, worksites, hospitals and communities.

The following pages provide a brief synopsis of the preliminary data generated from this project. It is important to keep in mind that the data and recommendations found in the following pages are

preliminary results, and therefore future correspondence or reports might present results and interpretations that differ from those contained in this document. Final recommendations from the CDC are forthcoming.

SCHOOLS: PRELIMINARY RESULTS

There were a total of 18 schools assessed including 11 elementary schools, two middle schools and five high schools. Five of the schools were in Gilmer County, eight in Clarksburg-Bridgeport and five in Harrison County outside Clarksburg-Bridgeport. While all schools were invited to participate we were unable to visit all schools in the identified areas.

The US Surgeon General has identified schools as a key setting for public health strategies to prevent and decrease the prevalence of overweight and obesity. Most children spend a large portion of time in school. Schools have the necessary infrastructure to provide many opportunities to engage children in healthy eating and physical activity and to reinforce healthy diet and physical activity messages.

The major components of the school assessment tool were: (1) to determine the amount of time that students receive physical education; (2) the percentage of students walking to school; and (3) to determine what nutrition policies, outside of the WV Department of Education School Nutrition Programs policies, were being implemented in West Virginia schools.

Results of the schools assessments are as follows:

- When preliminary results of these surveys were examined and compared to the newly passed West Virginia legislation (SB 2816), it was determined that, assuming no modifications occur or are allowed to the legislation requirements, all elementary schools in Gilmer County, half the elementary schools in Harrison County outside Clarksburg-Bridgeport, and none of the elementary schools in Clarksburg-Bridgeport would meet recently passed WV legislation requirements for PE time for grades K to five.
- Schools with grades six, seven and/or eight would not meet recently passed requirements with the exception of one middle school in Clarksburg-Bridgeport. In addition it was determined that, based on the National Association of Sport and Physical Education (NASPE) recommendations, there was insufficient PE in all elementary schools, high schools, and in 50% of the middle schools that were assessed.
- Schools reported that the vast majority of students in each community are bussed to school.
- The more rural areas appear to have higher percentages of students being bussed as compared to the urban area of Clarksburg-Bridgeport.
- Very few students at any school level were reported to walk to school and this was particularly true of high school students. The percentages of children walking to school in these communities appears to be lower than in WV overall.
- Almost no students were reported to bike to school.
- The two most common hazards cited overall for children walking or biking to school were speed of traffic and inadequate or missing sidewalks and bike trails. The amount of traffic appears to be an important hazard cited for Clarksburg-Bridgeport and other Harrison County schools.

- None of the 18 schools interviewed prohibited, and only one discouraged, the use of food or food coupons as a reward for good behavior or good academic performance.
- The majority of elementary schools in Clarksburg-Bridgeport had policies requiring fruits or vegetables to be among foods offered and/or prohibited junk foods at student parties. However, most other schools did not have such policies.
- The majority of schools with after-school or extended day programs did not have a policy requiring fruits or vegetables to be among foods offered in these programs.
- Although the majority of Clarksburg-Bridgeport elementary schools prohibited junk foods from being offered in after-school or extended day programs, high schools and most schools outside the Clarksburg-Bridgeport area did not have such a policy.
- The vast majority of schools with concession stands did not have a policy requiring fruits or vegetables to be among foods offered at these stands and none had a policy prohibiting junk foods.
- All middle schools and the vast majority of elementary and high schools in each community reported selling chocolate and/or other candy and non-low-fat baked goods as part of fundraising.

WORKSITES: PRELIMINARY RESULTS

West Virginians spend the majority of their day at a worksite. While at work, employees are often aggregated within systems for communication, education, and peer support. Thus, worksites provide many opportunities to reinforce the adoption and maintenance of healthy lifestyle behaviors. Public health approaches in worksites should extend beyond health education and awareness to include worksite policies, the physical and social environments of worksites, and their links with the family and community setting.

A total of six worksites were assessed – two in Clarksburg and four in Gilmer County. Because only two of the top 10 county employers located in Clarksburg and four of the top 10 county employers located in Gilmer County were assessed, worksites assessments constituted a small number of the major county employers in each community. Thus results may not be representative of other employers found in the two communities.

This assessment examined several aspects of the work environment. Results are summarized as follows:

- It was determined that few worksites offered point-of-decision information prompts encouraging people to take the stairs.
- With regards to nutrition, none of worksites offered signs, posters, or notices in any lunchroom or break room designed to encourage dietary fat reduction, increase fruit and vegetable consumption, or provide dietary information or information on weight loss.
- Of the six work sites assessed, none organized or sponsored lunch time and/or after work walking clubs.
- None of the sites assessed provided or subsidized fitness assessments nor did they provide any type of incentives for engaging in physical activity.

