Shaping Kentucky’s Future
Policies to Reduce Obesity

Partnership for a Fit Kentucky 2009
Who Is This Report For?

This report is for Kentucky policy makers, leaders, administrators, advocates, health professionals and anyone who cares about the health and future of Kentucky citizens. It is designed to educate and inspire discussion. The policies are intended to be a blueprint for effective action to lower obesity rates in Kentucky.

Who We Are

The Partnership for a Fit Kentucky (PFK) is a public/private partnership with a wide range of partners that is continually growing. The mission of PFK is to support policy and environmental changes that promote healthy eating and active lifestyles. (See www.fitky.org for more details.) The PFK selected stakeholders (listed on page 5) to serve on an ad hoc advisory team to assess and select obesity prevention policies for Kentucky. Support for this project is provided by the Kentucky Department for Public Health and the Council of State Governments’ SCORE initiative, the latter of which is funded by the Robert Wood Johnson Foundation through its Leadership for Healthy Communities national program.
Kentucky Obesity Epidemic Cannot Be Taken Lightly

As the grim numbers in this report show, too many Kentuckians weigh too much. More than two-thirds of Kentucky adults are overweight or obese, and childhood obesity rates have tripled since 1980. Weight-related illnesses like diabetes and heart disease are on the rise—a third of the babies born in Kentucky in 2000 will develop diabetes in their lifetimes. From the overweight fourth grader who can’t reach down to tie his shoes to the business owner reeling from rising health care costs, this obesity epidemic affects every Kentuckian. It is an obstacle to educational improvement and economic growth. It stands in the way of the better quality of life we all want, especially for our children. It threatens our future.

But we can change that. Many factors combined to create the obesity crisis, and there are many public policy changes that will make physical activity and good nutrition more accessible to Kentuckians. In this report, the Partnership for a Fit Kentucky proposes eight policies that we believe will, if effectively implemented, begin to reduce the levels of obesity in our state.

**Increase Physical Activity and Physical Education in Schools**
It’s simple: Physical fitness = Healthier, more focused students

**Establish a Body Mass Index (BMI) Surveillance System for Youth**
A vital tool for fighting obesity

**Support Breastfeeding in the Workplace**
Breastfeeding = Lower health care costs and higher worker productivity

**Require Standards for Nutrition and Physical Activity in Licensed Child Care Centers**
Introducing healthy habits early helps prevent obesity

**Establish Complete Streets Policies**
Complete Streets fight obesity by making walking and biking safe and convenient
Require Menu Labeling at Fast Food and Chain Restaurants
Informed consumers make better food choices

Require Healthy Food in State Agencies
Government can fight obesity by practicing what it preaches

Provide Worksite Wellness Tax Credits to Businesses
Wellness programs improve workers’ health and employers’ bottom line

You’ll find full details on Kentucky’s obesity epidemic and the Partnership for a Fit Kentucky’s policy proposals in the following pages. We appreciate your interest in a health crisis that is real and requires bold and decisive action now.
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A student with type 2 diabetes and hypertension recently visited the school nurse’s office in a Kentucky elementary school. She tended to his needs and as he walked out of her office she noticed that his shoes were untied. She said, “You better tie your shoes so you don’t trip and hurt yourself.” He responded that he couldn’t tie his shoes. The nurse thought the student had probably always worn shoes with Velcro closures and never learned this basic skill. She began to show him how to make a knot. “I’m in 4th grade,” he said indignantly. “I know how to tie my shoes!” And then he lowered his voice and said, “I just can’t reach them.”

The bad news
This young man is certainly not alone. Many Kentucky children know what it’s like to walk in his shoes. Childhood obesity rates have tripled since 1980. More than 331,000 Kentucky children — one in every three — are seriously overweight or at risk of becoming overweight. Kentucky’s percentage of overweight children ranks third in the nation.

Obese children are developing diseases that were formerly seen only in adults. Type 2 diabetes, hypertension, heart disease and arthritis are now commonly seen in pediatric offices across Kentucky. A third of the babies born in Kentucky in 2000 will develop diabetes during their lifetimes. The negative psychological impact of obesity on children is both short and long-term. Up to 80% of overweight children will become overweight adults, leading to lifetimes of poor health. This is the first generation predicted to have shorter life spans than their parents.

The weight of Kentucky adults is also of great concern. Since 1991, adult obesity has nearly doubled in the state. More than two-thirds of Kentucky adults are overweight or obese. Eighty percent of Kentucky males fall in the unhealthy weight categories. We have the seventh-highest rate of overweight adults in the country. This translates into more diabetes, heart
disease, hypertension, stroke, cancer, arthritis, and even Alzheimer’s disease and dementia. Within the next decade, obesity-related disability is predicted to spur a 10-25% increase in the number of people in need of nursing home care.\textsuperscript{11}

The obesity epidemic also takes a toll on Kentucky’s economy. Obesity costs Kentucky $1.2 billion a year in health care expenses.\textsuperscript{12} An unhealthy work force that is expensive to insure and whose productivity is reduced by obesity related health problems hurts our state’s ability to draw new businesses. A recent analysis found that obese workers filed twice the number of workers’ compensation claims, had seven times higher medical costs from those claims, and lost thirteen times more days of work from work injury or work illness than non-obese workers.\textsuperscript{13} Obesity not only leads to increased absenteeism but also to “presenteeism,” the term for employees coming to work in poor health and performing far below par.\textsuperscript{14} In an increasingly competitive national and global economy, Kentucky’s economic performance is closely tied to its ability to maintain a healthy work force.

\textbf{The good news}

The causes and solutions of the obesity epidemic are becoming clearer as research and practice progress. Multiple factors created this crisis: food choices, changes in the food system, community design, school and work place nutrition and physical activity environments, economic constraints, family and home influences, limited time, marketing and advertising, psychology, life stages, and genetics. (See \textit{What’s Behind the Obesity Epidemic?} on page 39.) Because the causes are found at so many levels, addressing the obesity epidemic must be a shared endeavor. Individuals, families, communities, schools, employers, businesses, insurers and government all have a role to play.

