

October 31, 2007

The Legislative Commission on Health Care Access  
Senator Linda Berglin, Chair  
Representative Tom Huntley, Chair

Members of the Legislative Commission on Health Care Access:

The members of the Public Health Working Group are pleased to make recommendations designed to reduce the prevalence of chronic conditions in Minnesota, lower the rate of childhood obesity, and provide a statewide system for monitoring the incidence of childhood obesity in our state.

The rising cost of health care and health care coverage is a major concern for all Minnesotans, and we know that utilization associated with chronic disease is the primary cost driver. For this reason, the Public Health Working Group chose to focus its recommendations on ways to reduce the prevalence of chronic conditions in Minnesota. We chose to emphasize primary prevention methods by focusing on programs that encourage and empower people to make healthy lifestyle choices. Additionally, the working group advises that implementing policies to reduce the incidence of childhood obesity will further reduce the incidence of costly chronic diseases associated with overweight and obesity among our children.

While the Public Health Working Group's recommendations address important public health concerns, we recognize they do not address all public health issues. The working group acknowledges there remain other important public health issues deserving attention that we were unable to take up due to our focused scope of work and limited time. The members of this working group recognize the need to address other public health needs, are encouraged by this opportunity to bring public health into the conversations around health care reform, and welcome future opportunities to contribute to the discussion.

Respectfully submitted,

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Representative Steve Gottwalt  
Public Health Working Group, Chair

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Senator Patricia Torres-Ray  
Public Health Working Group, Chair

SENATOR LINDA BERGLIN, 61  
Senator Paul E. Koering, 12  
Senator Tony Lourey, 08  
Senator John Marty, 54  
Senator Julie Rosen, 24



85<sup>TH</sup> LEGISLATIVE SESSION  
**THE LEGISLATIVE  
COMMISSION ON  
HEALTH CARE  
ACCESS**

## Health Care Access Commission Working Group Recommendation

**Working Group Name: PUBLIC HEALTH**

**Working Group Recommendation: Implement and fund the comprehensive health promotion program, developed by the Minnesota Department of Health (MDH), to promote partnerships among local communities, schools, workplaces and health care providers to address prevention of chronic conditions statewide. (PRIORITY: 1<sup>ST</sup>)**

### **Problem Issue:**

According to the Centers for Disease Control and Prevention (CDC), chronic conditions, such as heart disease, stroke and cancer, are the leading causes of death nationwide and in Minnesota.<sup>1</sup> Other examples of chronic conditions include arthritis, asthma, cardiovascular disease, diabetes, and obesity. Nationally, chronic conditions account for between 78 to 83 percent of health care spending.<sup>2</sup> The major causes of chronic conditions – tobacco use, physical inactivity and poor nutrition – are preventable. Even though we know that chronic conditions are prevalent, costly and preventable, the numbers of persons affected by chronic conditions continues to grow. In order to provide the most positive and effective change in the prevalence of chronic conditions, both the State and local communities must be involved in coordinated prevention strategies.

### Stakeholders

The stakeholders represented by members of this working group agree that the prevalence of chronic conditions is a major contributor to the rising costs of health care in Minnesota. The members agree that, to be effective, a health care reform strategy should include a plan for chronic disease prevention. There are several programs in communities around the state that address particular chronic diseases, but a comprehensive statewide program is necessary to successfully reduce the prevalence of chronic conditions throughout the state.

### Past Efforts

Currently, the MDH has several programs that address particular chronic diseases, including the Sage program, which provides breast and cervical cancer screening, the Minnesota Cancer Surveillance System, and the

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<sup>1</sup> Centers for Disease Control and Prevention (CDC), *Profiling the Leading Causes of Death in the United States*, November 14, 2005. Available at: <http://www.cdc.gov/nccdphp/publications/factsheets/ChronicDisease/minnesota.htm>

<sup>2</sup> National Conference of State Legislatures (NCSL), *Chronic Disease and Health Costs: A Snapshot for State Legislatures*, 2005. Available at: <http://www.ncsl.org/programs/pubs/summaries/0166603-sum.htm>; and The Council of State Governments (CSG), *Using Sound Science to Prevent Chronic Disease: State Policy Implications*, 2006. Available at: <http://www.healthystates.csg.org/Public+Health+Issues/Chronic+Diseases>.