It is highly recognized that individual behavioral change lies at the core of all strategies to reduce overweight and obesity. However, successful efforts must not only focus on individual behavioral change, but also on environmental and policy changes. Because policy plays such an important role worksite polices were examined. It was determined that none of the six worksites assessed had a written policy supporting employee physical fitness. In addition, no worksite had a written policy on lactation support in the workplace or designated lactation space.

RESTAURANT AUDITS: PRELIMINARY RESULTS

During this project, a total of 25 restaurants were assessed: 17 in the Clarksburg-Bridgeport area and 8 in Gilmer County. The tool used for the restaurant audits was a modified version of a questionnaire used previously by the WV Bureau for Public Health. It was modified to be shorter, easier to use, and to better assess the general availability of healthier food options including fruits, vegetables, low-fat milk, lean meats, as well as the presence of cues for healthy food choices and super-sizing. Determining the presence of these items was more difficult due to the variability in how this information is presented at each restaurant.

After reviewing the completed assessments, the following was determined:

- The majority of restaurants offered green salads (80%), non-breaded non-deep-fried poultry/fish (92%), and non-deep-fried vegetables (68%).
- Few restaurants offered fruit (4%) or low-fat milk (16%).
- Nutrition cues and/or labels for foods other than desserts were present in 16% of restaurants.
- No restaurant provided nutrition cues and/or labels for desserts.
- Super-sizing options were observed in 44% of restaurants.
- Healthy eating messages were not observed in any restaurant.

WALKABILITY AUDITS: PRELIMINARY RESULTS

In Clarksburg, the walkability of all road segments within a ¼ mile radius of 10 of the 15 schools and of 5 of the 7 top ten county employer main worksites located in Clarksburg-Bridgeport was assessed. In Clarksburg-Bridgeport, a total of 692 road segments were assessed for walkability. Community walkability audits were conducted of all town road segments in the main town of Glenville in Gilmer County. Walkability audits were conducted for all road segments within a ¼ mile radius of all schools (n=5) and of nine of the top ten employers in Gilmer County. In Glenville, a total of 134 road segments were assessed for walkability. Sixteen road segments were assessed in the rest of Gilmer County outside of Glenville.

Results of the Clarksburg-Bridgeport assessments are as follows:

- The majority of road segments around schools (61.4%) and worksites (74.3%) had sidewalks.

- The majority of segments lacking in sidewalks were quiet streets, meaning that they had an Annual Average Daily Traffic (AADT) count of <8,000, <3 lanes of traffic and a posted speed limit <30 mph.
- Most sidewalks that were present were found to be in fair to good condition.

Results of the Gilmer County assessments are as follows:

- In Glenville overall, road segments most frequently had no sidewalk but were quiet streets (60.9%).
- The majority of road segments around schools (64.9%) and 45.1% of road segments around top ten employer worksites in Glenville had no sidewalks but were quiet streets.
- In Gilmer County outside Glenville, all schools were elementary schools. The majority of road segments (62.5%) around these schools had no sidewalks but were deemed “busy” streets, meaning that they had an AADT count $\geq 8,000$, ≥ 3 lanes of traffic and/or a posted speed limit of ≥ 30 mph. Posted speeds around the majority of these schools (75%) were 30 mph or higher, with half of these segments being 45 mph or more. Traffic counts, however, were low for all segments around these schools.
- Roads without sidewalks but with shoulders tended to be higher traffic roads and roads with higher posted speed limits. Thus, the presence of shoulders did not necessarily tend to increase the walkability of roads without sidewalks.

General assessment results include:

- All schools and worksites had housing within a $\frac{1}{4}$ mile radius.
- A low percentage (17%) of segments containing housing had multi-family housing (housing such as apartment complexes that would house more than one family’s housing unit).
- Places for physical activity, including recreational facilities, parks and walking or biking trails, were found within a $\frac{1}{4}$ mile radius of four of five schools (80%) in Gilmer County and nine of 10 schools (90%) in Clarksburg Bridgeport.
- Places for physical activity were found within a $\frac{1}{4}$ mile radius of seven of nine worksites (78%) in Gilmer County and four of five worksites (80%) in Clarksburg-Bridgeport.
- All worksites assessed for walkability had at least one other category of premise (office/institution, restaurant, retail store, grocery store, or convenience store) to which employees might walk within their $\frac{1}{4}$ mile radius.
- All except for one worksite in Gilmer County had more than one other category of premise within their $\frac{1}{4}$ mile radius.
- Sixty percent of worksites assessed in Clarksburg-Bridgeport and 56% of worksites assessed in Gilmer County had restaurants within a $\frac{1}{4}$ mile radius.
- Forty percent of Clarksburg-Bridgeport worksites had fast food chain restaurants and 60% had other restaurants within a $\frac{1}{4}$ mile radius.
- Thirty-three percent of Gilmer worksites had fast food chain restaurants and 45% had other restaurants within a $\frac{1}{4}$ mile radius.
- Thirty percent of Clarksburg-Bridgeport worksites had grocery stores while 60% had convenience stores within a $\frac{1}{4}$ mile radius.
- Eleven percent (11%) of Gilmer worksites had grocery stores while 33% had convenience stores within a $\frac{1}{4}$ mile radius.

