Shaping a Healthier Generation:

Healthy Kids, Healthy America
State Profiles in Progress

NGA Center for BEST PRACTICES

Founded in 1908, the **NATIONAL GOVERNORS ASSOCIATION** is the collective voice of the nation's governors and one of Washington, D.C.'s, most respected public policy organizations. Its members are the governors of the 50 states, three territories, and two commonwealths.

The **NATIONAL GOVERNORS ASSOCIATION CENTER FOR BEST PRACTICES** is the nation's only dedicated consulting firm for governors and their key policy staff. The NGA Center's mission is to develop and implement innovative solutions to public policy challenges. Through the staff of the Center, governors and their policy advisors can:

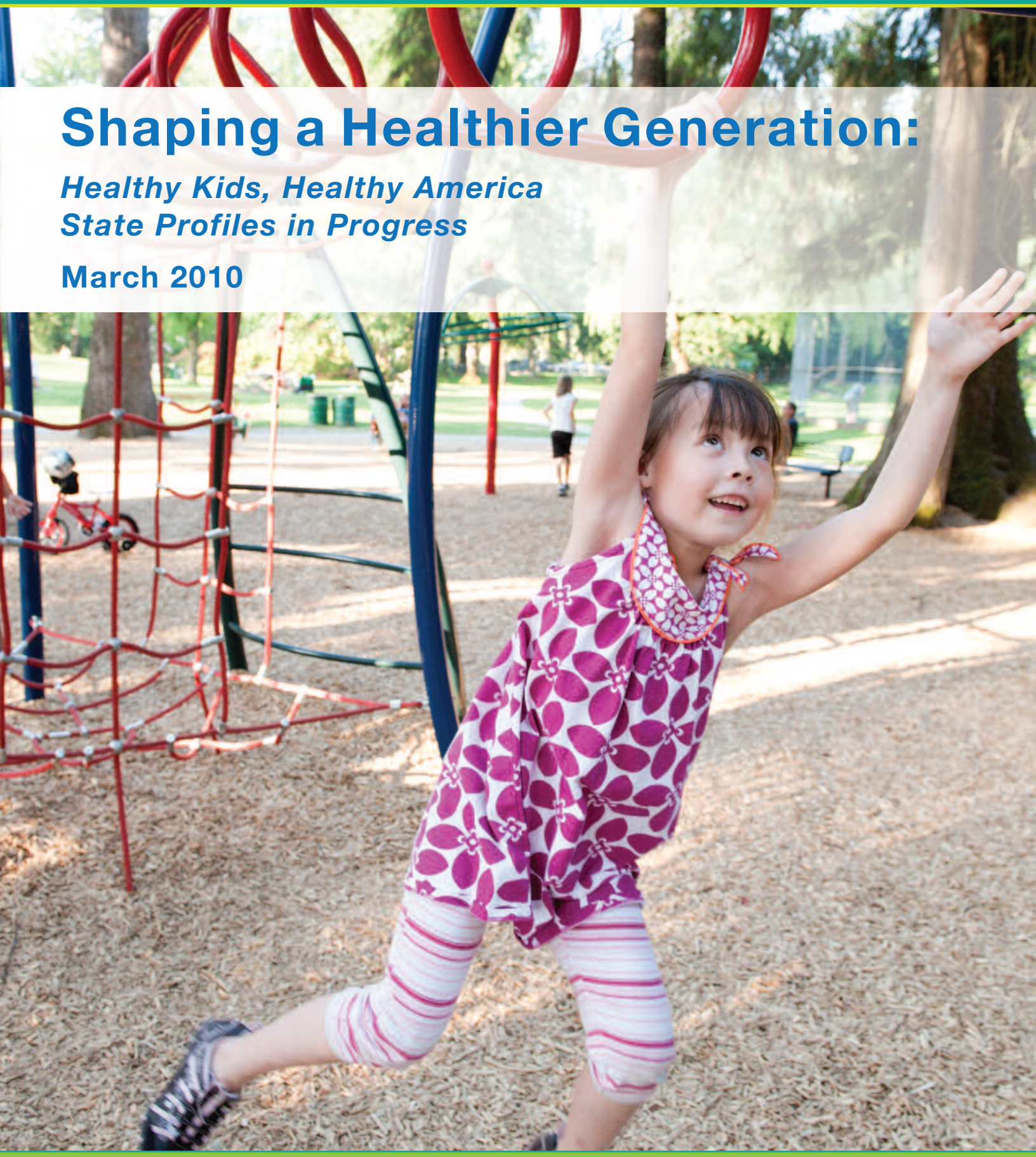
- **Quickly learn about what works,** what doesn't, and what lessons can be learned from other governors grappling with the same problems;
- **Obtain specialized assistance** in designing and implementing new programs or improving the effectiveness of current programs;
- **Receive up-to-date, comprehensive information** about what is happening in other state capitals and in Washington, D.C., so governors are aware of cutting-edge policies; and
- **Learn about emerging national trends** and their implications for states, so governors can prepare to meet future demands.

For more information about NGA and the NGA Center for Best Practices, please visit www.nga.org.

Shaping a Healthier Generation:

Healthy Kids, Healthy America
State Profiles in Progress

March 2010



Acknowledgments

This report was developed, written, and produced by staff from the Robert Wood Johnson Foundation and the National Governors Association Center for Best Practices (NGA Center).

The NGA Center would like to thank the numerous state staff and others who gave their time and participated in interviews to contribute to this effort.

Support for *Shaping a Healthier Generation: Healthy Kids, Healthy America State Profiles of Progress* was provided by a grant from the Robert Wood Johnson Foundation.

Table of Contents

Executive Summary

Childhood obesity has reached epidemic proportions in the United States. Today, nearly 23 million—or one in every three—American children are overweight or obese.[1] These numbers have increased over the past four decades and for children of all ages:

- Among children ages 2 to 5, rates have nearly tripled;
- Among youth ages 6 to 11, rates have more than quadrupled; and
- Among adolescents ages 12 to 19, rates have more than tripled.[2,3]

If the epidemic continues unabated, experts project that 23 percent of American children will be obese by 2015—meaning that they will be in the 95th percentile for weight among their peers.[4] Today's trends indicate that current approaches have not gone far enough to address the epidemic. But governors around the country are committed to improving the health of the nation's children and identifying policies for preventing childhood obesity at the state level.

NGA Center's *Healthy Kids, Healthy America* Program

To support gubernatorial action, the National Governors Association Center for Best Practices (NGA Center), with funding from the Robert Wood Johnson Foundation and the Centers for Disease Control and Prevention (CDC), awarded grants up to $110,000 to 15 states to help them develop policies to prevent childhood obesity. Funding received by states supported a number of activities; however, state strategies generally fell into three categories:

1) *Child care settings.* Two states—Kentucky and Tennessee—focused on child care efforts.

2) *Policy planning and priorization.* Four states—Michigan, Minnesota, Mississippi, and New Mexico—focused on prioritizing policy across the public and private sectors.

3) *School-based efforts.* Nine states—Indiana, Louisiana, New York, Rhode Island, South Dakota, Utah, Virginia, West Virginia, and Wisconsin—focused on school-based efforts.

Within each of those categories, common themes developed across states. For instance, the four states focusing on policy planning found it useful to conduct a comprehensive scan to better align existing obesity prevention efforts. In addition, these states tended to rely on leadership from the governor or state health commissioner to facilitate interagency collaborations and multi-sector involvement in the policy development process.

School-based efforts, explored by the most states, tended to center around three approaches: strategies for improving school wellness policy implementation; using fitness testing or other means for assessing children's health—and by extension a school's—progress; and creating a governor's award or recognition program to drive progress and recognize innovative efforts in schools. In addition, the child care setting proved a valuable state-level policy lever for the two states focused on improving the preschool nutrition and physical activity environment.

Child Care Settings

With more than 11 million children under age 5 currently spending a portion of their day in the care of someone other than a parent and more than 12 percent of American children ages 2 to 5 years obese, the importance of obesity prevention strategies early in a child's life cannot be overstated.[5,6] Obese adolescents are up to 80 percent more likely to become obese adults and suffer from associated chronic diseases, including diabetes, heart disease, stroke, hypertension, and some forms of cancer.[7,8,9] Recent research suggests that the origins of adult disease are predicated on developmental or biological disruptions experienced in the early years of life.[10] Promoting health in children from birth to age 5 can significantly enhance school readiness and establish healthy lifestyle habits early in development.[11]

The challenge for states lies in the historically patchwork approach taken to fund and deliver comprehensive services to young children and their families. These programs and services are spread across multiple state agencies and departments and are rarely coordinated, despite the fact that they may serve the same children and families.[12]

States currently coordinate as many as 80 separate federal, state, local, and private funding methods to pay for comprehensive programs and services.[13] These fragmented funding streams—and the differing requirements and standards of each—often result in inefficiencies and gaps in services for children and families.

In the Healthy Kids, Healthy America program, two states pursued voluntary measures to pilot new policies and programs, including:

- ***Kentucky.*** Kentucky established an early childhood committee to pursue nutrition and physical activity standards and staff training for licensed early child care centers.
- ***Tennessee.*** Tennessee established the Gold Sneaker Initiative program, which provides nutrition and physical activity standard training for child care staff, as well as designation for participating facilities.

Policy Planning and Prioritization

Although few easy answers exist to prevent childhood obesity, it is clear that a coordinated, multi-sector approach that engages all levels of government as well as the private sector, community-based organizations, and parents, is an essential first step. The many childhood obesity programs that exist in states today often lack common objectives and goals due to little or no coordination across community and state providers. Poor coordination and diffuse leadership can lead to fragmented services for children and families.

To overcome the state policy complexities and challenges posed by childhood obesity, four states pursued policy planning and prioritization efforts by:

- Consolidating efforts in one coherent strategy;
- Aligning state- and local-level programs and policies by coordinating across sectors, reducing duplication, and making the most of limited budgets; and
- Providing leadership, mitigating and analyzing problems as they arise, and coordinating public, private, and local efforts directed toward children's health.

By enhancing coordination across public and private programs, the governor can focus state resources on specific tools and processes to inform policy decisions and improve the health and welfare of children. This coordination enables the governor to collect relevant data, conduct analyses, track trends, and make strategic investments to improve children's health.

In the Healthy Kids, Healthy America program, four states pursued policy planning and prioritization, including:

- ***Michigan.*** Michigan created an executive-level workgroup to develop a five-year policy agenda and transition the workgroup's efforts to an independent coalition.

- ***Minnesota.*** Minnesota conducted a statewide survey of current policies and programs, then developed a five-year policy action plan to prevent childhood obesity.
- ***Mississippi.*** Mississippi established the Governor's Task Force on Childhood Obesity to develop policy recommendations for coordinated child wellness across all agencies, held a statewide policy summit, and developed a blueprint for childhood obesity policy moving forward.
- ***New Mexico.*** New Mexico created a special advisor position to the Secretary of Health to centralize state health efforts to improve children's health, coordinate the Governor's Interagency Task Force on Obesity, and launch a pilot childhood wellness program in a local community.

School-Based Efforts

With nearly one-fifth of the nation in a school setting on any given school day, policymakers have an opportunity to set quality nutrition and physical activity standards to affect the lives and welfare of 55 million children.[14] Therefore, it is important for policymakers to consider both the feasibility and the content of programs and policies—and where and when those policies should be employed—to yield the best outcomes for children.

Although obesity prevention efforts in the school setting can positively affect the health and welfare of millions of children and adolescents, school funding is predicated on academic testing performance and other conditions set forth by No Child Left Behind.[15] There are few financial incentives for schools to go beyond traditional instruction and enhance the nutritional content of school foods or improve the quality of physical education.

Encouraging schools to improve child health outcomes poses numerous cultural, institutional, and social challenges for both state and local policymakers. Although myriad state rules and regulations govern public health, education—both jurisdictionally and philosophically—is deemed a local matter. The two sectors recognize the importance of collaborating on specific issues—and have done so successfully on health-related topics such as childhood immunizations—but partnerships to prevent obesity or chronic disease are still evolving.

However, a child's health status influences many things, including academic attainment.[16] Research demonstrates that obese children miss an average of nine more days of school each year than their healthy-weight counterparts.[17] As attendance is a factor in the school funding equation for many states, a single absence can cost a school district $9 to $20 per student, which translates into millions of dollars in lost revenue for larger school districts such as New York City or Los Angeles.[18]

In the Healthy Kids, Healthy America program, nine states addressed the school environment, including:

- ***Indiana.*** Indiana implemented a wellness pilot combining classroom instruction with an online nutrition and physical activity program.
- ***Louisiana.*** Louisiana focused on improving school wellness policy implementation across the state.
- ***New York.*** New York developed guidelines for nutrition and physical activity programs in afterschool programs.
- ***Rhode Island.*** Rhode Island focused on school wellness policies and providing 100 percent of schools with technical assistance.
- ***South Dakota.*** South Dakota awarded mini-grants to a dozen schools, districts, and out-of-school-time programs to improve nutrition and physical activity policy.
- ***Utah.*** Utah created teacher training programs for using non-food incentives in the classroom and increasing physical activity time.
- ***Virginia.*** Virginia focused on improving the health habits of at-risk students via state assessments of nutrition, physical activity, and fitness.
- ***West Virginia.*** West Virginia instituted comprehensive wellness checks for all incoming kindergarteners in public schools.
- ***Wisconsin.*** Wisconsin established an award program to drive policy changes in schools statewide.

Introduction

In 2007, the National Governors Association Center for Best Practices (NGA Center) launched the *Healthy Kids, Healthy America* program, enabling governors to develop and initiate policy and programmatic activities to improve children's health and prevent childhood obesity. The Healthy Kids, Healthy America grant program sparked gubernatorial action by:

1) Motivating and guiding policy action by governors and senior state leaders to prevent childhood obesity;

2) Creating a state vision or policy action plan for advancing childhood obesity prevention initiatives in each grantee state; and

3) Identifying state-level policy levers for childhood obesity prevention that could be replicable for other states around the country.