The Partnership for a Fit Kentucky, comprised of over 50 community leaders, published \textit{The Kentucky Nutrition and Physical Activity Action Plan 2005}.\textsuperscript{15} This comprehensive state plan outlines strategies to reduce obesity and calls for involvement from all sectors. This report, \textit{Shaping...}
Kentucky's Future, is a companion piece to the state plan and focuses specifically on the role of government in designing and adopting policies to make healthy food and safe physical activity environments more accessible to Kentuckians.

The Centers for Disease Control and Prevention recommends policy change as one of the most effective strategies for making significant changes in obesity at the population level. Effective obesity policy promotes changes in the environment that help individuals take responsibility for improving their own nutrition and activity habits. For example, providing calorie information on fast food menus helps consumers make healthier food choices.

One reason states have been slow to address this crisis is because it is often seen as a matter of personal responsibility. From this perspective, individuals make decisions about food and activity and are to blame for their poor choices. While personal responsibility is a key part of the equation, obesity experts agree that there are many factors beyond individual control that have also contributed to the obesity epidemic. These include lack of access to healthy foods in neighborhoods, work places and schools, safe and accessible places to exercise, and opportunities to be physically active during the school and work day.

Many states have developed policy portfolios that chart a deliberate and effective course to stem the tide of the obesity crisis. The Council of State Governments has developed the Southern Collaborative on Obesity Reduction Efforts (SCORE) to focus on the obesity belt in the southern USA. As part of this initiative the Partnership for a Fit Kentucky convened an advisory team to research and assess a list of obesity prevention policies. The group selected eight as sound, feasible and timely for the state of Kentucky. Eight additional polices also hold promise for reducing obesity and are discussed briefly under Obesity Prevention Policies for Further Consideration. A common theme of the policies reflects the prevailing wisdom on what constitutes effective obesity policy, i.e. make the healthy choice, the easy choice. For example, serving healthy foods at events and programs paid for with Kentucky tax dollars, or making streets and roads safe for walking and biking will help make healthy habits a seamless part of people’s lives.
It should be noted that Kentucky has received national attention for some of its current obesity prevention policies. The school nutrition bill passed in 2005 (SB172) prohibits the sale of soft drinks and sugary, fatty snack foods during the school day. As a result of this legislation, Kentucky received the highest grade, an A-, on a national school nutrition report card. Since 1972, Kentucky has imposed a tax on the sale of soft drinks, candy and gum that generates $34 million a year for the state’s general fund. Legislation passed in 2006 and 2007 gives women the right to breastfeed in public and excuses lactating women from jury duty.

This policy portfolio builds on these existing laws by recommending eight other common sense policies shown to reduce obesity. In the following pages, these policies are considered more thoroughly, including the rationale for each of them, current status in Kentucky, notable policies in other states, and resources. The policies are offered as a blueprint for Kentucky policy makers, health advocates and citizens for reshaping Kentucky.

1. Increase Physical Activity and Physical Education in Schools
2. Establish a Body Mass Index (BMI) Surveillance System for Youth
3. Support Breastfeeding in the Workplace
4. Require Standards for Nutrition and Physical Activity in Licensed Child Care Centers
5. Establish Complete Streets Policies
6. Require Menu Labeling at Fast Food and Chain Restaurants
7. Require Healthy Food in State Agencies
8. Provide Incentives for Worksite Wellness

This policy portfolio then presents additional ideas for consideration under the section of Obesity Prevention Policies for Further Consideration.
Policies to Reduce Obesity in Kentucky

A deliberate plan of action to guide decisions and achieve rational outcomes
Increase Physical Activity and Physical Education in Kentucky Schools

It’s simple:
Physical fitness = Healthier, more focused students

Recommended Policy
Require daily physical activity for all Kentucky public school students K-8. Increase physical education requirements in elementary, middle and high schools.

Rationale
• Kentucky has the third highest rate of overweight youth in the nation. ¹⁷
• Kentucky is the fourth most sedentary state in the nation. ¹⁸
• Providing physical activity for students has been shown to improve “on task behavior” during academic instruction. ¹⁹
• Students who perform well on measures of physical fitness tend to score higher on state reading and math exams, regardless of socioeconomic status or gender. ²⁰
• High school students who participate in physical education five days a week are 28% less likely to be overweight adults. ²¹
• During the school week, children spend almost half of their waking hours in a school setting. It seems reasonable to include 30 minutes of physical activity during this six to eight hour period.
• There is broad public support for this idea. In the 2004 Kentucky Obesity Forums, “increasing physical activity in schools” was ranked as the number one priority in nine forums attended by 1300 people across the state. In a 2008 Partnership for a Fit Kentucky survey, 84% of the 885 respondents ranked this issue in the top four most important policies to combat obesity in their communities.

Current status in Kentucky
Physical activity refers to playing at recess, before and after school activities, and “energizers” that integrate movement into the classroom.
Physical education (P.E.) refers to a structured curriculum taught by a certified physical education instructor.

Currently there are no requirements for physical activity or physical education in Kentucky public elementary schools. Though most elementary schools offer both, some do not and there is a great deal of variation in the amount and quality from school to school. Elementary schools are allowed to use up to 30 minutes of curriculum time per day for physical activity. Some Kentucky teachers take recess away from students as a form of punishment.

Public middle school students in Kentucky are not required to take physical education, though most students take one semester during this two to three year period. Kentucky high school students are required to have one-half unit of physical education to graduate. Middle and high schools almost never offer recess to students.

Physical activity bills were filed in the 2006, 2007 and 2008 Kentucky General Assembly sessions but were not passed.

Two bills were introduced for the 2009 Kentucky legislative session. Representatives Addia Wuchner and Tom Burch were co-sponsors of HB 11, and Senator Katie Stine sponsored SB 6. Both bills proposed that schools provide for at least 30 minutes of structured, moderate to vigorous physical activity per day, or 150 minutes per week in a minimum of 10 minute intervals. Schools can incorporate physical activity into the classroom, structured recess or by other means. HB 11 targets students K-5th grade, and urges grades 6-8 to adopt similar policies. SB 6 covers public preschool to 8th grade, and prohibits exclusion from structured physical activity as a form of discipline.

**Notable policies in other states**

Eleven states passed new P.E. requirements in 2007 and 2008.22

**Arkansas** added 60 minutes of P.E. per week and 90 minutes of physical activity per week, which can include recess or P.E.

