WELCOME & INTRODUCTIONS

Tasha Tilghman-Bryant
C-CHANGE

@cchangetogether
@LegacyForHealth

facebook.com/cchangetogether
facebook.com/legacy
WEBINAR GOALS

- To inform comprehensive cancer control (CCC) coalitions of the role of obesity and physical activity in cancer etiology, prevention and survival.

- To empower CCC coalitions to better advocate for policies that promotes prevention and combat obesity.
IMPORTANT REMINDERS

- Webinar is being recorded
  - www.c-changetogether.org
  - facebook.com/cchangetogether

- Use ‘questions’ box to ask questions
TODAY’S PRESENTERS:

- **Kate Wolin**, ScD, FACSM
  Loyola University Chicago

- **Jeff Levi**, PhD
  Trust for America’s Health

- **Michelle Strangis**, J.D.

- **Julie Aoki-Ralston**, J.D.
  Minnesota Cancer Alliance
POLL

QUESTION #1
Cause of cancer

Estimated percentage of total cancer deaths attributable to established causes of cancer

- Tobacco: 30%
- Adult diet/obesity: 30%
- Sedentary lifestyle: 5%
- Occupational factors: 5%
- Family history of cancer: 5%
- Viruses/other biologic agents: 5%
- Perinatal factors/growth: 5%
- Reproductive factors: 3%
- Alcohol: 3%
- Socioeconomic status: 3%
- Environmental pollution: 2%
- Ionizing/ultraviolet radiation: 2%
- Prescription drugs/medicine procedures: 1%
- Salt/other food additives/contaminants: 1%
# Obesity & Cancer Risk

## Body Fatness, and the Risk of Cancer

In the judgement of the Panel, the factors listed below modify the risk of cancer. Judgements are graded according to the strength of the evidence.

<table>
<thead>
<tr>
<th></th>
<th>Decreases Risk</th>
<th>Increases Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Exposure</td>
<td>Cancer site</td>
</tr>
<tr>
<td><strong>Convincing</strong></td>
<td>Body fatness</td>
<td>Breast (premenopause)</td>
</tr>
<tr>
<td></td>
<td>Abdominal fatness</td>
<td></td>
</tr>
<tr>
<td><strong>Probable</strong></td>
<td>Body fatness</td>
<td>Breast (premenopause)</td>
</tr>
<tr>
<td></td>
<td>Abdominal fatness</td>
<td></td>
</tr>
<tr>
<td><strong>Limited — suggestive</strong></td>
<td>Body fatness</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Low body fatness</td>
<td></td>
</tr>
<tr>
<td><strong>Substantial effect on risk unlikely</strong></td>
<td>None identified</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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1. For oesophageal adenocarcinoma only.
2. Directly and indirectly, through the formation of gallstones.

For an explanation of all the terms used in the matrix, please see chapter 3.5.1, the text of this section, and the glossary.
endometrial cancer
dose response

Figure 6.1.18 BMI and endometrial cancer; cohort studies: dose response

Waist to hip ratio and endometrial cancer; cohort and case-control studies

Relative risk (95% CI)

Cohort
- Folsom 2003: 1.33 (1.18–1.51)

Case control
- Elliott 1990: 2.13 (0.94–4.83)
- Austin 1991: 1.01 (0.74–1.38)
- Goodman 1997: 1.22 (1.00–1.49)
- Xu 2005: 2.03 (1.63–2.53)
- Summary estimate: 1.45 (1.00–2.09)

Relative risk, per 0.1 increment

weight change
weight loss of 20+ lbs

- ANY CANCER: 0.89
- BREAST CANCER: 0.81
- COLON CANCER: 0.91
- ENDOMETRIAL CANCER: 0.96
- OBESITY-RELATED CANCERS: BREAST, COLON, ENDOMETRIAL, & KIDNEY: 0.86