Minnesota Diabetes Program. The MDH has also developed strategic plans to address asthma and heart disease and stroke prevention. Additionally, in the 2007 legislative session, bills were introduced that proposed funding for colorectal cancer screening, prostate cancer screening, and funding for heart disease and stroke prevention. There have been several efforts proposed in the past to address particular chronic conditions, but this effort is a comprehensive statewide approach to chronic disease prevention.

**Recommendation:** (PRIORITY: 1<sup>ST</sup>)

The Public Health Working Group recommends that the State implement and fund the comprehensive health promotion program, developed by the Minnesota Department of Health, to promote partnerships among local communities, schools, workplaces and health care providers to address prevention of chronic conditions statewide. Under this program, funding will be made available to local initiatives to provide the following:

- (1) Safe, accessible and affordable recreation facilities and activities for all;
- (2) Access to healthy fruits and vegetables, whole grains and low-fat dairy for all communities;
- (3) Adequate access to physical education classes for students in K-12;
- (4) Initiatives to involve parents and caregivers as key players in efforts to promote healthier lifestyles for their children;
- (5) Walk-able neighborhoods, accessible bike trails and community standards that ensure safe options for vehicles, pedestrians, bicyclists, transit and safe- routes to recreational facilities;
- (6) Nutritious meals and snacks in schools, homes, day care centers, after schools programs;
- (7) Wellness and nutrition education, and the opportunity to engage in outdoor and physical activity;
- (8) Environmental programs that encourage love of nature and appreciation of the natural world;
- (9) Information that can be disseminated to parents, schools and communities about healthy choices;
- (10) Partnerships with local food markets to provide tips on healthy meal choices or providing an easy and healthy alternative to fast food;
- (11) Incentives for workplaces to engage their employees in adult physical activity; and
- (12) Campaigns to promote access to and utilization of child check ups, preventive efforts, and culturally appropriate early screening for chronic conditions.

The Public Health Working Group recognizes the importance of being able to measure outcomes and emphasizes that monitoring BMI data statewide would be one effective method for tracking the progress of this comprehensive health promotion program.

Estimated Cost

Currently, four Minnesota communities have a “Steps to a HealthierMN” program. MDH, in partnership with these four communities, receives \$2.2 million per year for five years (2004-2009) from the CDC to implement these community-based programs. Steps is the primary model for the department’s comprehensive health promotion program.

Using the CDC’s mid-line cost estimate, it would cost approximately \$26.5 million per year to expand the program statewide, which includes a \$50,000 base to each community health board plus \$3.89 per person.<sup>3</sup>

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<sup>3</sup> Minnesota Department of Health, *Comprehensive Statewide Health Promotion Plan*, October 1, 2007. Available at: <http://www.health.state.mn.us/divs/hpcd/chp/chppages/pdfs/cshpp.pdf>

However, in order to achieve desired results, the CDC's suggested funding level is approximately \$8.00 per person. The Public Health Working Group recommends that the comprehensive health promotion program be funded at the optimal level. Using the CDC's optimal cost estimate, it would cost approximately \$41.5 million per year to expand the program statewide. This estimate includes a \$50,000 base to each community health board plus \$8.00 per person.

It can be difficult to quantify the savings associated with investments in primary prevention. However, there is evidence that increasing healthy behaviors, and, thereby, reducing the prevalence of chronic diseases, will result in reduced costs to the health care system. For example, it is estimated that \$5.6 billion in national heart disease costs could be saved, if 10% of the population began a regular walking program.<sup>4</sup> Additionally, there are studies that show wellness programs, particularly in the workplace, are highly cost effective. For example, Citibank saved \$8.9 million over two years by implementing wellness programs, which cost \$1.9 million (a return of \$4.70 for every dollar spent).<sup>5</sup>

### Time Frame

The members of this working group propose monitoring the progress of this comprehensive health promotion program on a yearly basis. Additionally, the working group proposes the following long-term outcomes goal for this program: (1) by 2023, increase the percentage of young adults (ages 20-39) who are at a healthy weight to 65% (up from 45% in 2006); and (2) by 2023, increase the percentage of middle-aged adults (ages 40-59) who are at a healthy weight to 50% (up from 30% in 2006).