**Oklahoma** increased P.E requirements from 60 minutes to 120 minutes per week in elementary schools.
Florida requires at least 30 consecutive minutes of daily P.E. for grades K–6.

Virginia requires school districts to provide 150 minutes of physical fitness programs with a goal of 150 minutes per week for all students.

Texas State Board of Education requires students in elementary schools to participate in physical activity for a minimum of either 30 minutes daily or 135 minutes weekly.

Mississippi implemented a daily physical activity requirement for K-8th grades by Executive Order of the governor.

Resources

• F as in Fat: How Obesity Policies are Failing in America. Trust for America’s Health 2008
  www.healthyamericans.org/reports/obesity2008/

• Model Local School Wellness Policies on Physical Activity and Nutrition. National Alliance for Nutrition and Activity
  www.schoolwellnesspolicies.org/resources/NANAWellnessPolicies.pdf

• Physical Activity for Youth Policy Initiative. National Coalition for Promoting Physical Activity
  www.ncppa.org/Physical%20Activity%20For%20Youth%20Policy%20Initiative.pdf
Establish a Body Mass Index (BMI) Surveillance System for Youth

A vital tool for fighting obesity

Body mass index (BMI) is a simple calculation of height and weight and when used for children also takes age and gender into account. It is considered a better assessment of obesity than weight alone and is widely used to identify obesity within a population. BMI surveillance refers to collecting BMI data regularly with public reporting of the aggregate data. BMI assessment refers to individual measurements of children.

Recommended Policy
Establish a statewide BMI surveillance system for Kentucky youth. Use the required school health entrance forms for kindergarten and 6th grade. Clinicians can calculate the BMI at the child’s medical home and discuss with the parent or guardian. BMI data is entered into student information system of the Kentucky Department of Education Infinite Campus data base and reports are generated using aggregate data.

Rationale
• Collecting BMI data can serve to expand the understanding of childhood obesity trends and determine the efficacy of obesity prevention programs.
• Height and weight is currently on the required health entrance form for kindergarten and 6th grade students in Kentucky public schools. Having clinicians calculate the BMI from this data encourages physicians to educate families about healthy weight. Keeping the assessment in the child’s medical home is more appropriate than having children screened in schools where there are a number of concerns: privacy protection, accurate measurement, effective parental notification and added work for schools.
• The recommended plan employs existing systems: the required health entrance forms and the Infinite Campus data base.
• This method provides more accurate data than currently exists in Kentucky. Studies comparing the Youth Risk Behavior Survey (YRBS) data with measured heights and weights show that the self reported data of the YRBS typically underestimates the prevalence of childhood overweight.

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**Current status in Kentucky**
Though a small number of schools and districts have calculated student BMI data, it is not collected statewide.

**Notable polices in other states**
Seventeen states have passed BMI screening requirements or other weight-related assessments in schools. 24

**Florida** statute requires school health programs to screen students for growth and development. BMI is encouraged as part of these screenings for all students in 1st, 3rd, 6th and, optionally, 9th grades.

The **Illinois** Department of Health is required to collect data measuring obesity as part of the mandatory health examination required for students to attend public schools.

The **West Virginia** legislature calls for schools to report BMI measurements in an effort to monitor the effect of requiring each child to participate in physical education classes.

**Arkansas** pioneered a program to systematically assess the weight of every public school student each year and report the results to parents as part of a multi-pronged initiative established by the General Assembly. The program has shown success in raising parental awareness of children’s weight status. The initiative was chosen one of 10 winners of the *Innovation in Prevention Awards* presented by the U.S. Department of Health and Human Services.

**Resources**


**State Actions to Promote Nutrition, Increase Physical Activity and Prevent Obesity: A 2006 First Quarter Legislative Overview.** NetScan's Health Policy Tracking Service. www.rwjf.org/files/research/NCSL%20FinalApril%202006%20Report.pdf
Breastfeeding = Lower health care costs and higher worker productivity

Recommended Policy
Require businesses to provide space and flexible scheduling for breastfeeding or expressing milk in the workplace.

Rationale
- Breastfeeding plays a foundational role in preventing weight problems in children.\textsuperscript{25} Children fed mainly on breast milk for the first 6 months of life are 22% less likely to be overweight by age 14.\textsuperscript{26}
- The greatest protection against obesity is seen when breastfeeding continues for more than three months.\textsuperscript{27}
- Women who exclusively breastfeed for 6 months are more likely to have a decrease in body fat mass and improved weight loss.\textsuperscript{28}
- In 2004, only 59% of all Kentucky infants were breastfed at birth, compared with 73% of infants nationwide. At six months only 26% of Kentucky babies were still being breastfed compared to 41% of babies nationally.\textsuperscript{29}
- Mothers are the fastest-growing segment of the U.S. work force. Approximately 70% of employed mothers with children younger than 3 years work full time. One-third of these mothers return to work within 3 months after birth and two-thirds return within 6 months. Given the substantial presence of mothers in the work force, there is a strong need to establish lactation support in the workplace.\textsuperscript{30}
- Working outside the home is linked to a shorter duration of breastfeeding and intentions to work full time are associated with lower rates of breastfeeding initiation and shorter duration.\textsuperscript{31}
- Barriers to breastfeeding identified in the workplace include a lack of flexibility in the work schedule for milk expression, lack of clean and private accommodations to pump or store breast milk, and concerns about support from employers and colleagues.\textsuperscript{32,33}
• Well-designed workplace lactation support programs increase breastfeeding rates and reduce health care costs for businesses.  
• Encouraging breastfeeding has many benefits for employers including less illness among the breastfed children of employees, reduced absenteeism to care for sick children, lower health care costs (an average of $400/baby over the first year), improved employee productivity and improved ability to attract and retain valuable employees.  
• Creating basic accommodations for lactating women can cost businesses next to nothing, yet the return on investment can be significant. One company conservatively estimated a return on investment for their worksite lactation support program at 2.8 to 1.  
• A policy supporting worksite lactation will help to insure equal access to accommodation regardless of employee position.

**Current status in Kentucky**

Kentucky passed two bills related to breastfeeding mothers in the 2006 and 2007 legislative sessions. Mothers have the right to breastfeed in public and may be excused from jury duty while breastfeeding an infant.