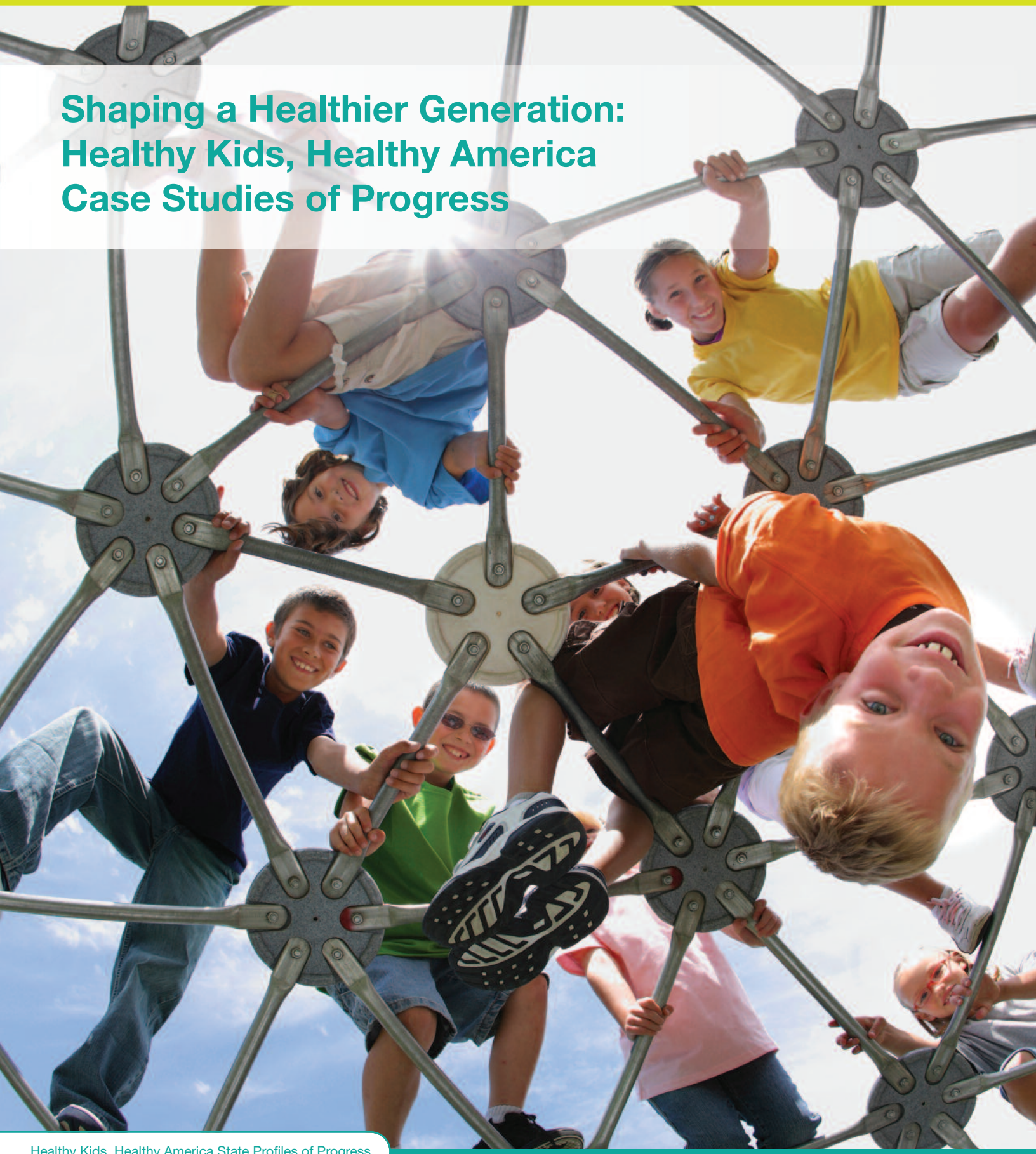
In July 2007, 10 states were awarded funding through the grant program; due to the volume of qualified applications and the receipt of supplemental funding, five additional states were awarded grants in September 2007. In total, 15 states were awarded $100,000 funding for up to one year to develop and implement sustainable childhood obesity policies and programs. The states supported under this grant included the following:

- Indiana
- Kentucky
- Louisiana
- Michigan
- Minnesota
- Mississippi
- New Mexico
- New York
- Rhode Island
- South Dakota
- Tennessee
- Utah
- Virginia
- West Virginia
- Wisconsin

In addition, the NGA Center collaborated with the CDC to provide grantee states with the option of applying for an additional $10,000 to conduct a statewide scan of efforts to address childhood obesity. Louisiana, Michigan, Minnesota, Mississippi, New York, and Rhode Island took advantage of this option.

This report examines state efforts by highlighting lessons learned and progress gained in each of the 15 Healthy Kids, Healthy America states. First, the report provides an in-depth look at policy activities in four states—Michigan, Mississippi, New Mexico, and Tennessee. Second, the report provides a compendium of state snapshots by offering a brief overview of each of the 15 state initiatives. The *Profiles of Progress* report examines the nuances of state-based policy initiated by the governor's office, and discusses the innovative partnerships and tools that can be used at the state level to prevent childhood obesity.

Shaping a Healthier Generation: Healthy Kids, Healthy America Case Studies of Progress



After identifying policy change as the missing element in much of its state and local obesity prevention work, the *Healthy Kids, Healthy Michigan* initiative focused top leadership and expertise on this goal. It not only produced a five-year strategic policy agenda but an independent coalition to advance it. Both achievements were the culmination of a comprehensive, highly articulated process involving an executive-level workgroup led by the state's surgeon general. Subject-specific policy teams backed the workgroup with critical research and recommendations; 18 strategies were approved for school and child care settings, the built environment, healthy food access, and health care. Six of those were judged immediate priorities, and those policies moved forward through regulatory and legislative channels. In addition, three school districts piloted nutrition and physical activity policy approaches with the support of $25,000 grants. Even as first-year gains were being celebrated, the coalition was starting on its second-year targets.

The Big Picture

A confluence of events and relationships, past as well as present, set the stage for the initiative: a history of strong collaboration between the state's Department of Community Health and Department of Education; increased public concern over Michigan's worsening obesity rates; previous legislative interest in the issue; and a well-established public health surveillance system.

Still, few people probably anticipated just how broadly and effectively Healthy Kids, Healthy Michigan would play across that stage—ultimately giving the state policy direction into 2013.

The initiative launched with instant visibility and legitimacy for two reasons. Governor Jennifer Granholm asked Surgeon General Kimberly Dawn Wisdom to head the Michigan Childhood Obesity Prevention Workgroup at the center of the effort. And Wisdom in turn solicited public, private, and nonprofit sector decision makers, making clear in a letter that their participation would be real, not symbolic, and that it would truly help guide the future of state policies. More than 230 leaders from more than 100 public, private, and nonprofit sector agencies and organizations responded affirmatively.

An environmental scan of obesity prevention statewide presaged the group's direction. It found many programs, primarily in elementary and middle schools, but few of the overarching policies that could make significant, long-lasting impact. It also revealed who else might be advocates in the initiative as the three policy teams commenced their work researching potential policies, considering avenues of implementation and weighing political feasibility. The teams' areas of concentration, shaped by the scan's findings, were education, community and health, family, and child care services.

Nine intense months later, the workgroup had before it a multiplicity of options and crucial decisions to make. In year one, members voted for half a dozen policy priorities. Changes in state regulatory and administrative language would make the first two proposals a reality. Legislative change would be required for the next three, and the final recommendation was proposed via a resolution, which would require a combination of recommendations by several levels of government to carry out. The recommendations included:

- Body mass index (BMI) surveillance—to add obesity measures to the Michigan Care Improvement Registry, an electronic, clinically based system that tracks childhood health information;
- Medicaid coverage—to ensure payment for medical screening and treatment of childhood obesity;
- Coordinated school health programs—to require such councils and hold them to certain standards of accountability;
- Improved fresh food access in underserved areas—to attract new food retailers or store expansions through property tax and other financial incentives;
- Physical and health education in schools—to separate the two areas of instruction and strengthen standards for both; and
- Complete streets and safe routes to school in communities—to detail infrastructure and safety needs and incorporate solutions into state, county, and local processes and funding.

As for 2009–2013, the workgroup approved 12 priorities integral to healthy eating in schools and communities, students' physical activity, and child care standards for nutrition and physical activity. Future deliberations will be informed by the experiences of the three school systems awarded $25,000 grants to develop and test new wellness-related policies on their campuses.

The workgroup took one more step, too. It began to transform the initiative into an independent coalition, one with sustainable funding and the credibility to continue making progress on childhood obesity prevention policies. Eighty organizations signed on, including several state agencies. A dozen contributed the $5,000 required to be a member of the coalition's steering committee.

Every signatory endorsed a one-page resolution that read like a call to arms. "The health of Michigan's children is in serious jeopardy due to poor nutrition and lack of physical activity, contributing to the growing rates of obesity in our state," it declared. "We need urgent action to turn back this rising tide."

Step by Step

Though the state community health department was designated lead agency on the initiative, it proceeded from day one in close partnership with the education department. Both agencies provided technical assistance and staff support to the workgroup, policy teams, and grantee school districts.

Their initial step was the environmental scan of obesity prevention efforts among public, private, and community groups across Michigan. The goal: to get a focus on the issues, to determine

the state's ready assets and biggest weaknesses. Survey responses were solicited by e-mail and phone during a two-month period. In all, 84 responses were received.

Scan results jumpstarted the delineation of the policy action teams, just as the surgeon general's letter—by triggering intense interest—jumpstarted formation of the workgroup. The latter welcomed a diversity of perspectives and interests, from the League of Michigan Bicyclists and state Housing Development Authority to the Detroit Science Center, Henry Ford Health System, and Arab Community Center for Economic and Social Services. Also represented were nontraditional partners such as the Michigan soft drink association. Everyone was expected to play an active role at the main table as well as on a policy team.

The workgroup held its first meeting in October 2007. The teams dug in, each aided by a facilitator and calling upon specific expertise as needed. Sometimes they subdivided into task forces that drilled down further—to assess clinicians' needs if BMI measures were added to the state health registry, for example. By March, they were presenting policy options to the larger body for actual balloting on a first-year agenda. Between March and July 2008, the complicated legal research and language drafts took place. And by July, the five-year plan was published.

The Lansing, Jackson, and Taylor school districts were by then well into their pilot projects. The three were selected in part because of a greater proportion of low-income students. The strategy behind this selection approach was that policy triumphs in these systems could show the way for others. Based on a lengthy assessment of their existing standards and school environments, each district picked at least two policy possibilities from a menu of offerings. À la carte cafeteria sales were the universal choice. The Jackson and Taylor districts loaded on other issues: class snacks, vending machines, and recess before lunch for Jackson; PE curriculum, fundraising, and school store offerings for Taylor. Monthly, the community health and education departments provided technical assistance and evaluation guidance.

Scheduling conflicts delayed an official announcement of the new coalition until early 2009, though the later date advantageously followed the governor's State of the State address and her direct charge to six departments to take certain leadership in concert with the new group. A major launch event at the capital raised the coalition's profile while highlighting the sweep of accomplishments from the Healthy Kids, Healthy Michigan initiative. Lawmakers reacted. Many asked how they might become involved.

Making a Difference

With impressive speed, Healthy Kids, Healthy Michigan did this and more. It broke down bureaucratic barriers, brought disparate groups together, attracted new advocates to childhood obesity prevention, and raised public and policymaker awareness of the issue. It leveraged its work at every step, learning how to secure legislative champions and how to supply the best facts and information needed to inform their colleagues.

In less than 18 months, participants could claim true victory in a new law for property tax incentives to increase healthy food access in needy communities. They also could take credit for revived momentum around a previously stalled PE bill through key House and Senate committees.

The coalition that grew out of the initiative maintained that pace. Adopting the name of the Healthy Kids, Healthy Michigan Coalition, it continued gathering research and supporters for a future bill requiring coordinated school health councils. In addition, it helped to keep the BMI addition to the Michigan Care Improvement Registry (MICR) on course. More than 30 states have similar systems to track health data through clinical settings, so Michigan's experience could prove instructive elsewhere.

The same could be said for the changes effected by the school system projects. In Jackson, southeast of Lansing, the coordinated school health council instituted recess before lunch in the elementary grades and replaced every school cafeteria's à la carte lines with fruit and vegetable stands. Candy was prohibited as a classroom reward and chocolate as a school fundraiser. Some parents expressed concerns about the changes, but the new policies stood and opposition eventually cleared.

Southwest of Detroit, Taylor students and staff witnessed equally striking modifications. No longer were their school stores filled with sodas and junk food or open from the first to last bell. A memorandum of understanding forced a restocking with "sensible snacking" items that met Institute of Medicine standards. Store hours were limited.

Despite opposition, the leaders here also held firm. Wellness began winning out. Dairy carts with milk, yogurt, and cheese sticks proved wildly popular as they were rolled through elementary schools. Healthier cafeteria offerings boosted lunch sales by more than 75 percent district wide.

In each setting, this was progress and impact, and as important to the initiative's overall success as every other accomplishment.

Its playbook is clear: Start with involvement from the highest levels of state government; emphasize collaboration across a spectrum of interests; build off a clear vision and understanding of policy implementation; and lastly, craft an agenda in which every priority is seen as integral—and interdependent—to reversing childhood obesity for the long-term. Then ensure that there is an entity invested in making that agenda happen.

Mississippi POWER (Preventing Obesity with Every Resource)

An in-depth examination of Mississippi's childhood obesity policy development

The *Healthy Kids, Healthy Mississippi* initiative called on state agencies, local school districts, community organizations, and private groups to maximize its POWER, as the state's Preventing Obesity with Every Resource initiative was named. Building on several years of legislative and regulatory momentum with schools, POWER established a Governor's Task Force on Childhood Obesity to develop policy recommendations for coordinated child wellness across all agencies, held a statewide policy-prioritization summit to rank those recommendations, and developed the blueprint for childhood obesity policy actions moving forward. Mini-grants to 20 schools resulted in wellness-centered success stories illustrating the need and potential for further change. Crucial support, plus funding, came from a prominent Mississippi health foundation. As the Governor's Task Force continues to elevate the childhood obesity issue, Mississippi could be seeing the first nascent signs that it is turning a corner.

The Big Picture

The initiative aimed ambitiously to be both a catalyst for policy change as well as a cross-sector collaborator, and its prime objective through the POWER project was a comprehensive plan that could direct state and local efforts to reverse childhood obesity. POWER announced six overarching goals:

- Provide consistent messages about the obesity epidemic and ways to combat obesity in children;
- Match program areas in state agencies to maximize resources;
- Promote legislative and state-level policies for physical education, health education, and nutrition standards;
- Identify promising obesity prevention efforts for schools and ways to encourage parental and community support;
- Seek funding opportunities at the federal, state, and private levels; and
- Decrease Mississippi's childhood obesity rates.

Implicit in these goals was an understanding that state leadership was essential, especially for broad policy implementation, and that successful interventions would need to be sustained, especially through financial investments.

With Governor Haley Barbour declaring very publicly that the health of Mississippians was a top concern, the project enjoyed a high profile from the start. Still, it faced equally visible challenges. Survey after survey labeled the state as the heaviest in the nation, with nearly a third of adults either obese or overweight and more than 44 percent of youth ages 10 to 17 in those categories.

Yet the timing ultimately proved fortuitous. Repeated identification as the "heaviest state" greatly heightened people's awareness of the problem. Recent legislative and regulatory actions laid important groundwork. In the assessment of a key state official, there was a tremendous degree of readiness statewide.

Since 2004, for example, Mississippi had made marked progress on the dual fronts of nutrition and physical activity in its 1,000 public schools. In that same year, the state Department of Education created an Office of Healthy Schools, which plays a major role in child wellness and obesity across the state. In 2006, the state education superintendent and state board of education adopted language allowing only healthy beverages and snacks in school vending machines.

Moreover, the legislature in 2007 passed the Mississippi Healthy Students Act, part of a package of measures put forth by the governor. The new law required 150 minutes of physical activity-based instruction and 45 minutes of health education weekly in kindergarten through 8th grade as a requirement for graduation. It also instructed the state board of education to develop stronger nutrition standards and guidelines on healthy meal preparation—a directive targeting the fried foods still common in school cafeterias across the state.