### Limitations

There are two identified drawbacks to this recommended approach. First, this comprehensive health promotion program, while it addresses the causes of some of the major chronic conditions, does not address all chronic diseases, such as AIDS. Members of the working group note that a truly comprehensive plan should address all chronic diseases. Second, the mid-line estimated cost may not be sufficient to achieve desired results. The Steps programs that are currently working in four Minnesota communities receive funding at the higher per-person rate (approximately \$8 per person). Therefore, funding this program at the higher level is likely necessary in order to reduce the incidence of chronic disease in Minnesota.

### Results/Successes Elsewhere

The four Minnesota communities that have implemented Steps programs are seeing positive results. The following are examples of these successes:

- ▶ School districts in each community have passed district wellness policies.
- ▶ In two communities, over 620 physical activity kits have been distributed to families of preschool age children.
- ▶ More than 600 residents in Minneapolis have attended nutrition education classes and nutrition information has been distributed to community members in North Minneapolis.
- ▶ During the summer of 2006, farmers markets were provided in low-income areas of Minneapolis and over 1,200 customers were served.
- ▶ In Rochester, \$5 coupons are available to underserved WIC families, which can be redeemed for fruits and vegetables at the downtown farmers market.

The department of health is monitoring progress in these four communities and will also measure and analyze core performance measures, as data is available.

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<sup>4</sup> Center for Disease Control and Prevention, *Preventing Chronic Diseases: Investing Wisely in Health, Preventing Obesity and Chronic Diseases through Good Nutrition and Physical Activity* (2003). Available at: <http://www.muni.org/iceimages/healthchp/Preventing%20chronic%20disease.pdf>

<sup>5</sup> The Council of State Governments, *Healthy States, Trends Alert. Costs of Chronic Diseases: What are States Facing?* (2006). Available at: <http://www.healthystates.csg.org/NR/rdonlyres/DA24108E-B3C7-4B4D-875A-74F957BF4472/0/ChronicTrendsAlert120063050306.pdf>

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Representative Paul Thissen, 63A

## Health Care Access Commission Working Group Recommendation

**Working Group Name: PUBLIC HEALTH**

**Working Group Recommendation: Require the Minnesota Department of Education (MDE) to set statewide curriculum standards for health, nutrition and physical education and to establish these as graduation requirements for Minnesota schools. The State must provide funding to the schools to implement these standards. (PRIORITY: 2<sup>ND</sup>)**

### Problem Issue:

Childhood obesity has become a major health problem. Studies suggest that overweight children are significantly more likely to become overweight or obese adults. Minnesota was recently ranked 28<sup>th</sup> in the nation for the percent of the population that is obese, with 61% classified as either overweight or obese.<sup>1</sup> Although we do not know the proportion of Minnesota children that are overweight or obese, national estimates indicate that the percentage of children (6-12) overweight has more than double in the past 20 years.<sup>2</sup> A presentation by the group *Switch* reported to the working group that school age children are spending an average of 44.5 hours per week engaged in 'screen time'. As a result, children are increasingly suffering from conditions traditionally associated with adulthood, including high cholesterol, high blood pressure, early coronary heart disease, congestive heart failure, stroke, asthma, type 2 diabetes, depression, and other psychological disorders.

### Stakeholders

Currently, locally developed standards apply for health and physical education requirements in schools.<sup>3</sup> Permitting locally developed standards gives school districts more flexibility, but also creates inequity in standards and programs for students across Minnesota. Interested stakeholders represented by members of this working group agree that children need to learn healthy eating and activity habits and that nutrition and physical education programs in schools would be beneficial. However, obstacles include the fact that hours in a school day are limited and school districts are financially strained. Schools are spending time and money on programs to meet federal education requirements, which carry very real consequences if they fall short.

<sup>1</sup> *F as in Fat: How Obesity Policies are Failing in America 2007*. Trust for America's Health. August 2007.