The Cabinet for Health and Family Services established a worksite lactation room at 275 E. Main Street in Frankfort in 2005. Requests have been made for similar facilities in other state office buildings in Frankfort.

**Notable policies in other states**

Twenty one states have laws related to breastfeeding in the workplace. Many make requirements for accommodation, yet have no enforcement or ombudsman mechanisms or penalties for non-compliance. Some laws are placed within public health statutes, some within labor or civil rights statutes (which often have stronger capacity for enforcement).  

**Tennessee** requires employers to provide daily unpaid break time for a mother to express breast milk for her infant child. Employers are also required to make a reasonable effort to provide a private location, other than a toilet stall, in close proximity to the workplace for this activity.

**Indiana** requires that state and political subdivisions make reasonable efforts to provide daily paid break time and a private location (not a toilet) for employees to express breast milk and a refrigerator or other cold storage for keeping breast milk. Employers with 25 or more employees are also to make reasonable efforts to provide the same.
Oregon also requires reasonable accommodation for clean and private breast milk expression and up to 30 minutes of unpaid break time per four work hours to express breast milk or breastfeed. Accommodations are specifically required for school teachers. The Bureau of Labor and Industries has jurisdiction to implement and enforce, which places breastfeeding accommodation and breaks as equivalent with other wage and hour law and which provides employers with a Technical Assistance framework with which they’re already familiar.

Texas passed legislation to standardize basic components of workplace support for breastfeeding. Employers that ensure these components are in place are eligible to receive Mother-Friendly Workplace designation from the Texas Department of Health.

California passed the Breastfeeding at Work law, which encourages all employers to ensure that employees are provided with adequate facilities for breastfeeding or expressing milk. In 2002, the state passed Lactation Accommodation, which expands prior workplace provisions to require adequate break time and space for breastfeeding or milk expression, with a violation penalty of $100.

Resources

The Business Case for Breastfeeding. U.S. Health Resources and Services Administration Maternal and Child Health Bureau

United States Breastfeeding Committee Issue Paper: Workplace Breastfeeding Support
www.usbreastfeeding.org/Issue-Papers/Workplace.pdf

Texas Mother-Friendly Worksite Program Texas Department of State Health Services
www.dshs.state.tx.us/wichd/lactate/mother.shtm

Investing in Maternal and Child Health: An Employer’s Toolkit.
Center for Prevention and Health Services, National Business Group on Health; 2007.
Introducing healthy habits early helps prevent obesity

Recommended Policy
Require nutrition and physical activity standards for licensed child care centers that address healthful eating, physical activity and media use. Policies should also address nutrition and physical activity training for staff.

Rationale
• Approximately 1 of every 3 children aged 2 to 5 years in Kentucky is seriously overweight or at risk of being overweight. 39
• Once a child becomes overweight, it is very difficult to reverse. Prevention is far more effective than treatment.
• Child care centers are in a unique position to support and facilitate healthy habits for young children. Child care participation in the United States is at an all-time high. Child care providers are sharing responsibility for a large and growing number of children during important developmental years.
• Approximately 178,000 children are in some kind of out of home care on daily basis in Kentucky.
• Child care centers serve as home-away-from-home settings, where children adopt early nutrition, physical activity, and television viewing behaviors. These behaviors are often a result of interactions with parents and other caregivers.40
• Preschool-aged children may consume 50% to 100% of their diets in child care settings, placing a great deal of responsibility on the facility to provide nutritionally adequate, healthful food.41
• Strong evidence links childhood obesity to television viewing.42
• Each US state creates and enforces its own child care licensing regulations. There is already an infrastructure in place to monitor
practices in Kentucky licensed day care centers. The Cabinet for Health and Family Services’ Office of Inspector General and the Division of Child Care are responsible for licensing, certifying and registering more than 3000 Kentucky child care facilities.

**Current status in Kentucky**

Implemented in July 2000, Healthy Start in Child Care provides consultation on health, safety and nutrition to child care providers. Trained Healthy Start Child Care Consultants from the local health departments participate in joint activities with the resource and referral agencies in their area to ensure collaboration and coordination regarding health, safety and nutrition issues impacting the quality of child care.

Kentucky, along with 39 states, requires that the activity program of child care facilities provide large muscle or gross motor activity, development, and/or equipment. Kentucky also limits viewing or listening to television to two hours a day in licensed child care centers.

**Notable policies in other states**

Thirty-six other states require that children have daily outdoor activity time in certified child care centers. Twelve states have regulations that limit foods of low nutritional value and nine states set specific minimum lengths of time that children should be outdoors each day. 43, 44

**Alaska** regulations require that opportunities be provided for a minimum of 20 minutes of vigorous physical activity for every 3 hours the facility is open between the hours of 7:00 a.m. and 7:00 p.m. Alaska also limits screen time for media exposure to 1.5 hours per day but allows an additional 2 hours per day for computer learning activities.

**Mississippi** requires that children in a full-day program have at least 2 hours of outdoor activity per day and that children in a part-day program have at least 30 minutes per day.

**Maine** and **New Mexico** limit screen time to 1 hour per day.

**Michigan** and **West Virginia**, specify that child care menus are consistent with the *Dietary Guidelines for Americans*. 


Resources

Child Care as an Untapped Setting for Obesity Prevention: State Child Care Licensing Regulations Related to Nutrition, Physical Activity, and Media Use for Preschool-Aged Children in the United States. Preventing Chronic Disease. CDC.
www.cdc.gov/Pcd/issues/2009/jan/07_0240.htm

www.biomedcentral.com/content/pdf/1471-2458-8-188.pdf

Color Me Healthy: Preschoolers Moving and Eating Healthy
www.colormehealthy.com/
Establish Complete Streets Policies

Complete Streets fight obesity by making walking and biking safe and convenient

Recommended Policy
Require all new and reconstructed roadways to accommodate all users: bicyclists, pedestrians, motorists, transit users, and people with disabilities. Bicycling and walking facilities will be incorporated into all transportation projects unless exceptional circumstances exist. Transportation agencies ensure that all road projects result in a complete street appropriate to local context and needs.