In a 2009 Centers for Disease Control and Prevention (CDC) *Morbidity and Mortality Weekly Report*, Mississippi was one of two states that reported the largest increases from 2006 to 2008 in the percentage of schools that do not sell candy, salty snacks, and soda. Statewide nutrition standards for foods in schools outside the school meals program helped to contribute to this gain.

POWER launched against this backdrop. Two integral partners came from outside of government—the Bower Foundation, which had already provided millions of dollars to support a variety of child-wellness initiatives in the state, and the Center for Mississippi Health Policy, an independent, nonpartisan organization involved in the analysis and application of research. It was, in fact, a 2006 center study that helped propel debate at the state capital by tracking the public's changing attitudes. It found that a majority of Mississippians thought government should play a significant role in reducing childhood obesity. Two-thirds supported BMI screenings in the school, and nearly 60 percent favored soda taxes.

The Office of Healthy Schools oversaw the project. And in little more than a year, it could claim as POWER accomplishments: an environmental scan; the school mini-grants; engagement across state agencies to develop the Mississippi Action Plan; a Governor's Task Force convening; and one statewide planning summit. The latter event, which Governor Barbour and First Lady Marsha Barbour helped to host, resulted in a top-10 ranking of policy initiatives that immediately began to fortify obesity prevention work on state and local levels.

The final list addressed an array of approaches from tax incentives for farmers to restricted advertising of unhealthy foods. But the leading priorities were to:

- Improve the built environment to promote physical activity in communities;
- Replace fryers with combination oven/steamers in school kitchens; and
- Increase the number of nurses in the schools.

Step by Step

Given the breadth and depth of the latest wellness-related policies affecting Mississippi students, it was little surprise that the state education department had chief responsibility for the Healthy Kids, Healthy Mississippi initiative through its Office of Healthy Schools. The office's unique reporting channel—direct to the deputy state superintendent—ensured that its work would be supported at the highest level.

So, too, did Governor Barbour's leadership and attention to the issue. Well before the POWER project and its task force, Barbour had stepped out personally on the issue. With his wife, he taped the kick-off public service announcement for an extensive Let's Go Walkin' Mississippi campaign funded by BlueCross & BlueShield of Mississippi. He repeatedly stressed the connection between obesity and the state's long-term health and economic productivity.

POWER's initial task was the environmental scan. Conducted in partnership with the governor's office and the state health department's Office of Preventive Health, it revealed the scope of programs underway—many funded by the Bower Foundation—as well as the gaps and duplication. It made clear that more coordinated activity and capacity building was needed.

The $1,000 seed grants awarded to 20 schools served a parallel purpose. Each successful practice identified, such as fitness testing and vegetable gardens to name two of the most popular, established a "change agent" that helped drive policy change in those schools and potentially throughout the state. In addition, these grants and subsequent efforts facilitated numerous partnerships among schools, the private sector, and local community organizations.

The convening by the Governor's Task Force on Childhood Obesity took place in spring 2008 and drew about three dozen representatives from virtually all state agencies, ranging from pensions to parks. With the Center for Mississippi Health Policy supplying the background on policy initiatives elsewhere in the country, the group considered various obesity prevention approaches in light of the scan's conclusions and culled the best potential strategies for Mississippi. Eighteen made the cut.

By late 2008, more than 275 stakeholders came together for a statewide planning summit. Directors from state agencies and other state officials along with teachers, doctors, parents, and lawmakers winnowed the 18 strategies to 10, then prioritized them highest to lowest. The outcome showed a reordered ranking from half a year before, when the top preferences had included menu labeling, improved access to supermarkets in underserved communities, and day care standards encouraging healthy lifestyles. Now, improvements in the built environment to increase physical activity, school kitchen upgrades, and more school nurses placed one, two, and three, respectively.

POWER's policy development activity is continuing through the Governor's Task Force. Several departments are reviewing regulatory language that could advance the identified priorities. Additionally, public will is growing, and the groundwork is laid to support potential future legislation.

Making a Difference

Without question, the legislative and regulatory progress that predated POWER was substantial. It was achieved despite opposition from the food industry and some concerns voiced by teachers, administrators, and school food service directors. It demonstrated a firm commitment by state leaders to tackle obesity in order to safeguard children's well-being.

But as the Healthy Kids, Healthy Mississippi initiative got under way, many elements of the state's new law were still being implemented. Various grants, most from non-state sources, were underwriting a small flurry of activity within individual schools, such as buying better equipment for physical education or better training of PE teachers, establishing school health councils, and purchasing the kitchen slicers and other machines that might boost students' fruit and vegetable consumption.

Through the POWER project, the initiative demonstrated how much greater the sum of these parts had to be than the whole for Mississippi to reverse its obesity epidemic. Indeed, the initiative highlighted the connections that must be made among programs and agencies. It brought together many of the officials most necessary for doing so, and the governor's involvement bolstered efforts.

POWER's approach gave Mississippi's obesity prevention work an overall, organizing context. Particularly within state government, it stimulated new relationships and furthered existing ones.

Among the early results were the creation of a standing joint subcommittee for the state board of health and the state school boards association to discuss obesity prevention collaboration, and a unified marketing campaign developed by the Division of Medicaid, the departments of Education and Human Services, and Mississippi Public Broadcasting. The momentum also helped Mississippi garner a five-year, $3.4 million CDC grant to strengthen its coordinated school health program.

According to the director of the Office of Healthy Schools, a network is now at the ready, one that can both develop and assist future legislative proposals. It is armed with a powerful combination of well-vetted policy priorities, supporting health data, and compelling anecdotes. Unexpectedly, those priorities were immediately useful as education officials were deciding how to allocate $1.7 million from the federal American Recovery and Reinvestment Act of 2009. They opted to hasten the replacement of school fryers by buying dozens of combination oven/steamers and covering their installation in school cafeteria kitchens.

Though the network does not have ready sources of new state funding identified—the one critical issue that POWER was unable to address—it knows that obesity prevention in Mississippi likely will continue to benefit from the generous backing of the Bower Foundation. The latter is the singular element of the state's initiative that other states cannot easily replicate.

While Mississippi cannot rewrite its past several decades of obesity, it can move beyond them. The state's most recent survey of childhood obesity prevalence showed modest decreases in middle school and high school rates and only a slight uptick among younger students.

If the numbers reflect the early impact of tougher school nutrition and physical activity standards, as officials are hoping, then the accomplishments of the Healthy Kids, Healthy Mississippi initiative will be even more meaningful.

With a special advisor positioned in the highest level of state government, *Healthy Kids, Healthy New Mexico* focused top officials and nearly a dozen departments on the policy changes needed to help children eat better and be more active. The initiative encouraged collaborative efforts through an interagency council even as it concentrated on a single community to make a sustainable difference. That pilot in the southwestern city of Las Cruces built enthusiasm and participation by modeling a bottom-up process that resulted in a five-year plan. The approach attracted other communities interested in serving as similar laboratories—as well as lawmakers' notice—and a second project was launched in a neighboring county as the initiative was ending. And having now garnered a major federal grant, officials hope to further develop the Healthy Kids, Healthy New Mexico template to prevent childhood obesity statewide.

The Big Picture

Officials wanted to think globally and act locally. That is, they wanted to address overarching changes that could benefit all New Mexico children and also target one community with extra resources to put the best policies and programs into action. In part, this strategy was born out of frustration over past endeavors; state health leaders agreed that there had been too little coordination and too little impact.

Key to the initiative's reach was creation of the new position of senior health advisor in the Office of the Secretary of Health. This individual not only acted as a crucial bridge between state and local partners but also coordinated and directed the childhood obesity work of the existing Interagency Council for the Prevention of Obesity. The council was established by Governor Bill Richardson during a period of heightened attention to wellness issues that included release of New Mexico's first comprehensive plan to promote healthier weight. After initially representing a narrower slice of government, the group grew to include representatives from nine departments with authority over more than three dozen programs—and greater potential for aligning policy, messaging, and progress.

Healthy Kids, Healthy New Mexico certainly built on the recent state efforts. In 2006, Richardson had signed into law a measure setting standards for all competitive foods and beverages sold on public school campuses during the day. The following year, the governor and legislators allocated $12.8 million to boost physical education in elementary grades, expand the school breakfast program, and improve nutrition and physical activity in after-school programs.

But the initiative sought to maximize the likelihood that those and other efforts would be successful through its concentration on Las Cruces. The city of 75,000 became a laboratory of sorts, though the parameters of the experiment there were determined by a diverse cross-section of local leaders and residents.

The resulting plan—Las Cruces' vision "to create a fit future generation"—identified five areas of intervention: the built environment, education settings, food systems, health care systems and families/community settings. Under the plan, any efforts had to aim for increasing children's healthy eating and physical activity. Local public health resources were also dedicated.

Step by Step

Led by the Secretary of Health's senior advisor, the Interagency Council took a much more active and concerted role in childhood obesity prevention. An expansive inventory of its members' programs showed the myriad places the council could intersect the issue—in day care licensure, park programs, and other areas.

Members agreed to focus their departments' nutrition and physical activity messaging, as well as actual programming, on half a dozen behavior changes noted in New Mexico's weight plan. High on the list, for example, was reduced consumption of sugar-sweetened beverages, smaller portion sizes and less TV and screen time, especially among lower-income populations. (Following the council's decision, a statewide coalition representing public and private groups involved in food security issues began emphasizing the same behaviors in its promotions.)

The Interagency Council continues its work today. It is crafting a comprehensive Healthy Kids, Healthy New Mexico policy agenda by strengthening nutrition and physical activity standards in child care centers; tightening school compliance with the New Mexico School District Wellness Policy Rule and Nutrition Competitive Food Sales Rule; and developing a state BMI surveillance system for elementary school children.

The planning in Las Cruces started separately with a two-day meeting that the state health department convened in late 2007. Local leaders from government, academia, business, and nonprofit and foundation groups attended, developing a five-year vision for their community. Within each of their targeted areas of intervention, they issued a definitive statement. Then they began the harder job of setting year-by-year goals and formulating the actions to carry those out.

Healthy Kids, Healthy Las Cruces officially kicked off in spring 2008 with appearances by state lawmakers and four Cabinet secretaries. Although the 550-student Conlee Elementary was chosen as the flagship school where strategies would be implemented most comprehensively, work went forward in more than a dozen schools and on the multiple fronts identified in the city's plan.

The on-the-ground leader was the regional public health office, which reassigned staff on its health promotion team to help direct the pilot. The Interagency Council served as an advisory board. Half of the initiative funding supported the activity in Las Cruces.

Making a Difference

Putting a senior health advisor in charge of the overall initiative signaled its importance. Top officials in state agencies and lawmakers quickly took note, and the result was new collaborations among numerous departments and greater legislative awareness of the need for policy interventions to prevent childhood obesity. And through its role in the initiative, the Interagency Council established its credibility on the issue and began building support for a coordinated policy agenda. One early priority, already approved by the Secretary of Health, was development of a system to monitor obesity rates among children and adolescents.

In Las Cruces, thanks to in-kind contributions from local and regional groups, the project leveraged its $40,000 budget to a more than two-fold return on investment. The intensity of attention and resources served its purpose, with progress in every targeted setting toward the city's 2012 vision. Among the highlights:

- In the schools: More than 7,000 children in 16 elementary schools participated in monthly tastings of fresh fruit, vegetables, and grains, and two schools created edible gardens. The number of elementary schools holding recess before lunch—a scheduling change that seems to positively affect students' physical activity, nutrition, and classroom attention—increased to 50 percent. Conlee Elementary added nearly a dozen new nutrition and fitness programs, including BMI screening. Further, the Las Cruces Public Schools Superintendent and the City of Las Cruces are developing a joint-use agreement to permit the city to use school property.
- In the food system: Weekly cooking demonstrations were held in the local state offices that assist food stamp recipients as well as in local Women, Infants, and Children (WIC) clinics. A study of food costs and availability was conducted for the city and surrounding county.
- In the built environment: With the goal of increasing the city's walkability, funding was secured for Safe Routes to School programs at three schools. More than a dozen new walking trails were developed. In addition, the Las Cruces City Council has passed a Complete Streets resolution to balance transportation and community design to address both health and traffic concerns.

As word got out, other communities volunteered to be the next test site. The Interagency Council chose the largely rural Chaves County. Las Cruces is serving as its mentor.

The initiative's accomplishments garnered a $2.4 million grant from the Centers for Disease Control and Prevention, which will fund full-time coordinators in Chaves and Las Cruces. But even more importantly, it will enable state officials to formally assess their community-centric approach.

If the model proves to be effective, they plan to replicate it in at least one county in each of their five public health regions and in at least three tribal communities. At that point, the impact and reach of Healthy Kids, Healthy New Mexico would truly cover the state.

Healthy Kids, Healthy Tennessee focused on physical activity and nutrition policies within licensed child care and preschool facilities to help children develop healthy living skills at an early age. Gold Sneaker, as the initiative was named, built on heightened statewide interest in preventive health and past state-funded and federally funded efforts to reduce obesity and overweight. Its centerpiece was a new voluntary certification program that awards Gold Sneaker recognition to child care providers that complete specific training and meet a standard set of nutrition and physical activity requirements in their facilities. To date, the program has trained staff from approximately 500 centers across the state and developed materials to help them meet rigorous evaluation criteria. The state also has leveraged funding from public and private sources, extending the reach of activities. While fewer facilities have aimed for Gold Sneaker status than hoped for—due to administrative barriers identified in the certification process—many attest to the training's value and plan to use what they've learned. As it seeks to streamline its requirements and increase its traction among child care providers, the program is poised to make a larger impact on childhood obesity in Tennessee.

The Big Picture

Until Gold Sneaker, Tennessee had focused most of its obesity prevention planning on school-age children and on adults. Few statewide efforts existed to foster healthy environments and behaviors among toddlers and preschoolers. But with an increasing number of children already at risk for overweight or obesity by the time they enter first grade, officials realized they needed to intervene sooner to make the greatest impact.

The initiative sought to address this gap through the new certification program for child care centers, where many youngsters spend eight or more hours a day. Criteria call for participants to improve nutrition and physical activity by:

- Providing a set amount of daily physical activity time for all children in their care;
- Restricting television, video games, and other sedentary time;
- Ensuring appropriately sized food portions;
- Ensuring that food is not used as an incentive or punishment to control behavior; and
- Encouraging and supporting breastfeeding of infants.

The state's work with older children proved a valuable foundation. Much of that stemmed from 2006, when Governor Phil Bredesen declared obesity prevention "the next frontier." Several key developments followed as a result of leadership from the governor's office and subsequent bipartisan support in the legislature: The state established an office dedicated to child nutrition and wellness within the Department of Health; launched a $7 million project to prevent Type 2 diabetes in children and adults; and created an online awareness program targeting adults and families with healthy behavior messages. In addition, lawmakers allocated $15 million to allow Tennessee's historically limited coordinated school health program to expand from 10 school systems to virtually every system in the state.

The health department took the lead on Gold Sneaker's design, in conjunction with the Governor's Council on Physical Fitness and Health. They envisioned strong policy adoption through public recognition, and so facilities that fulfill the special training and evaluation requirements are listed on the department's Web site. Those providers also receive a certificate of achievement and two Gold Sneaker stickers that can be placed at their entrance or used in promotional activities.