<sup>2</sup> Centers of Disease Control and Prevention (CDC), *Patterns of Childhood Obesity Prevention Legislature in the United States*, Preventing Chronic Disease, July 2007. Available at: [http://www.cdc.gov/pcd/issues/2007/jul/06\\_0082.htm](http://www.cdc.gov/pcd/issues/2007/jul/06_0082.htm).

<sup>3</sup> Minnesota Statutes § 120B.021, subdivision 1, clause 5.

### Past Efforts

The state legislature has addressed the issue of statewide health and physical education standards several times since 2004 when the requirement was changed to authorize locally developed standards. Since then, bills have been introduced that specifically state the number of health and physical education hours that would be required, and others that would permit the MDE to set the standard. However, none of these bills have gone to the governor for signature.

### **Recommendation:** (PRIORITY: 2<sup>ND</sup>)

The Public Health Working Group recommends that the State require the Minnesota Department of Education (MDE) to set statewide curriculum standards for health, nutrition and physical education and to establish these as graduation requirements for Minnesota schools. The State must also provide funding through MDE to the schools in order for the schools to implement these standards.

The working group emphasizes that this recommendation should not constitute an unfunded mandate to local schools. As new curriculum standards and graduation requirements are adopted, the State will provide the necessary funds for implementing those standards.

In setting the new standards, MDE should consider current initiatives to encourage schools to provide healthy food options for students throughout the day. The State should assist schools in implementing the wellness policies that they have already developed and adopted. Beverage vending policies should continue to be consistent with the "Alliance for a Healthier Generation's School Beverage Guidelines". Other vending and ala carte offerings should be consistent with the recommendations of the Minnesota Department of Health's "Recommendations to Prevent and Reduce Childhood Obesity in Minnesota." Additionally, schools should provide nutrition education classes to teach students to prepare healthy meals.

### Estimated Cost

In order to develop statewide nutrition and physical education standards, the estimated cost is \$100,000. This is based on the costs of developing the science, math and language arts standards. Also, the cost of the rulemaking process can range from \$30,000 to \$200,000. The development cost could be reduced if the statewide standards are required to be consistent with the National Physical Education Standards and the grade specific benchmarks developed by the MDE Quality Teaching network. Note that these cost estimates only cover the rulemaking process and does not address the cost of implementing new education standards. Until the new standards are defined, it is difficult to state how much it will cost schools to implement them.

### Limitations

One potential drawback to implementing this recommendation would be the additional pressures it would put on schools in Minnesota, both in terms of time and cost. Without knowing what exactly the new education requirements would be, it is difficult to state how much it will cost schools. However, providing state funding to schools in order to help them implement these new standards will relieve the financial pressure. The members of this working group agree that it is not their intent to support an unfunded mandate for Minnesota schools.

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## Health Care Access Commission Working Group Recommendation

**Working Group Name: PUBLIC HEALTH**

**Working Group Recommendation: Require the Minnesota Department of Health, in consultation with the Minnesota Department of Education and other state agencies, to establish and maintain a statewide system to monitor childhood obesity using body mass index (BMI) measures and to report to the legislature on the progress of the BMI monitoring system by July 1, 2008. (PRIORITY: 3<sup>RD</sup>)**

### **Problem Issue:**

Childhood obesity has become a major health problem. Studies suggest that overweight children are significantly more likely to become overweight or obese adults. Minnesota was recently ranked 28<sup>th</sup> in the nation for the percentage of the population that is obese, with 61% classified as either overweight or obese.<sup>1</sup> Although we do not know the proportion of Minnesota children that are overweight or obese, national estimates indicate that the percentage of children (6-12) overweight has more than double in the past 20 years.<sup>2</sup> A presentation by the group *Switch* reported to the working group that school age children are spending an average of 44.5 hours per week engaged in 'screen time'. As a result, children are increasingly suffering from conditions traditionally associated with adulthood, including high cholesterol, high blood pressure, early coronary heart disease, congestive heart failure, stroke, asthma, type 2 diabetes, depression, and other psychological disorders.