- Forty percent (40%) of schools in Clarksburg-Bridgeport where walkability was assessed had fast food chain restaurants within a ¼ mile radius and 40% had other types of restaurants.
- Sixty percent (60%) of schools in Clarksburg-Bridgeport around which walkability was assessed had convenience stores within a ¼ mile radius while 30% had grocery stores within a ¼ mile radius.

Conclusion

The purpose of this project was not to identify what we already know, that physical inactivity and poor dietary habits result in an individual being either overweight or obese, but to examine the issue of overweight and obesity in depth in order to determine if the citizens of West Virginia had access to opportunities that promote physical activity and proper dietary habits. Preliminarily, results show that current environments (i.e. worksite, schools, and communities) in West Virginia are not successfully supporting individuals with regards to physical activity opportunities and proper dietary habits. Therefore, the environments in West Virginia need to be modified to promote a healthy lifestyle. It should also be concluded that modifying the environment within our communities will require the careful attention of many individuals and organizations working together through multiple spheres of influence.

It is anticipated that the final report from the Centers for Disease Control and Prevention (CDC) will be made public in the near future. The report will contain a final analysis of the data obtained during this project as well as recommendations from the CDC to West Virginia on how best to approach our public health problem of overweight and obesity. Upon receipt of the final report, West Virginia is primed to take action using strategies identified in *The Surgeon General's Call To Action To Prevent and Decrease Overweight and Obesity*.

C.D.C. Team Investigates an Outbreak of Obesity

By **GINA KOLATA**

Published: June 3, 2005

For the first time, the Centers for Disease Control and Prevention has sent a team of specialists into a state, West Virginia, to study an outbreak of obesity in the same way it studies an outbreak of an infectious disease.

Kerri Kennedy, the program manager at the West Virginia Physical Activity and Nutrition Program, said the state had requested the agency's investigation.

"We were looking at our data," Ms. Kennedy said, and saw that "we are facing a severe health crisis."

The state ranked third in the nation for obesity - 27.6 percent of its adults were obese, compared with 20.4 percent in the country as a whole. And, Ms. Kennedy said, "our rate of obesity appears to be increasing faster than the rest of the nation."

Going along with the obesity was a high prevalence of diabetes and high blood pressure, which are associated with extra pounds. West Virginia ranks fourth in the nation for diabetes, with 10.2 percent of the population affected, compared with 6.4 percent nationwide. And it is No. 1 in its prevalence of high blood pressure, with 33.1 percent having the condition, compared with 25.8 percent of people nationwide.

So the state asked the agency's disease detectives to tackle its obesity problem, and a three-week investigation began on April 25. It focused, Ms. Kennedy said, on two places that represented towns and cities in the state - Gilmer County, with 7,160 residents, and Clarksburg, a city with 16,743 residents.

The investigative teams spent a week and a half in each place, going to schools and asking about physical education programs and about what sort of food was provided. They asked, for example, whether students "were offered at least one or two appealing fruits and vegetables every day," Ms. Kennedy said. And "would you replace regular sour cream with low-fat sour cream?"

They went to workplaces, asking whether there were policies to encourage physical activity. For example, Ms. Kennedy said, "if you choose to walk, could you have an extra 15 or 20 minutes

added to your lunch break?" And, were there items like 100-percent fruit juices and bottled water in vending machines?

They went to random grocery stores and restaurants, asking whether they offered fruits and vegetables and skim or 1 percent milk. And they asked whether it was safe to walk along the roads, whether there were sidewalks and whether they were in good repair, whether there was good lighting for walking at night.

"The C.D.C. came up with the questions for us," Ms. Kennedy said. But, she noted, many of the questions, like the ones about sidewalks, were designed for urban areas. She said she was not sure how well they would work in rural West Virginia, and some statisticians said they did not think the study would work at all.

Dr. Julie Gerberding, the director of the disease centers, said in a press conference yesterday that this type of investigation was a first for the agency.