The program's implementation depended on collaboration among several state agencies and outside groups. They came together not only for its launch but also for candid appraisals and course corrections after the program was under way. The outside groups' involvement and extra funding enabled Gold Sneaker to reach significantly more sites and will sustain it for the future.

Step by Step

State health officials teamed with their counterparts in the state Department of Human Services, which licenses child care facilities. The Department of Health administered the program and Human Services the customized training. From the start, that training was offered as part of the state's continuing education curriculum for child care centers. Officials also provided ongoing support as facilities adopted the new physical activity and nutrition policies.

But the organization on the ground leading the instruction was the Tennessee Child Care Resource and Referral Network (CCR&R). The network is part of a nonprofit organization that offers assistance at no charge to parents and other caregivers, professional providers, and employers statewide. In short order, its 10 offices were able to extend training to several thousand workers. CCR&R also helped the health department to facilitate several centralized train-the-trainer sessions that resulted in major cost savings.

The initiative's other partner was United Way of Chattanooga. As Gold Sneaker progressed, officials realized there was a dearth of obesity prevention resources appropriate for use with young children. They worked with United Way and a private firm called Chattham to develop an age-appropriate version of the company's "Kid Fun Fitness Break" kit, which already was a success in regular school settings. This tailored kit showed child care facilities how to incorporate structured physical activity and nutrition education into their daily schedule.

The Healthy Kids, Healthy Tennessee grant only funded the production and distribution of 1,025 kits, however. A separate grant that the United Way chapter secured from the state's diabetes project covered 4,025 more kits, which allowed distribution to more than 80 percent of all licensed child care providers. And

separate from the Gold Sneaker curriculum instruction, United Way of Chattanooga trained staff from approximately 500 facilities on how to use the materials.

Making a Difference

In less than a year, Gold Sneaker increased awareness among child care providers and parents of the importance of developing healthy habits very early in children's lives—habits that can last a lifetime. The program also helped providers better understand their role in pressing nutrition and wellness with their young charges. Enlisting child care facilities as partners in the promotion of healthy eating and increased physical activity is a crucial step toward reversing the childhood obesity epidemic.

But numbers give the best sense of the initiative's reach and immediate impact: Some 3,400 child care workers from approximately 500 day care and preschool centers received Gold Sneaker training. More than 5,000 of the state's 6,000 licensed facilities are now using the Kid Fitness kit.

Despite such achievements, only 14 providers became certified Gold Sneaker facilities during the first year, a total that fell far short of the program goal of 187. Feedback from providers revealed that although they valued the trainings and planned to implement the accompanying policies, they felt that the paperwork for the certification process imposed too much of an administrative burden on top of the large amount of record-keeping already required for state licensing.

The state has begun to respond. At issue is how to make a voluntary program easy to put into effect, with minimal reporting requirements, and yet still set a high enough bar, with enough monitoring, to assure compliance, consistency, and quality.

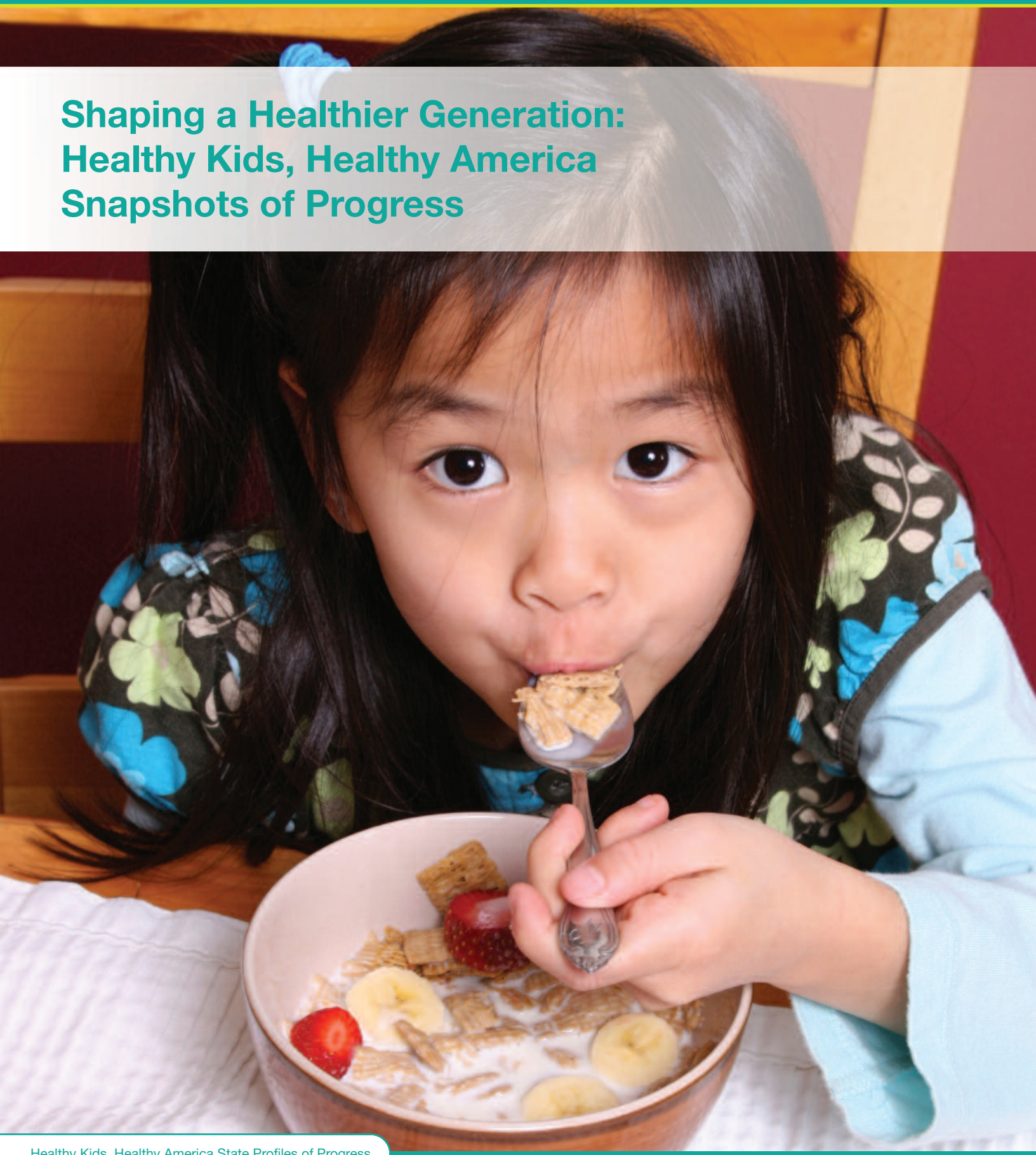
The health department allocated a portion of initiative funds to contract with United Way of Chattanooga and, through discussions with provider focus groups and CCR&R representatives, devise strategies to improve Gold Sneaker. The goal will be to reduce the administrative burden of certification so that more facilities will seek certification. The CCR&R is poised to expand its training and technical assistance for future participants.

Also under consideration is an approach similar to the three-star system that the human services department uses in licensing child care facilities. Those awarded three stars are deemed "best quality" providers and are eligible for a higher level of reimbursement than other facilities. Such an incentive could make the Gold Sneaker a financial boost as well as a symbol of quality.

Officials are optimistic that, with modest investment, Gold Sneaker is a scalable, replicable, sustainable program that can make a real difference in children's health. Because of the initiative, the political will and partnerships necessary for this already exist.

Gold Sneaker could indeed ensure that the work of Healthy Kids, Healthy Tennessee has lasting impact—most importantly, through the better well-being of the young children at its center.

Shaping a Healthier Generation: Healthy Kids, Healthy America Snapshots of Progress



The importance of obesity prevention strategies early in a child's life cannot be overstated. Children at risk for failure in school and poor health are most likely to benefit from high-quality early care and education programs, health care, family support, and proper nutrition.[19] According to the National Association of Child Care Resource and Referral Agencies (NACCRRA), more than 11 million children under age 5 currently spend a portion of their day in the care of someone other than a parent.

More than 12 percent of American children ages 2 to 5 years are obese.[20] Obese adolescents are up to 80 percent more likely to become obese adults and suffer from associated chronic diseases, including diabetes, heart disease, stroke, hypertension, and some forms of cancer.[21,22,23] Recent research suggests that the origins of adult disease are predicated on developmental or biological disruptions experienced in the early years of life.[24] Promoting health in children from birth to age 5 can significantly enhance school readiness and establish healthy lifestyle habits early in development.

The challenge for states lies in the patchwork approach historically taken to fund and deliver comprehensive services to young children and their families. These programs and services are spread across multiple state agencies and departments and are rarely coordinated, despite the fact that they may serve the same children and families.[25]

States currently coordinate as many as 80 separate federal, state, local, and private funding methods to pay for comprehensive programs and services.[26] These fragmented funding streams—and the differing requirements and standards of each—often result in inefficiencies and gaps in services for children and families.

In the Healthy Kids, Healthy America program, both Kentucky and Tennessee pursued voluntary measures to pilot new policies and programs. **Kentucky** developed policies to increase physical activity and improve nutrition choices among preschoolers and after-school youth. The program established new partnerships with early child care specialists and established an early child care committee within the Fit Kentucky Coalition. The goal of this early childhood committee is to pursue nutrition and physical activity standards for licensed child care centers and make training for staff a priority.

Tennessee developed a branding campaign, the Gold Sneaker Initiative, to establish high-quality physical activity and nutrition policies within licensed child care facilities. Under the program, child care facilities that implement standard requirements will earn a Gold Sneaker designation. Parents of all literacy levels can determine the quality of a center's nutritional and physical activity policies from the sticker placed on a center's front door. Additionally, this initiative provides training sessions as part of the state's continuing education curriculum for child care providers as well as implementation support to participating facilities.

A full description of each of program is outlined in the following section.

With four pilot day care centers in high-risk communities, the *Healthy Kids, Healthy Kentucky* initiative targeted physical activity and nutrition interventions for preschool-age children. It provided staff training, purchased physical activity resources and nutrition curriculum for the centers, and piloted a newly developed farm-to-classroom curriculum—all of which helped to initiate healthier policies in these centers. Results informed the development of early childhood objectives that were added as an update to Kentucky's 2005 Nutrition and Physical Activity Action Plan. New partnerships established through the initiative are now focusing on additional policy standards for this setting.

The Big Picture

The initiative aimed to improve wellness and increase physical activity among preschoolers—a group missing from the original 2005 state plan that addressed nutrition and physical activity as part of the Partnership for a Fit Kentucky coalition. New child care partners were identified and their valuable expertise brought to the table through an early childhood subcommittee established within the standing Fit Kentucky coalition.

Although the effort was led by the state's Cabinet for Health and Human Services, it involved an implementation team representing the state education department, researchers from the University of Kentucky, and a nonprofit community services organization.

The team's goal was to provide resources and training to encourage new, meaningful obesity prevention policies at four pilot centers. Efforts to increase opportunities for physical activity included buying equipment for age-appropriate play areas to make movement more enticing; supplying staff with workshops and training guides to aid their role in guiding children; and monitoring the policy changes that followed.

The broad hope was that collective progress made by these pilot sites—two urban Louisville locations and two on the state's rural eastern side—would be a model for statewide policy change.

Step by Step

As the initiative got under way, the program team worked with the University of Kentucky to tailor an existing physical activity curriculum toward the needs and capabilities of this much younger group. Space constraints at the pilot centers dictated that much activity be indoors or contained within small outdoor areas.

None of the centers was routinely teaching nutrition education, so teachers received training in Color Me Healthy, a curriculum that uses color, music, and taste to teach healthy food choices. To maximize impact, the same instruction was given to 100 early childhood consultants in a separate state project.

Additionally, one center piloted a nutrition-enhanced gardening curriculum developed for this initiative. The Preschoolers Learning about Nutrition and Nature Together (PLANNT) pilot was largely successful, expanded through a statewide training for child care providers, and now receives funding and evaluation support from the University of Kentucky Prevention Research Center.

Day care staffs at the pilot sites were paid to attend four trainings on physical activity (indoor and outdoor), nutrition, and the importance of being healthy role models. The latter was key to the initiative's success. The sessions encouraged workers to be active with their classes and eat the same healthy meals they served in their rooms.

In the end, each center developed weekly written schedules for physical activity specifying at least 30 minutes per day. All of the sites began using the Color Me Healthy curriculum once a week during "circle time," which is an integral component of the preschool day.

Making a Difference

All four centers were successful at defining and designing policies to meet nutrition and physical activity goals. By making musical chairs, dance, or a walk to the park as routine a part of the day as naptime, they were particularly successful in increasing their preschoolers' amount of moderate or vigorous activity.

These outcomes propelled the state's formulation of guidelines for day care providers and an update of its overarching Nutrition and Physical Activity Action Plan. The work of the initiative also helped Kentucky build new partnerships with child care specialists and ensure the inclusion of their perspective moving forward.

Though past grants focused the state's attention on school-age children, their younger counterparts now have a seat at the table. The Healthy Kids, Healthy Kentucky initiative made clear the importance of educating even preschoolers about eating healthy and getting moving—hopefully, for the rest of their lives.

Healthy Kids, Healthy Tennessee

A brief examination of Tennessee's childhood obesity policy development in child care settings

Gold Sneaker, as the *Healthy Kids, Healthy Tennessee initiative* was named, partnered with child care and preschool centers to promote healthy eating and increased physical activity among the state's youngest residents. Providers receive the Gold Sneaker designation after completing specific training and meeting nutrition and physical activity standards in their facilities. The state leveraged additional funding from a variety of public and private sources, extending the reach of the initiative's activities and ensuring that it would continue. As its traction increases, Gold Sneaker is raising awareness among providers and parents alike of the importance of developing healthy habits very early in children's development.

The Big Picture

The groundwork for Healthy Kids, Healthy Tennessee was laid in 2006 when Governor Phil Bredesen declared obesity prevention "the next frontier." His leadership coupled with bipartisan support in the legislature resulted in several key developments, including a state office dedicated to child nutrition and wellness, a $7 million project to prevent diabetes in children and adults, and a $15 million infusion that allowed Tennessee's historically limited program to expand to virtually every school system in the state.

But state officials realized that they also had to intervene earlier in children's lives to make an impact and decided to focus Healthy Kids, Healthy Tennessee efforts on child care and preschool centers, where many youngsters typically spend eight or more hours a day. In conjunction with the Governor's Council on Physical Fitness and Health, the Department of Health created Gold Sneaker as a voluntary certification program to improve physical activity and nutrition policies within these facilities.

The initiative's enhanced policies called for:

- Providing a set amount of daily physical activity time for all children enrolled in child care;
- Restricting television, video games, and other sedentary time;
- Ensuring appropriately sized food portions;
- Ensuring that food is not used as an incentive or punishment to control behavior; and
- Encouraging and supporting breastfeeding of infants.

Facilities that undergo training and fulfill the evaluation requirements receive a certificate of achievement, namely two Gold Sneaker stickers that can be placed at their entrance or used in promotional activities, plus recognition on the state Department of Health's Web site.