Parker & Folsom 2007 Int J Ob
postmenopausal weight gain & breast cancer

P = .002 for Overall Trend
P = .04 for Weight Loss Trend

Eliassen 2006 JAMA
<table>
<thead>
<tr>
<th>Cancer</th>
<th>Sample Size</th>
<th>Follow-up (yrs)</th>
<th>RR Men</th>
<th>RR Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast (premenopausal)</td>
<td>2.5 mil</td>
<td>11</td>
<td>-</td>
<td>0.92**</td>
</tr>
<tr>
<td>Breast (postmenopausal)</td>
<td>2.5 mil</td>
<td>11</td>
<td>-</td>
<td>1.12***</td>
</tr>
<tr>
<td>Colon</td>
<td>4.8 mil</td>
<td>11</td>
<td>1.24*</td>
<td>1.09*</td>
</tr>
<tr>
<td>Endometrium</td>
<td>3.0 mil</td>
<td>10.6</td>
<td>-</td>
<td>1.59*</td>
</tr>
<tr>
<td>Gallbladder</td>
<td>3.3 mil</td>
<td>12.7</td>
<td>1.09</td>
<td>1.59***</td>
</tr>
<tr>
<td>Gastric</td>
<td>4.7 mil</td>
<td>10.8</td>
<td>0.97</td>
<td>1.04</td>
</tr>
<tr>
<td>Leukemia</td>
<td>4.7 mil</td>
<td>13.7</td>
<td>1.08**</td>
<td>1.17***</td>
</tr>
<tr>
<td>Liver</td>
<td>3.3 mil</td>
<td>12.7</td>
<td>1.24</td>
<td>1.07</td>
</tr>
<tr>
<td>Lung</td>
<td>2.6 mil</td>
<td>11.9</td>
<td>0.76*</td>
<td>0.80***</td>
</tr>
<tr>
<td>Malignant melanoma</td>
<td>4.0 mil</td>
<td>10.6</td>
<td>1.17**</td>
<td>1.11*</td>
</tr>
<tr>
<td>Multiple myeloma</td>
<td>5.2 mil</td>
<td>14.6</td>
<td>1.11*</td>
<td>-</td>
</tr>
<tr>
<td>Non-Hodgkin lymphoma</td>
<td>5.0 mil</td>
<td>12.4</td>
<td>1.06*</td>
<td>1.07</td>
</tr>
<tr>
<td>Esophageal adenocarcinoma</td>
<td>4.7 mil</td>
<td>10.8</td>
<td>1.52*</td>
<td>1.51*</td>
</tr>
<tr>
<td>Esophageal squamous</td>
<td>4.7 mil</td>
<td>10.8</td>
<td>0.71*</td>
<td>0.57*</td>
</tr>
<tr>
<td>Ovarian</td>
<td>2.7 mil</td>
<td>12.2</td>
<td>-</td>
<td>1.03</td>
</tr>
<tr>
<td>Pancreas</td>
<td>3.3 mil</td>
<td>9.4</td>
<td>1.07</td>
<td>-</td>
</tr>
<tr>
<td>Prostate</td>
<td>3.0 mil</td>
<td>10.6</td>
<td>1.03</td>
<td>-</td>
</tr>
<tr>
<td>Rectum</td>
<td>4.8 mil</td>
<td>11</td>
<td>1.09*</td>
<td>1.02</td>
</tr>
<tr>
<td>Renal</td>
<td>5.5 mil</td>
<td>10.6</td>
<td>1.24*</td>
<td>1.34*</td>
</tr>
<tr>
<td>Thyroid</td>
<td>3.3 mil</td>
<td>14.4</td>
<td>1.33***</td>
<td>1.14***</td>
</tr>
</tbody>
</table>

Relative risk for a 5 point increase in BMI. For example, the relative risk linked to a BMI of 26 compared to a BMI of 23, or a BMI of 32 compared to 27.

*p < .0001; **p < .01; ***p < .05
Increased BMI and Cancer-Related Mortality (Women)

- Multiple Myeloma (≥ 35): 1.44
- Colon & Rectum (≥ 35): 1.46
- Ovarian (≥ 35): 1.51
- Liver (≥ 35): 1.68
- All Cancers (≥ 40): 1.88
- Non-Hodgkin Lymphoma (≥ 35): 1.95
- Breast (≥ 40): 2.12
- Gallbladder (≥ 30): 2.13
- Esophagus (≥ 30): 2.64
- Pancreas (≥ 40): 2.76
- Cervical (≥ 35): 3.20
- Kidney (≥ 40): 4.75
- Uterus (≥ 40): 6.25

Relative Risk of Death (95% Confidence Interval)

Calle EE et al. NEJM 2004; 348, 1625-1638
Post diagnosis health in cancer survivors