Rationale
• Physical inactivity, coupled with unhealthy eating habits, is a major cause of the obesity epidemic. Kentucky has the fourth-highest rate of adult physical inactivity in the country. 45
• A new trend in transportation design has emerged in response to the emphasis on active lifestyles, energy conservation, and the importance of accommodating users of all ages and abilities. Experts agree that streetscapes should no longer be designed just for the automobile.46
• Concerns about safety are a major obstacle to physical activity. Parents list safety concerns as the top reason their children do not walk or bike to school.47
• In 2001, 7.3% of roadway fatalities in Kentucky were bicyclists and pedestrians, 1.3% of transportation spending was on bike/pedestrian facilities and 0 was spent on bike/pedestrian transportation safety. 48
• The KY Highway User Survey 2004 found that over 50% of respondents indicated the need for additional bike/pedestrian travel accommodations in the state (higher in urban/suburban areas).49
• A 2003 study found that 43% of people with safe places to walk within 10 minutes of their home met the recommended activity levels compared to just 27% of people without safe places to walk. 50
• Residents are 65% more likely to walk in neighborhoods with sidewalks. 51
• Complete streets increase pedestrian safety, help people drive less and save money on gas, and reduce pollution.
• Complete streets help ease transportation woes. They provide independence and mobility to the one-third of Americans who do not drive. Complete streets ensure that the public right of way serves all citizens in a community including people who use wheelchairs, have vision impairments, and older people and children.
• More than one quarter of all trips are one mile or less and almost half are under five miles. Most of those trips are now made by car. Streets that provide travel choices give people the option to avoid traffic jams and increase the overall capacity of the transportation network.52
• Complete streets make fiscal sense. Integrating sidewalks, bike lanes, transit amenities, and safe crossings into the initial design of a project spares the expense of retrofits later.
• Complete streets spur economic development by improving conditions for existing businesses and attracting new development.

Current status in Kentucky
In 2002, the Kentucky Transportation Cabinet adopted the Pedestrian and Bicycle Travel Policy and was nationally recognized as one of the first states to adopt a policy requiring that bicycle and pedestrian facilities shall be considered during roadway project design. However, the policy has not consistently resulted in the construction of complete streets. More recent and effective policies adopted by other states explicitly require that facilities shall be provided except under exceptional circumstances.

In 2008 Senator Katie Stine introduced a bill requiring full consideration of bicycle and pedestrian ways in the planning and development of state transportation facilities. The bill was not passed.

Louisville has adopted a complete streets policy and developed one of the most comprehensive design documents of its kind in the U.S. Lexington passed a Bicycle and Pedestrian Master Plan in 2008 that includes a street plan, policies and projects.

Notable state policies
To date, more than 75 states, counties, regional governments and cities have complete street policies.
Illinois law requires that bicycle and pedestrian ways shall be given full consideration in the planning and development of transportation facilities. Within one mile of an urban area, bicycle and pedestrian ways shall be established in conjunction with the construction, reconstruction, or other change of any state transportation facility, with some exceptions for excessive expense or lack or appropriateness.

Florida passed legislation requiring that bicycle and pedestrian ways be established in conjunction with the construction, reconstruction or other change in a transportation facility with special emphasis given to projects within one mile of an urban area.

Oregon legislation requires that a minimum of 1% of funding for city/county highway projects be spent on footpaths and bike trails.

Resources

Kentucky Transportation Cabinet Pedestrian and Bicycle Travel Policy
www.planning.kytc.ky.gov/bike_walk/from%20OSP/files/Task%20Force%20FINAL%20June%202018_02%20policy%20rec%20to%20Sec%20Codell.PDF

Metro Louisville Complete Streets Manual
www.louisvilleky.gov/BikeLouisville/Complete+Streets/


Design Guidance: Accommodating Bicycle and Pedestrian Travel /U.S. Department of Transportation Policy Statement
www.fhwa.dot.gov/environment/bikeped/design.htm

Complete street policies
www.completestreets.org/policies.html
Require Menu Labeling at Fast Food and Chain Restaurants

Informed consumers make better food choices

Recommended Policy
Require fast food and chain restaurants that have 10 or more stores in the state to list calorie information on menus, inside menu boards and at drive through windows. Require information on saturated and trans fat, sodium and carbohydrate be made available at cash registers for customers who request it.

Rationale
- The 1994 Nutrition Labeling and Education Act requires that packaged foods have nutrition information on the label. Currently there are no requirements that fast food restaurants provide any nutrition information to consumers.
- Approximately 50% of America's food expenditures go for foods consumed outside the home. Americans spent $16.8 billion dollars on fast food in 2008.53
- People eat more calories when they eat out. Adults eating at fast food restaurants consume 205 more calories/day than those who do not eat out. 54
- Fast food intake is associated with increased body weight. 55
- 78% of Americans say they use nutrition labels on packaged foods. 48% of these people say the labels prompt them to make healthier selections. 56
- Consumers have a right to information. Stickers with miles per gallon on car windows, signage with estimated annual energy use on appliances, and tags with care instructions on clothing are examples of providing product information in a user friendly manner.
- 65% of sales at fast food restaurants are at drive through windows. Adding calories to the drive through menu boards has proven to work well in other places.
• Nine out of ten people underestimate calories in fast food menus by an average of more than 600 calories. Even experienced nutritional professionals underestimated fast food by 200-600 calories.
• The calorie levels of many fast food items are counter-intuitive. Most people don’t know that a large chocolate shake at McDonalds’ has more calories than two Big Macs or that Country Fried Steak and Eggs at Denny’s has half the calories of the French toast.
• Nutrition information is not easily accessible. In a study of the 300 largest chain restaurants, 46% did not make nutrition info available to customers.
• Menu labeling affects ordering. People tend to order fewer calories when calories are posted.
• A majority of consumers in national polls, 62% -87%, said they support requiring restaurants to post nutrition information.
• Providing calorie information at the point of purchase helps consumers take personal responsibility for their food choices.
• Menu labeling provides chain restaurants an incentive to add a wider range of healthy choices to their menus.
• A Health Impact Assessment done in Los Angeles found that mandated menu labeling could have a sizable impact on the obesity epidemic, even with only modest changes in consumer behavior. If 10% of the LA fast food patrons reduced their order by 100 calories, menu labeling would avert 39% of the 6.75 million pound average annual weight gain of the county population age 5 years and older.