Step by Step

From the start, Gold Sneaker offered specific training as part of the state's continuing education curriculum for child care providers, as well as assistance in implementing the new physical activity and nutrition policies. The state Health Department and Department of Human Services worked together with a valuable outside partner, the Child Care Resource and Referral Network, to conduct the trainings with providers around the state.

Gold Sneaker also worked with United Way of Chattanooga to develop a preschool age-appropriate version of its "Kid Fun Fitness Break" kit, which had previously proved successful in the school setting. This tool helped to introduce structured physical activity and nutrition education into child care facilities as a daily part of their schedule. With funding from the initiative and a grant that United Way of Chattanooga secured from the state's diabetes project, the kits were disseminated to virtually all child care centers across Tennessee.

Making a Difference

Since Gold Sneaker's launch in 2008, 3,400 workers at approximately 500 child care and preschool centers have been trained in implementing the program's physical activity and nutrition policies. More than 5,000 Kid Fitness kits were produced and distributed statewide.

Though the number of certified centers has not yet reached target levels, state officials are optimistic that Gold Sneaker is a scalable, replicable program that can make a significant difference. The political will and the partnerships needed to support it already exist. And except for the certification process, which is under review so that administrative steps and paperwork can be streamlined, the program has received positive feedback from providers.

Gold Sneaker could ensure that the work of the Healthy Kids, Healthy Tennessee initiative has lasting impact—most importantly, through the better well-being of the young children at its center.

Policy Planning and Prioritization

With no easy actions to prevent childhood obesity, it is clear that a coordinated, multi-sector approach that engages all levels of government as well as the private sector, community-based organizations, and parents is an essential first step. The many childhood obesity programs that exist in states today often lack common objectives and goals because of little or no coordination across community and state providers. Poor coordination and diffuse leadership can lead to fragmented services for children and families.

To overcome the state policy complexities and challenges posed by childhood obesity, four states pursued policy planning and prioritization efforts by:

- Consolidating efforts in one coherent strategy;
- Aligning state- and local-level programs and policies by coordinating across sectors, reducing duplication, and making the most of limited budgets; and
- Providing leadership, mitigating and analyzing problems as they arise, and coordinating public, private, and local efforts directed toward children's health.

By enhancing coordination across public and private programs, the governor can focus state resources on specific tools and processes to inform policy decisions and improve the health and welfare of children. This coordination enables the governor to collect relevant data, conduct analyses, track trends, and make strategic investments to improve children's health.

In the Healthy Kids, Healthy America program, four states pursued policy planning and prioritization, including:

- ***Michigan.*** Michigan created an executive-level workgroup to develop a five-year policy agenda and transition the workgroup's efforts to an independent coalition.
- ***Minnesota.*** Minnesota conducted a statewide survey of current policies and programs, then developed a five-year policy action plan to prevent childhood obesity.
- ***Mississippi.*** Mississippi established the Governor's Task Force on Childhood Obesity to develop policy recommendations for coordinated child wellness across all agencies, held a statewide policy summit, and developed a blueprint for childhood obesity policy moving forward.
- ***New Mexico.*** New Mexico created a special advisor position to the Secretary of Health to centralize state health efforts to improve children's health, coordinate the Governor's Interagency Task Force on Obesity, and launch a pilot childhood wellness program in a local community.

A full description of each program is outlined in the following section.

Healthy Kids, Healthy Michigan

A brief examination of Michigan's childhood obesity policy development

An executive-level workgroup led by Michigan's surgeon general served as the nucleus of the *Healthy Kids, Healthy Michigan* initiative. With support from subject-specific policy teams, the workgroup hammered out a five-year policy agenda for preventing childhood obesity, then transitioned into an independent—and independently funded—coalition to ensure the agenda is accomplished. As six immediate priorities began to move forward through administrative and legislative channels, several school systems piloted nutrition and physical activity policy approaches that could prove promising as models for other districts.

The Big Picture

Governor Jennifer Granholm launched the initiative by asking Surgeon General Kimberlydawn Wisdom to head the Michigan Childhood Obesity Prevention Workgroup. Wisdom, in turn, recruited more than 230 leaders from more than 100 public, private, and nonprofit sector agencies and organizations to participate in this effort to direct future state policy.

In its first half-year, the initiative completed an environmental scan of obesity prevention activity around the state and formed three policy teams to provide research and analysis to support the workgroup's discussion. As the long-term strategic plan was being developed, the group targeted as immediate goals:

- Adding body mass index (BMI) surveillance to the state's electronic health registry;
- Ensuring Medicaid coverage of medical screening and treatment for childhood obesity;
- Requiring coordinated school health councils;
- Improving fresh food access in underserved areas;
- Strengthening school standards for health and physical education; and
- Incorporating complete streets solutions at state and local levels.

The workgroup also awarded $25,000 grants to three school systems to develop and test new wellness-related policies on their campuses. Their lessons learned are being incorporated into the five-year agenda that the new coalition will push statewide.

Step by Step

Although the state Department of Community Health was the designated lead agency on the initiative, it worked in close partnership with the Department of Education. Both agencies provided technical assistance and staff support to the workgroup, policy teams, and grantee school districts.

The first step was the scan among public, private, and community groups across Michigan. Based on results, the policy action teams were divided by subject area: education, community and health, and family and child care services. The workgroup held its first meeting in October 2007, and by March 2008, the teams were presenting policy options to the larger body, with a vote to approve the year-one agenda. The five-year plan was released that July.

The Lansing, Jackson, and Taylor school districts were by then well into their pilot projects. The three were selected in part because of a greater proportion of low-income students, with the thinking that policy triumphs in these school systems could show the way for others. The Departments of Community Health and Education made monthly site visits to the grantees, providing technical assistance and evaluation guidance.

Each school district chose at least two policy possibilities to pursue. À la carte cafeteria lines were a universal target for change. Jackson also instituted recess before lunch in the elementary grades, banned candy from classrooms and chocolate sales from school fundraisers, and removed all but one vending machine from its campuses.

The Taylor district, which saw its lunch sales jump by more than 75 percent with a switch to healthier offerings, also improved its PE curriculum and successfully pulled soda and junk food from its school stores.

Making a Difference

The Healthy Kids, Healthy Michigan initiative broke down bureaucratic barriers, brought disparate groups together, attracted new advocates to childhood obesity prevention, and raised public and policymaker awareness of the issue. It leveraged its work at every step, learning how to secure legislative champions and how to supply the best facts and information needed to inform their colleagues.

In less than 18 months, participants could claim true victory—a new law for property tax incentives to increase healthy food access in needy communities. They also could take credit for revived momentum around a previously stalled physical education bill through key House and Senate committees. The coalition that grew out of the initiative has only maintained the pace, continuing work on the remaining first-year priorities even as it began tackling year two.

The Healthy Kids, Healthy Minnesota initiative sought to put childhood obesity prevention front and center as a health priority. After conducting a statewide survey of current policies and programs, the state convened a steering committee to develop a five-year action plan to overcome gaps and take advantage of opportunities. This process resulted in two major successes, both supporting childhood obesity objectives. The first was the legislature's investment of $47 million over two years to fund 86 local public health agencies and eight tribal health services to focus on reducing obesity and tobacco use throughout the state. In addition, the Centers for Disease Control and Prevention (CDC) awarded the state multi-year funding to further advance its nutrition, physical activity, and obesity prevention efforts.

The Big Picture

The state Department of Health took the lead on the initiative, which took its charge from Governor Tim Pawlenty's ambitious goal: Minnesota should cut its rate of obesity in half by 2012.

The department's scan looked at programs and policies in a variety of settings around the state, including government, communities, worksites, educational systems, industry, and health care. It revealed that much more could be done to help people of all ages prevent obesity and lead healthier lives. The findings were integrated with recommendations from a past multi-agency childhood obesity task force and handed to the newly formed Minnesota Childhood Obesity Prevention Steering Committee.

Though the Health Department and the Department of Education both had a seat at the table, as did the governor's office, the steering committee reflected a diversity of private and community interests. Participants included representatives from the University of Minnesota, BlueCross BlueShield of Minnesota, General Mills, Big Brothers and Big Sisters of the Twin Cities, the Mayo Clinic, School Nurses of Minnesota, and more.

The group set three top priorities: 1) improving school wellness, including developing policies to encourage healthy food choices and ensure adequate time for physical activity; 2) developing community partnerships and prevention programs for at-risk populations; and 3) establishing a statewide childhood obesity measurement system to track trends.

Step by Step

The Health Department's scan established the parameters for much of the initiative's work. The report identified gaps in collaboration among state agencies, the resource needs of community public health programs, and the paucity of surveillance data to track obesity trends and disparities.

Over the course of a year, workgroups of the steering committee met frequently to support staff in creating the Minnesota Childhood Obesity Prevention Action Plan 2008–2013. The final document laid out a year-by-year timeline for implementing and sustaining the recommended actions.

The initiative gleaned additional insights after issuing a request for proposals to school districts across the state to award mini-grants to lower-income schools to strengthen local wellness policies. The 50 responses indicated a substantial need for technical assistance if schools' wellness policies and programs were to succeed. Seven grants were given to help schools implement wellness polices and increase parent involvement.

The legislature's $47 million investment to reduce obesity and tobacco use came as these efforts intersected with health care reform in Minnesota. The two-year appropriation through the Statewide Health Improvement Program provided grants to local public health agencies and tribal health services to pursue community-based obesity and tobacco use prevention programs, directly addressing the steering committee's community partnership priority.

Making a Difference

At nearly every stage, Healthy Kids, Healthy Minnesota effected some change. The biggest change, of course, was the new funding from state lawmakers and the CDC.

The steering committee's action plan was a key ingredient in Minnesota's application for the CDC's five-year Nutrition, Physical Activity, and Obesity cooperative agreement. The CDC award provided funding to hire staff to design and lay the groundwork for a comprehensive obesity surveillance system, another of the committee's priorities.

The Healthy Kids, Healthy Minnesota initiative proved to be a catalyst for new working relationships in government, the community, and private sector. Through the initiative, the state was able to build on previous accomplishments, plan its future direction in childhood obesity prevention, leverage existing funds to secure additional state and federal dollars, and then without delay, move ahead with its plan.

Healthy Kids, Healthy Mississippi

A brief examination of Mississippi's childhood obesity policy development

Building on the momentum of regulatory and legislative measures to address childhood obesity in school settings, the *Healthy Kids, Healthy Mississippi* initiative established a Governor's Task Force on Childhood Obesity to develop policy recommendations for coordinated child wellness across all agencies. Mississippi also held a statewide summit to rank those recommendations and developed a blueprint for childhood obesity policy actions moving forward. Mini-grants to 20 schools resulted in wellness-centered success stories illustrating the need and potential for further change. As the task force continues to elevate the issue, Mississippi could be seeing nascent signs that it is turning a corner on childhood obesity.

The Big Picture

With Governor Haley Barbour publicly declaring the health of Mississippians a top concern, the initiative enjoyed a high profile from the start—along with fortuitous timing. Since 2004, Mississippi made marked progress on nutrition and physical activity in its 1,000 public schools.

The state Department of Education created an Office of Healthy Schools, and the state superintendent and board of education adopted language allowing only healthy beverages and snacks in school vending machines.

In 2007, the legislature passed the Mississippi Healthy Students Act, which requires 150 minutes of physical activity-based instruction and 45 minutes of health education weekly in kindergarten through 8th grade as a requirement for graduation. Lawmakers also instructed the state education board to develop stronger nutrition standards and guidelines on healthy meal preparation.

Against this backdrop, Mississippi launched Preventing Obesity with Every Resource (POWER), a project overseen by the Office of Healthy Schools. In little more than a year, POWER's accomplishments included an environmental scan of public programs, the school mini-grants, engagement across state agencies, a Governor's Task Force convening, and one large statewide planning summit. The latter event, which Governor Barbour and First Lady Marsha Barbour helped host, resulted in a top-10 ranking of policy priorities for the state.

Step by Step

POWER's initial task was the environmental scan, which revealed the scope of programs already underway as well as the gaps and duplication. Many efforts were funded by the Bower Foundation, a key supporter of child-wellness initiatives in the state. The scan made clear that more coordinated activity and capacity building was needed.

The $1,000 grants awarded to 20 schools served a parallel purpose. Each successful practice identified, such as fitness testing and vegetable gardens to name two of the most popular, established a "change agent" that helped drive policy change in those schools and potentially throughout the state.

The Governor's Task Force convening in spring 2008 drew about three dozen representatives of virtually all state agencies to develop the MS POWER Action Plan. Armed with background on policy initiatives under way around the country, the group considered various obesity prevention approaches and culled the 18 best potential strategies for Mississippi. By late 2008, more than 275 stakeholders—including directors from many state agencies, teachers, doctors, parents, and lawmakers and other state officials—came together for a planning summit, winnowed the 18 strategies to 10, and then prioritized them.

The three leading priorities were to:

- Improve the built environment to promote physical activity in communities;
- Replace fryers with combination oven/steamers in school kitchens; and
- Increase the number of nurses in the schools.

Today, POWER is continuing through the Governor's Task Force. Several departments are reviewing regulatory language that could advance the identified priorities. Future legislation seems likely.

Making a Difference

POWER's approach gave Mississippi's work an overall, organizing context. Particularly within state government, it stimulated new relationships and furthered existing ones. Among the early results were creation of a standing joint subcommittee for the state board of health and the state school boards association to discuss obesity prevention collaboration as well as a marketing campaign developed by the Division of Medicaid, the departments of Education and Human Services, and Mississippi Public Broadcasting. The momentum also helped Mississippi garner a five-year, $3.4 million Centers for Disease Control and Prevention (CDC) grant to strengthen its coordinated school health program.

The state's most recent survey of childhood obesity prevalence showed only a slight uptick among younger students and modest decreases in middle school and high school rates. In a 2009 CDC *Morbidity and Mortality Weekly Report*, Mississippi was one of two states that reported the largest increases from 2006 to 2008 in the percentage of schools in which students could not purchase candy, salty snacks, and soda. Statewide nutrition standards for foods in schools outside the school meals program helped to contribute to this gain.

If the prevalence numbers reflect the early impact of tougher school nutrition and physical activity standards, as officials are hoping, then the accomplishments of the Healthy Kids, Healthy Mississippi initiative will be even more meaningful.

With a special advisor positioned in the highest level of state government, *Healthy Kids, Healthy New Mexico* focused top officials and nearly a dozen departments on the policy changes needed to help children eat better and be more active. The initiative encouraged collaborative efforts through an interagency council even as it concentrated on a single community to make a sustainable difference. The approach attracted other communities interested in serving as similar laboratories—as well as lawmakers' notice—and a second project was launched in a neighboring county. Having now garnered a major federal grant, officials hope to further develop the Healthy Kids, Healthy New Mexico template to prevent childhood obesity statewide.

The Big Picture

Officials wanted to both think globally and act locally: That is, they wanted to address overarching changes that could benefit all New Mexico children and also target one community with extra resources to put the best policies and programs into action.