"This has never happened in the history of the C.D.C.," she said.

The centers held the news conference to clarify its position on weight and obesity. Agency scientists recently published a study concluding that overweight people had a lower risk of death than normal-weight people and that even obese people did not have much of a risk of early death unless they were extremely obese. A year earlier, different researchers at the agency published a study saying that obesity and extra weight were markedly raising death rates in this country.

Obese people were defined as having a body mass index, a measurement of weight in relation to height, of 30 to 34.9; the extremely obese had an index of 35 or higher.

Dr. Gerberding said that there were still questions about the best ways to estimate death risks from extra weight but that there was no question about the health impacts of being obese or overweight, which can increase the risk of diseases like diabetes, high blood pressure, arthritis and some cancers. Being obese or overweight, Dr. Gerberding emphasized, are "critically important health threats" and the agency is increasing efforts to understand the causes of the obesity epidemic and how to help people lose weight and keep it off.

The West Virginia data are now at the agency, being analyzed. Some preliminary information may be available in August, Ms. Kennedy said.

Rudy Philips, a 27-year-old clinical nursing assistant who lives in Clarksburg, said that he was unaware of the study, but that he knew something of the dietary problems in the state. He himself had a good diet, he said, and while "I could stand to lose 5 or 10 pounds, I am not obese." But obesity is a problem in the state, he observed.

"We tend to eat a lot of fried foods, we're meat-and potatoes type people," Mr. Philips said. "Most restaurants don't have healthy choices."

But some statisticians said it was hard to see what could be learned from the agency's investigations.

Daniel McGee, a professor of statistics at Florida State University who has analyzed obesity data, burst out laughing when he heard about it. "My God, what a strange thing to do," he said.

"They'll find out what we all know - that the country is no longer set up for physical exercise," Dr. McGee said. And that schoolchildren "don't get a nutritious diet." And that "there is a lot of high-fat food on the shelves of every supermarket."

But, he said, "that doesn't tell you much."

"I'm sure skinny people go to those same restaurants," Dr. McGee said. "Skinny kids go to those same schools."

David DeMets, a professor of biostatistics at the University of Wisconsin, was also extremely skeptical.

"We get a lot of false positives from that kind of investigation," Dr. DeMets said. "We get people worried," but there is no way to know whether what is found - a lack of fruits and vegetables in the schools, for example - has anything to do with the obesity epidemic.

"Perhaps it is true, perhaps it is not," Dr. De Mets said.

Attachment 7

West Virginia calls on disease investigators for obesity problem

CHARLESTON, W.Va. (AP) - West Virginia, a state with one of the worst obesity problems in the country, has called in the big guns for help. For the first time, federal disease investigators in Atlanta are studying obesity, just as they would investigate the rapid spread of an infectious disease.

"We didn't suddenly realize we have this problem," state health official Keri Kennedy said Friday. "But we are facing a severe health crisis and this is a new way of looking at it."

West Virginia is consistently among the top three states in the nation for obesity, according to the Centers for Disease Control and Prevention and the state Bureau of Public Health. In 2002, the latest data available, 28 percent of West Virginians were considered obese.

The extra weight can lead to high blood pressure, diabetes, arthritis, some cancers and other problems. West Virginia leads the nation in high blood pressure and is fourth in diabetes.

"Health officials in West Virginia appropriately recognized that they had a serious problem with obesity in their state, and they really wanted to do more than just describe it," CDC director Dr. Julie Gerberding said Thursday.

She said the state "wanted to get a team of people in there to ... use our best epidemiologic disease detective science to profile where the problem was, how is it growing, who had it, how bad was it, and really get a much deeper understanding of it."

Three CDC investigators teamed with Kennedy and two other state health officials for three weeks in April and May. The teams visited schools, businesses, restaurants, grocery stores, parks and communities. Gilmer County with its 7,160 residents was chosen as the rural site and Clarksburg with 16,743 residents was the urban site.

"People grew up on gravy and biscuits and they think they still need it, but they don't do the exercise they once did to work it off anymore," said Rose Clark, a health coordinator at United Hospital Center in Clarksburg. The hospital has been offering gastric bypass surgery since last year, Clark said.

Obesity, defined as having a body-mass index above 30, also is spreading among West Virginia's children. Nearly 43 percent of 5,887 children screened in a coronary artery risk project from 1999-2002 were considered overweight and more than 25 percent were obese.

"The purpose was not so much to determine what we already know and that is that poor nutrition and physical inactivity can lead to obesity," CDC spokesman Llewelyn Grant said Friday.

The purpose was to find out whether people have access to healthy food and exercise options, he said.