Current status in Kentucky
In the 2008 legislative session, Senator Denise Harper Angel introduced the MEAL (Menu Education and Labeling) Act. It was not passed. She plans to propose a similar bill in the 2009 session.

Notable policies in other states

California requires the number of calories to be posted on menu boards. Printed menus show the number of calories, grams of saturated fat, trans fats, sodium and carbohydrates. The law will be phased in between 2009 and 2011.
Resources

www.cfsan.fda.gov/~lrd/bgowg2.html

Menu Labeling: Opportunities for Public Policy / Scientific Studies Related to Menu Labeling.  Yale University Rudd Center For Food Policy And Obesity.

www.publichealthadvocacy.org/printable/CCPHA_LAPHmlaspotentialstrategy.pdf

Center for Science in the Public Interest menu labeling web site
www.cspinet.org/menulabeling/

Video showing people trying to find information on brochures in fast food restaurants
www.youtube.com/watch?v=zD4m6WN3Tlg
Government can fight obesity by practicing what it preaches

**Recommended Policy**
Require state funded agencies to serve healthy foods in cafeterias, vending machines and at events and programs funded with tax dollars.

**Rationale**
- State funded agencies should “walk the talk”, modeling and normalizing a healthy approach to food choices.
- Prioritizing healthy food in government facilities sends a powerful message that good nutrition is important. Nutrition messages are more credible and doable if government supports them in a practical and observable fashion.
- Government is more credible if it doesn't just talk about the obesity epidemic, but actually supports healthy practices in a meaningful way.
- People eat what is available. When healthier food is available, people eat it more frequently.
- Access to healthy foods makes it easier for people to make healthy food choices and exercise personal responsibility.
- Healthy food in the workplace begins to shift the food culture.
- Tax dollars should not contribute to the obesity epidemic.
- Nutrition standards have been set for Kentucky public schools. It seems only logical to set standards for state government, which employs 35,000 people.\(^{65}\)

**Current status in Kentucky**
No legislation has been introduced.
Notable policies in other states

**New York City** passed an executive order requiring all city funded programs that serve food to meet nutrition standards. The city serves over a million meals a day in public schools, hospitals, senior centers, correctional facilities, homeless shelters and other facilities. A Food Policy Coordinator position was established to develop and coordinate initiatives to promote healthy food in all city funded programs.

**Washington** State Department of Health developed an *Energize Your Meetings* program that offers information about how to include healthy food at work events. It includes a list of pre-approved caterers who can provide foods that follow the guidelines and stay within per diem limits.

**Missouri** Department of Health and Human Services initiated a healthier vending machine project in offices with approximately 800 state employees. Signage, contests and email messages promoted the new options. Surveys showed satisfaction among employees, and an average increase in vending revenue of $224 per month.

**Vermont** has created a *Worksite Healthy Eating Pledge* that encourages employers to improve access to healthy foods and beverages in the workplace.

Resources

**Eat Smart Kentucky: Guidelines for Healthy Foods and Beverages at Meetings, Gatherings and Events.** Lexington Fayette County Health Department.
www.fitky.org/Default.aspx?id=15

**Washington State Guidelines to Energize Your Meetings.** Washington State Department of Public Health.

**Missouri Healthier Vending Machine Project.** Missouri Department of Health and Human Services
www.cdc.gov/NCCdphp/examples/pdfs/missouri.pdf

**Vermont Worksite Healthy Eating Pledge.** Fit and Healthy Vermont.
Wellness programs improve workers’ health and employers’ bottom line

**Recommended Policy**
Provide a tax credit to employers for the cost of implementing qualified employee wellness programs. The yearly credit could be equal to 50% of the costs incurred by the employer, not to exceed $100 per employee. Qualified programs are comprehensive and include at least three of the following elements: health education, behavioral change, supportive environment and employee engagement.

**Rationale**
- 66% of the U.S. workforce is overweight. 66
- Wellness tax credits would encourage employers to provide programs to promote healthy lifestyles and lower health care costs. This model creates a partnership between business and government to invest in the prevention of disease in Kentucky.
- Costs of the tax credits to the state could be offset by stimulating new spending on employee wellness programs and reducing health care costs. 67
- A review of 73 published studies of worksite health promotion programs shows the average return on investment of $4.30 for every $1 spent on wellness programming. 68
- According to the Centers for Disease Control more than 75% of employers’ health care costs and productivity losses are related to employee lifestyle choices.
- Comprehensive employee wellness programs result in average reductions of 25% in sick leave, health plan costs and workers’ compensation and disability costs. 69
- At the current rate of increase, the cost of health care to employers will likely be the single most significant detriment to profitability and viability over the next decade. 70
Healthy employees boost a company's bottom line. They experience less sick time, take fewer disability days, run lower risk of premature death, and are more productive.

**Current status in Kentucky**
Representative John Tilley introduced HB 111, an act to encourage healthy lifestyles, for the 2009 session. It would establish a wellness project tax credit for Kentucky businesses for 50% of program costs not to exceed $100 per employee. The bill requires the Cabinet to develop an employer wellness project model, to certify employers’ projects based on the model, and to establish a state employee personal fitness pilot program. A similar bill, filed in 2008, did not pass.

**Notable policies in other states**
Fifteen states have introduced legislation to award tax credits to employers who provide wellness programming.

**Indiana** passed the *Small Employer Wellness Tax Credit Program*, which gives employers with two to 100 employees a tax credit for 50 percent of the annual costs of providing qualified wellness programs to their employees.

**Rhode Island** provides a tax credit for qualifying businesses that employ less than 100 people. The credit is limited to $100 per employee.

**Texas** enacted legislation to create a model state employee wellness program and a multidisciplinary Worksite Wellness Advisory Board. Among other provisions, it allows employees 30 minutes a day for exercise, provides for identification of food service vendors that successfully market healthy foods, encourages worksite architectural design with wellness features, and encourages and provides time for completion of health risk assessments.