Key to the initiative's reach was creation of the new position of senior health advisor in the Office of the Secretary of Health. This individual not only acted as a crucial bridge between state and local partners but also coordinated and directed the childhood obesity work of the existing Interagency Council for the Prevention of Obesity. The council was established by Governor Bill Richardson during a period of heightened attention to wellness issues that included release of New Mexico's first comprehensive plan to promote healthier weight. The group now grew to include representatives from nine departments with authority over more than three dozen programs.

The initiative sought to maximize the likelihood that obesity prevention efforts would be successful through its concentration on the city of Las Cruces. Local leaders and residents came together on a multi-year vision and identified five areas of intervention: the built environment, education settings, food systems, health care systems, and family/community settings. Under the plan, any efforts had to aim for increasing children's healthy eating and physical activity.

Step by Step

Led by the Secretary of Health's senior advisor, the interagency council took a much more active and concerted role in childhood obesity prevention. An expansive inventory of its members' programs made clear the myriad places they could intersect the issue. Members agreed to focus their departments' nutrition and physical activity messaging, as well as actual programming, on half a dozen behavior changes noted in New Mexico's weight plan.

The Interagency Council continues its work today. It is crafting a comprehensive Healthy Kids, Healthy New Mexico policy agenda by strengthening nutrition and physical activity standards in child care centers and homes; tightening school compliance with the New Mexico School District Wellness Policy Rule and Nutrition Competitive Food Sales Rule; and developing a BMI surveillance system for elementary school children.

The planning in Las Cruces started separately with a two-day meeting convened by the state Department of Health. Local leaders from government, academia, business, and nonprofit and foundation groups attended. Within each of their targeted areas of intervention, they issued a definitive vision statement. Then began the harder job of setting year-by-year goals and formulating action plans.

The project officially kicked off in spring 2008 with appearances by state lawmakers and four Cabinet secretaries. Though one elementary school was chosen for implementation of the most comprehensive strategies, work went forward in more than a dozen schools and on the multiple fronts identified in the city's plan.

The on-the-ground leader was the regional public health office, which reassigned staff on its health promotion team to help direct the pilot. The Interagency Council served as an advisory board. Half of the initiative funding supported the activity in Las Cruces.

Making a Difference

Putting a senior health advisor in charge of the overall initiative signaled its importance. Top officials in state agencies and lawmakers quickly took note, and the result was new collaborations among numerous departments and greater legislative awareness of the need for policy interventions to prevent childhood obesity.

In Las Cruces, thanks to in-kind contributions from local and regional groups, the project leveraged its $40,000 budget to a more than two-fold return on investment. The intensity of attention and resources served its purpose, with progress in every targeted setting toward the city's 2012 vision.

The initiative's accomplishments garnered a $2.4 million grant from the Centers for Disease Control and Prevention, which will fund full-time coordinators in Las Cruces and the second site of Chaves County. But even more importantly, it will enable state officials to formally assess their community-centric approach. If the model proves to be effective, they plan to replicate it in their five public health regions and at least three tribal communities. At that point, the impact and reach of Healthy Kids, Healthy New Mexico would truly cover the state.

School-Based Efforts

With nearly one-fifth of the nation in a school setting on any given school day, policymakers have an opportunity to set quality nutrition and physical activity standards to affect the lives and welfare of more than 55 million children. Therefore, it is important for policymakers to consider both the feasibility and the content of programs and policies—and where and when those policies should be employed—to yield the best outcomes for children.

Obesity prevention efforts in the school setting can positively affect the health and welfare of millions of children and adolescents. Yet school funding is predicated on academic testing performance and other conditions set forth by No Child Left Behind.[27] There are few financial incentives for schools to go beyond traditional instruction and enhance the nutritional content of school foods or improve the quality of PE.

Encouraging schools to improve child health outcomes poses numerous cultural, institutional, and social challenges for state and local policymakers. Although myriad state rules and regulations govern public health, education—both jurisdictionally and philosophically—is deemed a local matter. The two sectors recognize the importance of collaborating on specific issues—and have done so successfully on health-related topics such as childhood immunizations—but partnerships to prevent obesity or chronic disease are still evolving.

However, a child's health status influences many things, including academic attainment.[28] Research demonstrates that obese children miss an average of nine more days of school each year than their healthy-weight counterparts.[29] Because attendance is a factor in the school funding equation for many states, a single absence can cost a school district $9 to $20 per student, which translates into millions of dollars in lost revenue for larger school districts such as New York City or Los Angeles.[30]

In the Healthy Kids, Healthy America program, nine states addressed the school environment, including:

- ***Indiana.*** Indiana implemented a wellness pilot combining classroom instruction with an online nutrition and physical activity program.
- ***Louisiana.*** Louisiana focused on improving school wellness policy implementation across the state.
- ***New York.*** New York developed guidelines for nutrition and physical activity programs in after-school programs.
- ***Rhode Island.*** Rhode Island focused on school wellness policies and providing 100 percent of schools with technical assistance.
- ***South Dakota.*** South Dakota awarded mini-grants to a dozen schools, districts, and out-of-school-time programs to improve nutrition and physical activity policy.
- ***Utah.*** Utah created teacher training programs for using non-food incentives in the classroom and increasing physical activity time.
- ***Virginia.*** Virginia focused on improving the health habits of at-risk students via state assessments of nutrition, physical activity, and fitness.
- ***West Virginia.*** West Virginia instituted comprehensive wellness checks for all incoming kindergarteners in public schools.
- ***Wisconsin.*** Wisconsin established an award program to drive policy changes in schools statewide.

A full description of each of program is outlined in the following section.

Drawing upon the Web-savvy nature of children today, the *Healthy Kids, Healthy Indiana* initiative implemented a wellness pilot combining classroom instruction with an online nutrition and fitness program. This effort aimed to identify relevant obesity prevention tools for Indiana's students that could be replicated widely. The insights gained and partnerships formed through the initiative are already aiding the development of a statewide obesity prevention plan.

The Big Picture

Guided by the Indiana Department of Health and advised by an interdisciplinary task force, the initiative offered mini-grants to two Indianapolis-area schools to test a special health education curriculum—an eight-week enhanced program for elementary school students and a video project at the high school level. The resulting student-produced videos, which required research into nutrition, exercise, and effective communication, played in schools as public service announcements (PSAs) for improved health.

But the online approach became the core of the initiative and offered the greatest potential reach. Some funding was used to enhance an existing state Web site, *INShape Indiana*, which features resources and events geared toward better health among all ages. Additionally, through a public-private partnership with the company GoTrybe™, every student and all K–12 educators received free access to a new, interactive Web site that aimed to turn passive screen time into physical activity.

The initiative encouraged teachers to use the GoTrybe.com activity videos, interactive quizzes, and nutrition messages in their classes. And teachers responded. Some regularly incorporated the workouts into instruction and tracked the minutes of movement. Others fit them in between lessons, logging on to allow students stretching or dance breaks.

Step by Step

About 40,000 students participated in a fitness awards program through INShape Indiana, which Governor Mitch Daniels introduced in 2005. Capitalizing on public interest and momentum from that program, Governor Daniels established an interdisciplinary group made up of leaders from state agencies, community organizations, and private-sector groups to advise the Healthy Kids, Healthy Indiana initiative. Given past collaboration by the initial core partners, including the state health and education departments and Indiana University, the group's membership grew to 40 partners within months.

For example, the nonprofit system Clarian Health Partners provided health education to fifth-graders using its "Committed to Kids" curriculum. Weekly, hands-on sessions focused on understanding portion size, avoiding sugary drinks, reading food labels, and other related topics. At the high school level, Clarian also provided health education programming while helping students make three PSAs on healthy eating and active living. Those announcements were then showed campuswide.

For the Web approach, the Department of Health worked with the for-profit GoTrybe™ to create "GoTrybe Indiana." The company offered its site free of charge to students and educators across the state. Officials enlisted task force members to publicize GoTrybeIN.com via e-mail blasts, other Internet sites, and newsletter reports.

Making a Difference

At Garden City Elementary School, more than a dozen teachers were trained on the "Committed to Kids" curriculum and will continue to integrate health and wellness into the classroom. Students hope to maintain a new after-school wellness club and related activities such as the "Are You Healthier Than a Fifth Grader?" contest, which reinforced healthy messages and awarded prizes to participants. At Ben Davis High School, the PSAs were viewed by more than 3,000 students and faculty.

The extensive promotion of "GoTrybe Indiana" resulted in almost 6,500 visits to its Web site over three months. Students and teachers in every county signed on.

The knowledge and relationships advanced through these efforts helped Indiana become one of eight states to receive Centers for Disease Control and Prevention funds to develop a statewide obesity prevention plan. Officials consider the connections made during their work on Healthy Kids, Healthy Indiana a critical foundation for the new plan.

Healthy Kids, Healthy Louisiana

A brief examination of Louisiana's childhood obesity school policy development

Intent on turning words into action, the *Healthy Kids, Healthy Louisiana* initiative set its sights on improving school wellness policy implementation across the state. An interdisciplinary policy team, representing governmental, public, and private-sector groups, directed the effort. It surveyed schools and administrators, provided technical assistance, developed a resource guide, and later assisted with work on a separate statewide obesity plan. The partnerships and collaboration initiated throughout the process have continued, with further projects, grants, and new legislation providing proof of their growing impact.

The Big Picture

The *School Wellness Policy Implementation Project* sought to deal with the reality of many of Louisiana's schools. Although federal regulation already required school wellness policies, that didn't necessarily mean they were in place, much less promoting action.

The interdisciplinary team, challenged to shift this reality, was led by the coordinator of the Louisiana Council on Obesity Prevention and Management, with primary planning by the state's Department of Education, Department of Health and Hospitals, and the Louisiana State University Agricultural Center. To underscore the initiative's significance, the heads of those agencies joined the governor in signing a letter to every local superintendent and all elementary and middle school principals, requesting their involvement in the initiative.

The team gathered details on existing policies through an online survey of principals and focus groups with key school wellness personnel. They asked about successful approaches and barriers to implementation. And they learned, with some surprise, that most principals equated school wellness with physical activity, not nutrition. The information became the core of a *Louisiana School Wellness Policy Action Plan Guide* to advise schools in both areas.

Step by Step

Throughout the initiative, the project team gleaned information from state conferences of principals, school nutritionists, nurses, and food service workers.

The first concerted undertaking was the online survey to principals. It elicited 412 responses, covering nearly half of the state's public elementary and middle schools. Less than a quarter of principals reported having robust wellness policies for their students and staff. Many acknowledged needing increased support from parents, teachers, and administrators.

Ten regional focus groups led by trained facilitators followed. The participation of staff from low-income schools was emphasized, though much of the discussions applied across the board. The participants cited inadequate time and money as obstacles to successful policy implementation. They also noted the limits of many schools' staff and program capacity, a lack of monitoring, and squeezed scheduling because of standardized testing.

The action plan guide addressed these concerns. Just as importantly, it offered ways to overcome them and to effectively advance policy to improve schools' nutrition and physical activity environments. Copies were sent to each elementary and middle school in the state, plus all local school district offices, and were distributed through partner organizations.

Making a Difference

As useful as the project's guide ultimately may be to schools, the communication and coordination preceding its publication could make the bigger difference. The relationships established as part of the process have continued to grow among state and local officials, community advocates, and private-sector leaders.

In addition, several complementary initiatives resulted from these new relationships. For example, an Alexandria, Louisiana, foundation sponsored a summit on school wellness, then backed its interest with more than $450,000 in grants to nearly 91 schools.

More lawmakers have taken up the cause, too, successfully championing measures on health-related fitness testing for students, school health advisory councils, and tougher school vending and nutrition program laws.

Part of the funding helped implement the obesity council's multiyear strategic plan aimed at policy and environmental change; council convenings are ongoing. In addition, the council created five regional teams within its Louisiana Action for Healthy Kids coalition. The coalition's mission will be to increase parental and community engagement in efforts to improve nutrition and physical activity in schools.

As a model for other states, Healthy Kids, Healthy Louisiana demonstrates the potentially exponential impact of collaboration—if well-timed, well-supported, well-publicized, and well done.

With roughly two-thirds of the nation's elementary school children in after-school programs, the *Healthy Kids, Healthy New York After-School* initiative identified this setting as an important but often untapped opportunity in which to teach healthy nutrition and instill good physical activity habits. New York's childhood obesity prevention effort led to the development of voluntary guidelines for nutrition and physical activity in after-school programs, which garnered widespread support from licensed after-school care providers across the state. More than 130 sites implemented the guidelines within the first year, and the state committed funding to sustain project efforts.

The Big Picture

New York's initiative concentrated on three ways in which these programs could create healthier environments:

- Nutrition, to eliminate sugar-sweetened beverages and ensure that children are served only nutritious snacks and drinks;
- Physical activity, to engage children in increased levels of moderate to vigorous movement; and
- Screen time, to reduce the amount of television, videos, and computer programs that children watch.

To assist providers, a 17-person team convened by Governor David Paterson for this project created a toolkit with self-assessment measures, lesson plans for play, snack menus, and other tips for policy implementation.

The voluntary guidelines for snacks, for example, promote low-fat or fat-free milk, fruits, and vegetables (with no added sugar, salt, or fat) and whole-grain crackers, breads, and cereals. They also encourage staff to eat the same snacks to model healthful eating for their children. The physical activity recommendations suggest 30 minutes of moderate to vigorous activity per three-hour period, with staff participating fully. And, with the exception of computer use for homework, the guidelines cap children's screen time at 2.5 hours a week.

The program included a formative evaluation to assess the toolkit's development, dissemination and effectiveness. A Governor's Recognition Program was created to acknowledge providers that successfully implement the guidelines.

Step by Step

With support from the governor and legislature, New York already had spent several years focusing on childhood obesity prevention, crafting nutrition standards for day care facilities in New York City and launching the Activ8Kids program to help create healthier school environments. Yet after-school settings, which offer considerable opportunities for influencing children's habits, had been largely overlooked.

The team from the governor's office and nearly a dozen public agencies, community-based organizations, and after-school provider associations met four times over four months to draft voluntary guidelines. The coordinating agency was the state Department of Health. But the project director came from the New York State Healthy Eating and Physical Activity Alliance (NYSHEPA), an advocacy group.

The discussion revealed varied strategies but common objectives. On the nutrition side of the equation, some people wanted proscriptive language limiting the amount of fat, sugar, and sodium in snacks. Others pushed for more flexibility. Ultimately, the group's shared goals led to consensus around categories of healthy foods that should be served.

Team members then took their proposals on the road, a move that helped them better understand providers' concerns and constraints. They held roundtable discussions in Buffalo, Albany, the Bronx, and Brooklyn, and the feedback further refined the guidelines. As a signal of the initiative's importance, Governor Paterson and and First Lady Michelle Paige Paterson issued a joint statement of support when the 57-page toolkit was released.

Making a Difference

Thanks to the partnerships forged early on, the toolkit has been widely circulated by advocates—and, in a matter of months, the guidelines implemented. Nearly five dozen after-school providers, representing more than 130 sites and roughly 10,000 children, sought formal acknowledgment through the Governor's Recognition Program. Those measuring up will be honored by Governor Paterson.

NYSHEPA subsequently received $145,000 in state funding, a portion of which will be used to continue the initiative and further evaluate its impact. Support from the governor's office proved to be a powerful lever in bringing state agencies together for this effort. Several had not previously collaborated; because of the initiative, however, relationships now exist among these agencies to help advance future policies aimed at preventing childhood obesity.