### Stakeholders

The stakeholders represented by members of this working group agree that Minnesota is lacking a statewide system to measure and track the rates of childhood obesity. National data can be helpful to estimate the prevalence of the problem in Minnesota, but having reliable state-specific data would be more informative. The members also agree that monitoring BMI data is an appropriate measure of overweight and obesity rates, but they acknowledge that there are other ways of measuring overweight and obesity in children that may also be appropriate.

### Past Efforts

Currently, there are a number of initiatives around the state that are aimed at reducing the rate of overweight and obese children in Minnesota. Examples include the governor's fit schools program, which provides

<sup>1</sup> *F as in Fat: How Obesity Policies are Failing in America* 2007. Trust for America's Health. August 2007.

<sup>2</sup> Centers of Disease Control and Prevention (CDC), *Patterns of Childhood Obesity Prevention Legislation in the United States*, Preventing Chronic Disease, July 2007. Available from: [http://www.cdc.gov/pcd/issues/2007/jul/06\\_0082.htm](http://www.cdc.gov/pcd/issues/2007/jul/06_0082.htm).

incentives for schools to meet certain health and nutrition criteria, and the *SWITCH* pilot program that encourages students to be more active, eat more fruits and vegetables, and to reduce screen-time. With regard to monitoring rates of childhood obesity, pediatricians and other health care providers record BMI data on the patients that come into their clinics, but there has not been a statewide effort to monitor childhood overweight and obesity rates in Minnesota.

**Recommendation:** (PRIORITY: 3<sup>RD</sup>)

The Public Health Working Group recommends that the State require the Minnesota Department of Health (MDH), in consultation with the Minnesota Department of Education and other state agencies, to establish and maintain a statewide system to monitor childhood obesity using body mass index (BMI) measures. With this monitoring system, MDH will monitor the incidence of overweight and obese children throughout Minnesota to more accurately target intervention and prevention services to communities. MDH will inform health professionals and the public of the prevalence of overweight and obesity in children in Minnesota. Additionally, MDH will be required to report on the progress of the BMI monitoring system and make recommendations to the legislature by July 1, 2008.

A statewide BMI monitoring system will provide a baseline measure of childhood obesity rates in Minnesota so that the State can monitor the progress and outcomes of prevention initiatives. The working group emphasizes the importance of having legitimate, measurable results to report as the State works to prevent childhood obesity.

Reasons for this Recommendation

Currently, there are no state-specific data on the rates of overweight and obesity of children in Minnesota. The most accurate numbers we have are derived from national data. This BMI monitoring system would provide an accurate way to measure and track obesity rates in Minnesota. It is important to have a monitoring system in place to measure whether we are making progress as a state, and whether children are benefiting from current obesity prevention initiatives and from those that will be implemented in the future.

Estimated Cost

The MDH is currently working to estimate the cost of implementing and maintaining a BMI monitoring system. The working group has not yet received the department's estimate. However, the School Nurse Organization of Minnesota estimated that it would cost \$15 per child per year to measure and report each child's BMI data. This cost also includes providing referrals or follow-up services for the students when necessary.

Time Frame

The working group recommends that the MDH develop a BMI monitoring system and report to the legislature by July 2008 as to the development progress and any recommendations for implementation.

Limitations

One drawback to developing a BMI monitoring system is that this recommendation alone would do little to prevent increased rates of childhood obesity. Establishing a monitoring system is important, but only as a compliment to childhood obesity prevention efforts throughout the state because the purpose of a monitoring system is to identify needs and target prevention efforts.

Results/Successes Elsewhere

Several states now have BMI monitoring systems to track obesity rates among various populations. For example, Georgia, which tracks BMI data through its obesity surveillance system, reported that from 2003 to 2005 the percentage of obese children in middle school and high school increased (middle school: from 14% to

16%; high school: from 11% to 12%).<sup>3</sup> Monitoring BMI data alone will not prevent childhood obesity, but it is an important tool to quantify trends, measure progress, and target specific communities in need of intervention and prevention services.

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<sup>3</sup> Georgia Department of Human Resources, Division of Public Health, Obesity Surveillance, Obesity Data Summary 2005 and Obesity Data Summary 2006. Available at: <http://health.state.ga.us/epi/cdiee/obesity.asp>