**Healthy Arkansas** targets the state’s 50,000 employees, Medicaid recipients and other residents by encouraging them to quit smoking, lose weight and exercise more. State employees receive nutrition counseling, walking breaks, paid leave as a reward for healthy behavior, and discounted health insurance premiums if they agree to undergo a voluntary health risk assessment.
Resources

**Summary of state wellness tax incentive legislation.** National Council of State Legislatures.
www.ncsl.org/programs/health/WellnessOverview.htm

**Return on Investment Calculator Shows How Worksite Wellness Programs Lower Employee Health Care Costs.** WellSteps.
http://findarticles.com/p/articles/mi_m0EIN/is_2008_March_25/ai_n24946808


**Healthy Arkansas.**
www.arkansas.gov/ha/home.html

**KY prefilled bill for 2009 session:**
**BR 412:** http://www.lrc.ky.gov/record/09RS/HB111.htm
Obesity Prevention Policies for Further Consideration

**Obesity Prevention Funding:** Establish funding for obesity prevention programs.

**Food Marketing in Schools:** Limit the marketing of low nutrition foods on campus. On elementary school campuses, only the following foods should be marketed to children: water, 1% and fat-free milk, fruits, and non-fried vegetables. Foods and beverages marketed on middle and high school campuses should meet strong nutrition standards.

**Distributing Local Foods:** Support the development of infrastructure for processing and distributing local food in Kentucky.

**Farm to School:** Create Kentucky Farm to School programs to provide schools with fresh foods, help children develop healthy eating habits and to improve Kentucky farmers’ incomes and direct access to markets.

**Supermarkets in Underserved Areas:** Provide economic development financing to encourage the development of supermarkets in underserved areas throughout the state, including urban and rural communities that are sometimes referred to as “healthy food deserts”.

**Monitor and Enforce Competitive Food and Beverage Sales:** Monitor and enforce compliance of KRS 158.854 (SB172) that sets minimum nutritional standards for food and beverage items offered for sale through school vending machines, school stores, canteens and as a la carte items on the cafeteria lines.

**Taxes on Foods or Beverages with Minimal Nutritional Value:** Impose additional tax on certain unhealthy food and beverage items and on the sale or rental of video, computer games and movies which are linked to physical inactivity. Direct the revenues to an Obesity Prevention Program Fund. In 1972, Kentucky implemented a 6% sales tax on candy, gum, and soft drinks, bringing $34 million a year into the general fund. If the tax was raised one cent it would bring in approximately $5.5 million more per year.
Rails to Trails: Develop a statewide Rails to Trails plan with a full time Rails to Trails coordinator for the state. Kentucky has the fourth-lowest number of Rails to Trails miles in the country. There are numerous studies about the economic and tourism benefits of rail trails. KY should develop an aggressive strategy to take advantage of the 1,250 miles of abandoned rail lines in the state.

Trans Fat: Prohibit trans fats from being served or used in the preparation of foods in restaurants and other food facilities. Trans fat consumption is associated with increased risk of heart disease and stroke.
What’s Behind the Obesity Epidemic?

MANY ISSUES INFLUENCE NUTRITION AND PHYSICAL ACTIVITY BEHAVIORS

Food Choices and Changes
- Higher caloric intake – Adults consumed approximately 300 more calories daily in 2002 than they did in 1985.
- Higher caloric density of foods.
- Limited access to supermarkets and nutritious, fresh foods in many urban and rural neighborhoods.
- “Portion distortion,” or the rise of bigger portions.
- “Value sizing” or placing a higher value on the amount of food versus the quality of food.
- Less in-home cooking and more frequent reliance on take-out food and eating in restaurants.
- The proliferation of microwaves and faster, easier to prepare foods.

Schools
- A variety of food and beverage options are available throughout the school day including soda, fruit drinks that are not 100 percent juice, high energy dense foods, and fast food.
- These foods and beverages are available at venues such as a la carte lines, school stores, snack machines, fundraisers, and classroom parties.
- Reduction in the amount of physical education, recess, and recreation time.
- Few safe routes to school.
- Limited health education classes.
- Lack of opportunities to participate in physical activity that are lifelong in nature.
Communities Not Designed for Physical Activity
- Communities designed to foster driving rather than walking or biking.
- Lack of public transportation options.
- Poor upkeep of sidewalk infrastructure.
- Walking areas often unsafe or inconvenient.
- Limited parks and recreation space, including indoor facilities.
- Poor upkeep and security in local parks.
- Weather conditions limit outdoor physical activity options.
- Lack of affordable indoor physical activity options.

Marketing and Advertising
- Greater advertising and marketing of less nutritious foods.
- Marketing of “fad” diets.

Workplaces Not Conducive to Health
- Many desk jobs limit or discourage activity, part of the sedentary lifestyle.
- Worksites typically not designed to foster movement.
- Limited opportunities for physical activity or recreation during the work day.
- Unhealthy options in cafeterias or work lunch sites.
- Lack of bike racks and/or shower facilities discourage active transportation.

Economic Constraints
- Health insurance coverage for obesity-prevention services is often limited or not available.
- People without health insurance often do not receive either appropriate preventive services or follow-up care.
- “Value sizing” of less nutritious foods and the higher costs of many nutritious foods.
- Expense of and taxes on gym memberships, exercise classes, equipment, facility use, and sports league fees.
- Lower-income neighborhoods have fewer and smaller grocery stores and less access to affordable fruits and vegetables.
Limited Time

• Long work hours mean more meals – many of them high in calories - are eaten outside of the home.
• Car time and commuting cut into free time that could be used for physical activity.

Family and Home Influences

• Influence of other family members’ eating and activity habits.
• “Electronic culture” options for entertainment and free time, including TV, video games and the internet.
• More people working outside the home or far from home.

Genetics, Physiology, and Life Stages

• Metabolism.
• Childbearing.
• Increased risk factors for obesity and related diseases in children with obese parents, particularly mothers.
• Aging factors, including menstruation, pre-menopause, and menopause for women.

Psychology

• Weight-gain as a side effect from some commonly used medications such as insulin, antidepressants, oral contraceptives, and injectable contraceptives.
• Body image concerns.
• Consumers’ frustration with conflicting nutrition information and advice.
• Eating to combat stress.
• Turning to eating as a replacement for smoking or other unhealthy behaviors.