Healthy Kids, Healthy Rhode Island

A brief examination of Rhode Island's childhood obesity school policy development

The *Healthy Kids, Healthy Rhode Island* initiative targeted school wellness policies and provided 100 percent of school districts with customized technical assistance, helping them achieve statewide wellness goals. Prominent gubernatorial support, timely legislative victories, and collaboration at multiple levels were instrumental to the initiative's success and long-term impact. Specific achievements include policies in every district limiting the availability of unhealthy foods and beverages, the foundation for a new surveillance system tracking comprehensive data statewide, and five years of additional funding for obesity prevention efforts through a grant from the Centers for Disease Control and Prevention (CDC).

The Big Picture

In 2005, Rhode Island passed a law requiring each of the state's 36 school districts to form a Health and Wellness Committee to focus on nutrition, physical activity, and health and physical education for students and staff. In 2006 and 2007, laws were passed mandating stringent nutrition criteria for all beverages and snacks offered in schools. The Healthy Kids, Healthy Rhode Island initiative's primary goal was to facilitate the establishment of those school district committees, and to make certain that all districts' wellness policies were being actively implemented and critically assessed. The committees would also serve to support implementation of the 2006 and 2007 laws and to develop community accountability as a means of ensuring compliance.

Governor Donald Carcieri named the executive director of Kids First, Inc., a well-respected child advocacy organization in the state, to head the overall effort. This valuable non-governmental partner brought increased nimbleness and relationships with multiple state agencies to the effort. Also, two facilitators from Kids First were assigned solely to assist the local committees and school officials.

Though Kids First worked most closely with the governor's office and state Department of Health, the program pulled together an interdisciplinary team representing other state agencies and community groups. One group, the Rhode Island Healthy Schools Coalition, saw its membership jump by more than 50 percent as enthusiasm grew.

Step by Step

To better coordinate with the state's school systems and wellness committees, organizers set up an electronic communications network and regularly e-mailed resources and updates. They encouraged teachers' and superintendents' support through a series of trainings that emphasized school wellness and teachers' role in modeling healthy lifestyles for students.

Legislation that passed in 2008 accelerated momentum by requiring comprehensive physical education standards for all public schools by 2012. Additionally, the state's education governing body tackled nutrition guidelines for competitive foods that support, implement, monitor, and continuously improve the nutrition criteria specified in the 2006 and 2007 laws and the RI Nutrition Requirements (RINR) for school meals mandated in 2009. As part of this initiative, the state worked with local distributors to identify more than 1,500 law-compliant snacks and beverages and make those available to schools through existing purchasing contracts.

Governor Carcieri convened a multi-sector Healthy Weight in 2008 Council to coordinate and promote activities related to physical activity, nutrition, and obesity prevention. This group, which included several state agencies, private health insurers, and the Rhode Island Hospitality and Tourism Association, launched a statewide campaign with a Web site and summer event series.

Making a Difference

Healthy Kids, Healthy Rhode Island propelled sweeping action on wellness promotion. It also drew new agencies and groups into state-level planning efforts. The state tourism association, for one, began discussions with the health department on a project to make restaurant menus healthier.

The technical assistance and communications network tailored for school systems were deemed so successful that both were included in a separate five-year state healthy weight initiative funded by the CDC. That same funding will support a statewide online surveillance system due to come on line in the near future. The system will gather and track data on programs, policies, and environmental supports for wellness initiatives; children's dietary and physical activity patterns; and BMI screenings to aid the evaluation of school-based policies and approaches.

The program's impact may continue in other ways, too. The state education department tackled nutrition criteria for school meals as part of its involvement, and beginning in fall 2009, food service providers were required to serve students a greater variety of fruits, vegetables, and legumes as well as all whole grains and less sodium for breakfast, lunch, and after-class snacks.

In a small state, this initiative made big progress through the combined power of focused leadership, clear purpose, and broad cooperation. Children are already benefiting.

The *Healthy Kids, Healthy South Dakota* initiative awarded mini-grants to a dozen schools, districts, and out-of-school-time programs intent on policy and environmental change through improved nutrition and opportunities for physical activity. Three state agencies collaborated on in-depth, face-to-face trainings with the grantees—training that was turned into online modules to magnify their impact. The combination of in-person sessions, Web-based materials, and listserve connections helped to reach across this largely rural state and increase awareness of ways to tackle obesity rates.

The Big Picture

South Dakota has collected student height and weight data for over a decade, but much of its focus on childhood obesity stems from a Statewide Nutrition and Physical Activity Plan written following a 2005 summit convened by Governor Mike Rounds. Officials saw the opportunities inherent in Healthy Kids, Healthy South Dakota as a natural fit with their ongoing efforts.

The state Department of Health targeted the mini-grants to schools or districts interested in improving their wellness practices and to community organizations running out-of-school-time programs that encourage youth to eat right and be more active. In partnership with the state Department of Education and Department of Social Services, health officials provided grantees with training to help them plan, implement, and evaluate their projects. The modules that resulted from this instruction were posted on www.HealthySD.gov for such settings as teacher in-service trainings, PTA meetings, or community stakeholder meetings.

Step by Step

The initiative invited districts and programs from across the state, particularly those serving populations at high risk for obesity, to submit proposals for projects aiming to improve children's nutrition and physical activity. Twelve mini-grants of up to $5,000 were awarded through the initiative, plus five more through the state's Maternal and Child Health Block Grant.

The 17 grantees pursued a variety of efforts, from purchasing equipment for a salad bar to increase students' exposure to fresh greens to encouraging more milk-and less soda-consumption through nutrition education and daily food journals.

One small district in the state's northeast corner got students to move more by allowing them supervised access to Wii interactive video game systems, which incorporate physical activity into game play. In western South Dakota, another grantee implemented Girls and Mothers Excelling through Sports (GAMES), a health, fitness, and nutrition education program for girls ages 6 to 17 and their mothers or other female adult role models.

Still another grant supported a Sioux Falls school's "Great Chefs/Healthy Snacks" competition, where teams of students learned to prepare nutritious snacks and then were judged on the results. A cookbook of the student recipes was sold to fund another health-related project.

Before implementing their projects, representatives from each site participated in a daylong training that framed the challenge and the importance of wellness-related policy change in their local environments. Presentations by experts in school health and nutrition were mixed with discussion of resources, advocacy, and related issues. Grantees left with a binder of resource materials, as well as access to a listserve designed to facilitate information sharing and problem solving.

The organizers videotaped the sessions for adaptation as six separate training modules. Those were posted on the state's health-related Web site along with various materials used in the training. Organizers have promoted the free modules and accompanying PowerPoint presentations through newsletters, presentations, and meetings.

Making a Difference

The 2006 obesity prevention state plan calls for providing "environments for youth to learn and practice skills today for a lifetime of fitness and healthy eating." The Healthy Kids, Healthy South Dakota initiative moved school districts and communities closer to that goal—and the goal of reducing childhood obesity throughout the state. Many of the grantee sites have sustained their programs beyond the funding period, and the cadre of trained, community-based advocates left behind will use their newfound knowledge to spread the goal of policy and environmental change for healthier lifestyles.

Much of the training, resources, and connections that assisted 17 sites in launching their projects now lives online, where it has the capacity to guide many more sites as they strive to create healthier environments for young people.

Healthy Kids, Healthy Utah

A brief examination of Utah's childhood obesity school policy development

The *Healthy Kids, Healthy Utah* initiative tackled two tough school lessons: Physical activity isn't just for PE class, and candy isn't the best reward for good behavior. To guide teachers, a team of health, education, and government officials, in partnership with the Utah Parent Teacher Association (PTA), developed training modules and a policy on non-food incentives. The initiative also focused on major recruiting for the state's Gold Medal Schools program, which was established by former Governor Jon Huntsman and designed to highlight policy and environmental changes that help students eat healthy, be active, and avoid tobacco. This push led to nearly 775 new local school policies being developed and implemented.

The Big Picture

The initiative directed much of its attention to Davis County, just north of Salt Lake City. The school system there already had a Healthy Lifestyles Coordinator, plus a good relationship with the local health department. Officials considered it a promising location to gear up for a state recommendation that schools give 3rd- through 6th-grade students 150 minutes of structured, sustained physical activity weekly.

One of the initiative's overarching goals was to enroll all county elementary schools in the Gold Medal Schools program, with special assistance to those schools with substantial populations of low-income students. As part of Healthy Kids, Healthy Utah, every participating school received a mentor to help assess—and improve—its policies affecting student and staff wellness.

Three schools were picked to pilot the best ideas for incorporating the expanded minutes into academic instruction, physical education, recess, and other school time. ("Five-minute energizers" were a particular favorite. During a spelling lesson, for example, a child who completed a word might skip to the center of the classroom to pick up a beanbag.)

And planners teamed with the state PTA to craft a policy on non-food rewards in the classroom. A companion booklet, *You Did It! How to Reward and Motivate Kids Without Using Food*, was published with ideas for school and home settings.

Step by Step

The state Department of Health officially oversaw the initiative's projects, though the state Office of Education and coordinators from the Gold Medal Schools program were centrally involved.

Officials from the Davis County Health Department and the Davis School District met with principals from each local elementary school to recruit them for the program. Those who signed on were provided technical assistance and other support as their effort got under way.

Davis school administrators also worked with state health and education officials to develop training sessions on how to

increase physical activity time. Nearly 600 teachers and playground supervisors attended trainings throughout the year. Their counterparts at the three pilot schools were surveyed about the strategies they had used and that feedback was shared at a conference of all Utah school districts.

Meanwhile, the policy team moved forward on the PTA non-food incentive resolution. Numerous meetings and presentations with top association leaders and members preceded its adoption in spring 2008.

Making a Difference

The Gold Medal push almost doubled the program's numbers in Davis County—to 43 out of 57 elementary schools, up from 23 at the initiative's start. In concert with teacher turnout at the physical activity training sessions and the 314 new local school policies developed and currently being implemented, the increase seemed a favorable portent of changes to come in many students' school environment.

The PTA resolution passed, albeit with weaker language that encouraged but did not ban non-food rewards. Yet debate over the issue sparked widespread discussion statewide, and growing numbers of parents and teachers now understand that there are healthier ways to recognize good behavior and hard work. The 44-page booklet suggesting a variety of alternative incentives was sent to all Utah elementary schools and posted on a state health department Web site.

The Healthy Kids, Healthy Utah initiative benefited from the close collaboration of local and state agencies as well as the inclusion of partners such as the state PTA. Its approach was to encourage rather than require, and the true impact of that course will become clearer as more Utah schools step up to the 150-minute physical activity line—and step away from the candy, cookies, and cupcakes of classrooms gone by.

Healthy Kids, Healthy Virginia focused on improving the health habits of at-risk students via two prominent state assessments of nutrition, physical activity, and fitness. By awarding mini-grants to schools that previously participated in the state assessment, the initiative brought local school districts and health departments together to work on sustained obesity prevention efforts. The singular focus helped schools evaluate past problems and determine their most effective solutions, which have since been shared statewide as replicable model strategies. Nearly all the schools saw significant improvements in how they and their students measured up.

The Big Picture

The initiative directed funding toward low-income schools where students are most at risk for obesity. Participating districts, in partnership with local health departments, determined which prevention activities they undertook, but all were intent on the same outcome: improved performance on both the Governor's Nutrition and Physical Activity Scorecard and the Virginia Wellness Related Fitness Test.

The Scorecard, a voluntary incentive program, awards points to schools based on their implementation of best practices in physical education, nutrition education, nutrition standards for foods, and activities to promote student wellness. The Fitness Test, a voluntary assessment tool that helps schools measure student's fitness levels, gauges students' aerobic capacity, strength, endurance, flexibility, and body composition. Both are integral components of the state's broader efforts to improve Virginians' health.

Funding for this effort came at an opportune moment for Virginia. In 2006, Governor Tim Kaine's Health Reform Commission identified obesity prevention as a top state priority and recommended greater school involvement in the Scorecard and Fitness Test to improve children's wellness. The following year, at the governor's urging, the Virginia General Assembly passed legislation requiring the state's health and education departments to work together to combat obesity and other health conditions affecting school-age children.

In 2009, the legislature expanded the mission of the Virginia Tobacco Settlement Foundation, a political subdivision focused on youth tobacco use prevention, to include childhood obesity prevention. The legislature also authorized the foundation's name change to Virginia Foundation for Healthy Youth (VFHY) to better reflect its mission. VFHY will work with communities and policy makers throughout the state to implement a comprehensive strategy to reduce the number of children who are overweight and obese.

Step by Step

As part of this initiative, the state health and education departments created the Childhood Obesity Prevention Grants program. Funding of up to $30,000 was awarded to school systems based on demonstrated need and previous participation in the Scorecard assessment. Schools were eligible to apply if their previous Scorecard tallies fell below a certain threshold; if at least 40 percent of their students were eligible for free or reduced-price meals; and if the adult obesity rate in their local health district exceeded the state average of 25.1 percent.

Fifteen school systems competed for grants. The five districts picked were from virtually every corner of the state: Prince William, from the Washington, D.C., suburbs; Harrisonburg and Roanoke City, along the Blue Ridge and Appalachian mountains; Dickenson, in far southwestern Virginia; and Danville, near the North Carolina border.

The 20 participating schools from those jurisdictions used their mini-grants in many different ways. Some created more opportunities for fun physical activity for students and families. Others increased the availability of healthy foods in schools. Several wove health and physical education into academic subjects.

Making a Difference

Based on the schools' experience, the state health and education departments developed a blueprint of particularly promising and replicable practices.

Among these is expanded use of the Scorecard and Fitness Test, which proved to be very effective at pushing positive change in school environments. At the one-year mark, for example, 17 of the 20 initiative schools had earned more points on the Scorecard than during the previous year. Seven placed high enough, based on the Scorecard's rigorous criteria, to earn silver or bronze Governor's Awards for the first time.

Just as critical was the close collaboration of education and health officials, as well as the cooperation of teachers and staff at the schools themselves. Indeed, the program showed the importance of sustained engagement by all those with a stake in children's well-being. This collaboration continued to pay dividends as the state rolled out its comprehensive CHAMPION Obesity Prevention Plan in 2009.

Healthy Kids, Healthy Virginia revealed the elements that can turn potential promise into documented success, helping to lead to healthier students and the prevention of childhood obesity.

Healthy Kids, Healthy West Virginia

A brief examination of West Virginia's childhood obesity school policy development

All incoming kindergartners in the Mountain State's public schools now receive a comprehensive wellness check through the Kids First Screening Initiative, a central element of *Healthy Kids, Healthy West Virginia*. An alliance of public agencies and private companies pays the cost so that no child goes without an exam if a family is uninsured. Beyond promoting better health child by child, the screening provides an opportunity to enroll eligible children in Medicaid or other public coverage and connect them with a medical home. It also allows for crucial data collection, including BMI information, which will help state officials anticipate program and resource needs.

The Big Picture

Beginning with the 2008–2009 school year, any youngster entering public kindergarten in West Virginia must receive a HealthCheck exam that assesses oral health; vision; hearing; speech and language development; and height, weight, and BMI.

The requirement applies to about 20,000 children annually, and though most will be screened by their pediatricians, the initiative has ensured that those without insurance will be enrolled in Medicaid if eligible or covered by other public insurance programs. Uninsured children needing follow-up referrals will be assisted through agreements between school systems and health care provider networks.

Kids First is administered through the Department of Health and Human Resources, which is responsible for coordinating West Virginia's obesity prevention efforts—one of Governor Joe Manchin's top priorities. The department developed the initiative in partnership with other agency divisions, the state's Department of Education and Department of Administration, and private insurers such as Mountain State Blue Cross Blue Shield.

Step by Step

Implementation of the screening initiative benefited from strong support by Governor Manchin, demanded policy action at state and federal levels of government, required collaboration with schools systems and providers across West Virginia, and secured the cooperation of public and private insurers.

The state Board of Education, for example, had to amend school entrance requirements. Months of meetings took place before the state Medicaid and Children Health Insurance Program (CHIP), the Public Employees Insurance Agency, and private payers consented to pay the cost of the new exam for their enrollees.

The state also needed permission from the Centers for Medicaid & Medicare Services to secure a waiver that would allow CHIP administrative dollars to be used on behalf of uninsured children whose families could not afford the exam.

Trainings were held with regional school and health agencies to help develop the agreements key to local implementation and to train local school and health personnel in how to administer the program, including how to explain the requirement to parents, refer families to providers, and report data to the state. Webinars, in-person workshops, technical assistance, and a Kids First Web site were developed.

Outreach to parents aimed to educate them about the new HealthCheck exam and preventive health care practices while encouraging them to secure a medical home for their children.

Making a Difference

Kids First made an immediate difference, connecting families to primary care providers and extending coverage to uninsured children. But the coalescing of many public and private interests around this unusual approach to improved children's health is likely to have other equally significant ramifications.

For the first time, the state can track BMI and other important health indicators in children. Eventually, it will be able to correlate that data with larger health trends and educational outcomes. And because of the partnerships formed or strengthened, the initiative's impact will grow.

A $1.5 million commitment by the Blue Cross Blue Shield organization will allow the screening mandate to be extended to three additional grades in the upcoming years. Moreover, the state chapter of the American Academy of Pediatrics soon will launch a Pediatric Obesity Prevention Pilot project that will provide BMI screening for at-risk youth at every well-child visit through age 18.

The Healthy Kids, Healthy West Virginia program has triggered the start of a cultural shift, organizers believe—one focused on preventive health and sustained for the long-term through systemic policy change.

The *Healthy Kids, Healthy Wisconsin* initiative used an established award program to drive policy change in schools statewide. The Governor's School Health Award recognizes improvements in nutrition and physical activity environments. Through the *Healthier Wisconsin Schools Project*—a 20-school pilot project and evaluation of this award program—the initiative determined whether participation in the School Health Award accelerated improvements. Armed with that information, an interdisciplinary panel of policy officials and experts was convened to consider future legislative measures that address student wellness and childhood obesity. Its recommendations are being carried forward by the state's obesity prevention coalition.

The Big Picture

The Healthy Kids, Healthy Wisconsin initiative sought a micro as well as macro focus—school-based change and statewide policy prioritization. Both were feasible because of several years of work on local and state levels to lay the groundwork for children's health and obesity prevention.

One illustration of previous progress is the state nutrition and physical activity plan, which provides a framework for policies and programming designed to improve all residents' wellness. But officials have devoted special attention to school-age children through efforts such as the statewide *Movin' and Munchin' Schools* activity and nutrition program and the Wisconsin *Homegrown Lunch Project*, aimed at getting locally grown produce into schools.

Healthy Kids, Healthy Wisconsin, headed by the state Department of Public Instruction, concentrated on the Governor's School Health Award program. Governor Jim Doyle and the Wisconsin schools superintendent established the program in 2005 to spotlight exemplary policies and programs; the question was whether the award helps effect change as public schools and school districts aim for recognition.

More broadly, the charge of the interdisciplinary panel, which included representatives of Doyle's office, the state Department of Public Instruction, the state Department of Health Services, and outside experts, was to develop policy recommendations and a detailed plan for moving the policy agenda from paper to reality.

Step by Step

Officials recruited 20 schools from more than 100 registered in the 2007–2008 Governor's School Health Award program; each agreed to participate in the pilot project, plus a multi-year assessment. In return, each was offered one-on-one consultation, technical assistance resources, and staff professional development.

The assessment component involved telephone interviews and follow-up calls with relevant staff. Schools were asked to rate the degree of change in their wellness policies and a variety of nutrition and physical activity areas.

Meanwhile, the interdisciplinary panel was at work. It held four meetings to develop policy recommendations and a fifth session to set priorities and identify strategies for best implementing the top proposals. The group agreed to immediately recommend increased access to fruits and vegetables in schools and development of district-level school health advisory councils. For both policy approaches it delineated the organizational issues, likely allies, expected opponents, targets, and tactics that would have to be considered.

A report summarizing the panel's conclusions was produced and shared with a special committee on health formed by the legislature to address, among other things, childhood obesity.

Making a Difference

State officials declared the *Healthier Wisconsin Schools Project* an overall success. Through the pilot project and evaluation, it determined that the Governor's School Health Award indeed improves school environments by helping administrators create strong policies and programs supporting student wellness.

Of the 20 pilot schools, 13 completed all required activities, and all noted positive changes in their efforts to enhance student health, boost parent and community participation, and increase staff commitment. State officials are using their stories to encourage additional schools to apply, and the state has pledged to continue the program with staff, financial resources, and technical assistance for future participants.

And the progress that those schools make, individually and collectively, will only be bolstered by future state policy actions. The recommendations of the interdisciplinary panel created through Healthy Kids, Healthy Wisconsin will remain part of the agenda of the Wisconsin Partnership for Activity and Nutrition. The partnership and other advocate groups hope to maintain the momentum built through this initiative and help carry the proposed policies through the legislature and on to the governor for signature.

Moving Forward

States have long been considered incubators of national reform, and governors, as the CEOs of their states, are uniquely positioned to bring about policy change for successful childhood obesity prevention. In 2007, the NGA Center launched the Healthy Kids, Healthy America program, which was designed to put childhood obesity on the radar screens of governors, to motivate state action, and to encourage interagency collaboration within states.

Many governors recognize the need for a multi-sector obesity prevention strategy even as they realize that efforts to date have not fully addressed the epidemic. Still, governors from coast to coast are committed to improving the health of our nation's children by identifying the policy practices that work best at the state level to prevent childhood obesity.

This compendium of state actions demonstrates that many governors are elevating obesity prevention policies and programs by building wellness practices into child care settings and schools, as well as by establishing statewide policy planning and prioritization to coordinate public and private-sector efforts, thereby making the most of limited resources. The willingness of governors to proactively address childhood obesity through state-level policy innovations has accelerated national progress and will ultimately help today's children and youth grow into healthy and productive adults.

Notes

[1] Levi, J., S. Vinter, L. Richardson, R. St. Laurent, L.M. Segal. July 2009. *F as in Fat: How Obesity Policies Are Failing in America 2009*. Washington, D.C.: Trust for America's Health. http://www.rwjf.org/files/research/20090701tfahfasinfat.pdf. Accessed Aug. 2009.

[2] Ibid.

[3] U.S. Centers for Disease Control and Prevention. 2005. *QuickStats: Prevalence of Overweight Among Children and Teenagers, by Age Group and Selected Period-United States, 1963–2002.*http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5408a6.htm. Accessed June 2009.

[4] Anderson, S.E., and R.C. Whitaker. 2009. Prevalence of obesity among U.S. preschool children in different racial and ethnic groups. *Archives of Pediatric and Adolescent Medicine* 163(4):344–8.

[5] National Association of Child Care Resource and Referral Agencies. Child Care in America: 2008 State Fact Sheets. http://www.naccrra.org/policy/docs/childcareinamericafactsheet.pdf.

[6] National Center for Health Statistics. *Prevalence of Overweight Among Children and Adolescents: United States, 2003–2004*. http://www.cdc.gov/nchs/data/hestat/overweight/overwght_child_03.htm.

[7] American Academy of Pediatrics, Committee on Nutrition. "Prevention of Pediatric Overweight and Obesity." *Pediatrics*, 112(2): 424–430, August 2003; and Guo, S., and Chumlea, W. "Tracking of Body Mass Index in Children in Relation to Overweight in Adulthood." American Journal of Clinical Nutrition, 70(1): 145S-148S, July 1999.

[8] U.S. Centers for Disease Control and Prevention. *Third National Health and Nutrition Examination Survey (NHANES III), 1988–94.*ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/Datasets/NHANES/NHANESIII/2A/YOUTHK-acc.pdf. Accessed June 2009.

[9] Calle, E., C. Rodriguez, K. Walker-Thurmond, and M.J. Thun. 2003. Overweight, obesity, and mortality from cancer in a prospectively studied cohort of U.S. adults. *The New England Journal of Medicine* 348(17):1625–38.

[10] Shonkoff, J.P., W.T. Boyce, and B.S. McEwen. 2009. Neuroscience, molecular biology, and the childhood roots of health disparities. *Journal of the American Medical Association* 301(21):2252–2259.

[11] High-quality programs include a combination of some of the following characteristics: highly skilled teachers; small class sizes and high adult-to-child ratios; age-appropriate curricula and stimulating materials in a safe physical setting; a language-rich environment; warm, responsive interactions between staff and children; and high and consistent levels of child participation. (National Scientific Council on the Developing Child. *A Science-Based Framework for Early Childhood Policy.* http://www.developingchild.net/pubs/persp/pdf/Policy_Framework.pdf. Accessed July 2009.)

[12] Flynn, M., and C. D. Hayes. *Blending and Braiding Funds to Support Early Care and Education Initiatives.* http://www.financeproject.org/Publications/FP%20Blending%20Funds%201_24.pdf. Accessed June 2009.

[13] Mitchell, A., L. Stoney, and H. Dichter. *Financing Child Care in the United States: An Expanded Catalog of Current Strategies.* http://sites.kauffman.org/pdf/childcare2001.pdf. Accessed June 2009.

[14] Federal Interagency Forum on Child and Family Statistics. *America's Children in Brief: Key National Indicators of Well-Being, 2008*. Federal Interagency Forum on Child and Family Statistics, Washington, DC: U.S. Government Printing Office.

[15] U.S. Congress. *No Child Left Behind Act of 2001*. PL 107–110. 107th Cong. (Jan. 8, 2002). http://www.ed.gov/policy/elsec/leg/esea02/107–110.pdf. Accessed July 2009.

[16] Dunkle, M.C., and M.A. Nash, eds. *Beyond the Health Room*. Washington, D.C.: Council of Chief State School Officers, Resource Center on Educational Equity; 1991.

[17] Action for Healthy Kids. *The Learning Connection: The Value of Improving Nutrition and Physical Activity in Our Schools.* http://www.actionforhealthykids.org/resources/files/learning-connection.pdf. Accessed June 2009.

[18] Ibid.

[19] High-quality programs include a combination of some of the following characteristics: highly skilled teachers; small class sizes and high adult-to-child ratios; age-appropriate curricula and stimulating materials in a safe physical setting; a language-rich environment; warm, responsive interactions between staff and children; and high and consistent levels of child participation. (National Scientific Council on the Developing Child. *A Science-Based Framework for Early Childhood Policy.* http://www.developingchild.net/pubs/persp/pdf/Policy_Framework.pdf. Accessed July 2009.)

[20] National Center for Health Statistics. *Prevalence of Overweight Among Children and Adolescents: United States, 2003–2004.* http://www.cdc.gov/nchs/data/hestat/overweight/overwght_child_03.htm.

[21] American Academy of Pediatrics, Committee on Nutrition. Prevention of pediatric overweight and obesity. http://aappolicy.aappublications.org/cgi/content/full/pediatrics;112/2/424. Accessed June 5, 2009.

[22] U.S. Centers for Disease Control and Prevention. T*hird National Health and Nutrition Examination Survey (NHANES III), 1988–94.* ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/Datasets/NHANES/NHANESIII/2A/YOUTHK-acc.pdf. Accessed June 2009.

[23] Calle, E., C. Rodriguez, K. Walker-Thurmond, and M.J. Thun. 2003. Overweight, obesity, and mortality from cancer in a prospectively studied cohort of U.S. adults. *The New England Journal of Medicine* 348(17):1625–38.

[24] Shonkoff, J.P., W.T. Boyce, and B.S. McEwen. 2009. Neuroscience, molecular biology, and the childhood roots of health disparities. *Journal of the American Medical Association* 301(21):2252–2259.

[25] Flynn, M., and C. D. Hayes. *Blending and Braiding Funds to Support Early Care and Education Initiatives*. http://www.financeproject.org/Publications/FP%20Blending%20Funds%201_24.pdf. Accessed June 2009.

[26] Mitchell, A., L. Stoney, and H. Dichter. *Financing Child Care in the United States: An Expanded Catalog of Current Strategies.* http://sites.kauffman.org/pdf/childcare2001.pdf. Accessed June 5, 2009.

[27] U.S. Congress. *No Child Left Behind Act of 2001*. PL 107–110. 107th Cong. (Jan. 8, 2002). http://www.ed.gov/policy/elsec/leg/esea02/107–110.pdf. Accessed July 2009.

[28] Dunkle, M.C., and M.A. Nash, eds. *Beyond the Health Room*. Washington, D.C.: Council of Chief State School Officers, Resource Center on Educational Equity; 1991.

[29] Action for Healthy Kids. *The Learning Connection: The Value of Improving Nutrition and Physical Activity in Our Schools.* http://www.actionforhealthykids.org/resources/files/learning-connection.pdf. Accessed June 2009.

[30] Ibid.

NGA CENTER DIVISIONS

The NGA Center is organized into five divisions with some collaborative projects across all divisions.

- Education provides information on early childhood, elementary, secondary, and postsecondary education, including teacher quality, high school redesign, reading, access to and success in postsecondary education, extra learning opportunities, and school readiness.

- Health covers a broad range of health financing, service delivery and policy issues, including containing health care costs, insurance coverage trends and innovations, state public health initiatives, obesity prevention, Medicaid and long-term care reforms, disease management, health information technology, health care quality improvement, and health workforce challenges.

- Homeland Security & Technology supports the Governors Homeland Security Advisors Council and examines homeland security policy and implementation, including public health preparedness, public safety interoperable communications, intelligence and information sharing, critical infrastructure protection, energy assurance, and emergency management. In addition, this unit assists governors in improving public services through the application of information technology.

- Environment, Energy & Natural Resources analyzes state and federal policies affecting energy, environmental protection, air quality, transportation, land use, housing, homeownership, community design, military bases, cleanup and stewardship of nuclear weapons sites, and working lands conservation.

- Social, Economic & Workforce Programs focuses on policy options and service delivery improvements across a range of current and emerging issues, including economic development, workforce development, employment services, criminal justice, prisoner reentry, and social services for children, youth, and low-income families.

NGA Center for
BEST PRACTICES

John Thomasian, Director
NGA Center for Best Practices
444 N. Capitol Street, Suite 267
Washington, DC 20001
202.624.5300
www.nga.org/center