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Kentucky Obesity Facts at a Glance

**Kentucky Adults**
- Since 1991 adult obesity has nearly doubled in the state.
- Kentucky has the 7th highest rate of adult obesity.
- Approximately 40% of adults are overweight and an additional 28% are obese.
- Almost 80% of men and 59% of women are overweight or obese (BMI ≥25 kg/m²).
- Overweight and obesity are highest among those with lower levels of education and lower incomes.
- Only 30% of adults get the recommended amounts of physical activity.
- Physical activity is lowest among those with lower levels of education and lower incomes.
- Only 18% of adults eat the recommended 5-9 servings of fruits and vegetable each day.
- Obesity costs Kentucky $1.2 billion dollars in health care costs. ¹²

**Kentucky Children**
- More than 331,000 Kentucky children—one in every three—are seriously overweight or at risk of becoming overweight. ², ³ and ⁴
- One in three babies born in Kentucky in 2000 will develop diabetes during their lifetime. ⁶
- Kentucky has 3rd highest rate in the U.S. of children who are overweight or at risk of overweight.
- In 2004, only 59% of all Kentucky infants were breastfed at birth, compared with 73% of infants nationwide. ²⁹
• Almost 16% of children ages 2 to 4 served by the WIC Program are already seriously overweight, and another 18% are at risk for continued problems with weight.

• Slightly over 20% of middle school boys and 12% of girls are seriously overweight and an additional 18% are heavy enough to be considered “at risk” of becoming overweight.

• Almost 16% of high school students are seriously overweight, and an additional 16% are heavy enough to be considered “at risk” of becoming seriously overweight.

• Almost 20% of high school boys are overweight compared to 11% of girls.

• Approximately 27% of high school students watch 3 or more hours of TV each day.

• Only 13% of high school students eat the recommended 5-9 servings of fruits and vegetables each day.

• This is the first generation that is predicted to have a shorter life span than their parents.4

All adult data is from 2007 BRFSS unless otherwise noted. All youth data is from 2007 YRBS unless otherwise noted.
The Partnership for a Fit Kentucky (PFK) is a public/private partnership with a wide range of partners that is continually growing. Some of the members include: Local Health Departments, Cooperative Extension, American Heart Association, Kentucky Department of Education, Trover Foundation, Kentucky Chambers of Commerce, Foundation for a Healthy Kentucky, UAW/Ford Motor Company, Kentucky Rails to Trails, Department of Agriculture, KET, KC Wellness, Kentucky Medical Society, Pennyrile Allied Community Services and KIPDA Area on Aging.

The mission of PFK is to support policy and environmental changes that promote healthy eating and active lifestyles. The focus is on building healthy nutrition and physical environments in six venues: Early Childhood, Schools, Family and Communities, Worksites, Built Environment and Healthcare.

In August 2004 the Partnership for a Fit Kentucky held nine regional obesity forums. Over 1300 participants gave their input on what their community currently was doing to combat obesity and what they would like to see in the future in the context of CDC’s six key strategies to prevent and control obesity: increase fruit and vegetable consumption, increase breastfeeding initiation and duration, increase physical activity, reduce TV viewing time, increase parental involvement, and address other dietary concerns.

Each community developed its top 5 priorities. The Partnership for a Fit Kentucky used the results of the forums to develop The Kentucky Nutrition and Physical Activity State Action Plan 2005. The overall top 5 priorities were:

- Provide mandatory physical education in K-12th grades.
- Increase healthy choices/develop legislative polices on vending machines.
- Improve worksite wellness policies.
- Provide more safe, walkable communities and bike paths.
- Provide more low cost or free physical activity opportunities.
Developing a statewide Partnership and conducting regional forums were the first steps in building a strong network of partners interested in preventing obesity in Kentucky. The Kentucky State Action Plan continues to be the guiding document for regional coalitions working on improving nutrition and physical activity environments in their communities. Coalitions are a vehicle of communication for state partners. Using participants from the forums and coalition meetings, a statewide listserv was established. The listserv has proven to be the fastest, most efficient way to spread messages to PFK partners throughout the state. The Partnership for a Fit Kentucky continues to be a resource for obesity prevention and seeks community input on new projects.

The Kentucky Department for Public Health (KDPH) was awarded a grant from the Council for State Governments with the goal of developing written policies to address childhood obesity. KDPH recognized that the PFK was poised to address this topic and proposed a collaborative project. The PFK seized this opportunity to promote policy change and collected partner policies to supplement current obesity prevention policies seen in other states. An online survey was conducted to rank the importance of current public health policies addressing obesity. The SCORE team developed as an ad hoc policy advisory team for PFK. This team is charged with the task of writing assessments of the obesity prevention policies that were surveyed.

This report details the results of the PFK survey and the SCORE Team’s assessments. The purpose is to heighten awareness of the need for sound and practical public policies to address obesity.
The Partnership for a Fit Kentucky (PFK) had great success gathering community input from the 2004 regional obesity forums. Results of the forums were used to develop Kentucky’s Nutrition and Physical Activity State Action Plan. In keeping with the theme of using grassroots input, a survey was conducted to rank obesity prevention policies through the PFK listserv to supplement the SCORE advisory team’s policy assessments.

Who took the survey?
- 885 people completed the survey.
- 89% of counties were represented in the survey.
- 50% of respondents worked in public health and school settings.

Respondents were asked to rank obesity prevention policies in order of the importance to their communities.

**First: Physical Activity in School**
- 84% (739) ranked Physical Activity in Schools in the top four most important policies to combat obesity in their community.
- Of the 84%, 53% (391) ranked Physical Activity in Schools number one.
Second: Obesity Prevention Funding
  • 54% (478) ranked Obesity Prevention Funding in the top four most important policies to combat obesity in their community.

  • Of the 54%, 27% (128) ranked Obesity Prevention Funding number one.

Third: Healthy Foods in all State Funded Programs And Agencies
  • 48% (421) ranked Healthy Foods in all State Funded Programs and agencies in the top four most important policies to combat obesity in their community.

  • Of the 48%, 19%(79) ranked Healthy Foods in all State Funded Programs and Agencies as number one.
References


22. Trust for America's Health. F as in Fat 2008: How Obesity Policies are Failing in America. 43.


52. www.completestreets.org


70. U.S. Corporate Wellness. ROI-Based Analysis of Employee Wellness Programs. 2008.
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