- Increased risk of diabetes
- Increased risk of heart disease
- Diminished quality of life
- Fatigue
- Lymphedema
- Diminished bone density
- Functional limitations
- Cognitive function
- Pain
- Neuropathy
- Sleep (quality and quantity)
- Recurrence and Survival
Breast Cancer
Obesity and survival after breast cancer

<table>
<thead>
<tr>
<th>Study ID</th>
<th>HR (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chang et al., 2000</td>
<td>0.83 (0.34, 1.55)</td>
</tr>
<tr>
<td>Mason et al., 1990</td>
<td>0.87 (0.58, 1.32)</td>
</tr>
<tr>
<td>Saxe et al., 1990</td>
<td>0.74 (0.32, 1.71)</td>
</tr>
<tr>
<td>Carmichael et al., 2004</td>
<td>0.81 (0.62, 1.06)</td>
</tr>
<tr>
<td>dan Tonkizer et al., 1995</td>
<td>0.83 (0.51, 1.38)</td>
</tr>
<tr>
<td>Moon et al., 2009</td>
<td>0.87 (0.58, 1.32)</td>
</tr>
<tr>
<td>Ewerst et al., 1991</td>
<td>0.98 (0.71, 1.31)</td>
</tr>
<tr>
<td>Majid et al., 2008</td>
<td>1.12 (0.99, 1.25)</td>
</tr>
<tr>
<td>Bertoluz et al., 2004</td>
<td>1.14 (1.03, 1.27)</td>
</tr>
<tr>
<td>Reeves et al., 2007</td>
<td>1.14 (0.78, 1.60)</td>
</tr>
<tr>
<td>Barlow et al., 2008</td>
<td>1.16 (0.80, 1.68)</td>
</tr>
<tr>
<td>Kremen et al., 2005</td>
<td>1.20 (0.95, 1.52)</td>
</tr>
<tr>
<td>Labiri et al., 2006</td>
<td>1.28 (0.83, 2.50)</td>
</tr>
<tr>
<td>Dal Maso et al., 2008</td>
<td>1.29 (0.99, 1.68)</td>
</tr>
<tr>
<td>Dignam et al., 2006</td>
<td>1.31 (1.03, 1.63)</td>
</tr>
<tr>
<td>Dignam et al., 2003</td>
<td>1.31 (1.12, 1.54)</td>
</tr>
<tr>
<td>de Azambuja et al., 2006</td>
<td>1.54 (1.06, 2.20)</td>
</tr>
<tr>
<td>Dondi et al., 2008</td>
<td>1.40 (1.03, 1.89)</td>
</tr>
<tr>
<td>Tao et al., 2006</td>
<td>1.40 (1.00, 2.00)</td>
</tr>
<tr>
<td>Pierce et al., 2007</td>
<td>1.42 (0.87, 2.31)</td>
</tr>
<tr>
<td>Abrahamson et al., 2006</td>
<td>1.48 (1.09, 2.01)</td>
</tr>
<tr>
<td>Reeves et al., 2000</td>
<td>1.48 (1.18, 1.86)</td>
</tr>
<tr>
<td>Mohile-Boelani et al., 1988</td>
<td>1.50 (1.07, 2.11)</td>
</tr>
<tr>
<td>Nichols et al., 2009</td>
<td>1.52 (1.17, 1.98)</td>
</tr>
<tr>
<td>Loi et al., 2006</td>
<td>1.56 (1.01, 2.40)</td>
</tr>
<tr>
<td>Caan et al., 2006</td>
<td>1.80 (1.10, 2.90)</td>
</tr>
<tr>
<td>Cleveland et al., 2007</td>
<td>1.83 (1.06, 2.64)</td>
</tr>
<tr>
<td>Liton et al., 2008</td>
<td>1.85 (1.18, 2.90)</td>
</tr>
<tr>
<td>Goodwin et al., 2002</td>
<td>1.78 (1.25, 2.53)</td>
</tr>
<tr>
<td>Greenberg et al., 1985</td>
<td>1.80 (0.90, 3.70)</td>
</tr>
<tr>
<td>Chang et al., 2000</td>
<td>1.86 (1.02, 3.40)</td>
</tr>
<tr>
<td>Vallen et al., 1991</td>
<td>2.10 (1.20, 3.80)</td>
</tr>
<tr>
<td>Holmberg et al., 1984</td>
<td>2.36 (1.84, 8.77)</td>
</tr>
<tr>
<td>Daling et al., 2001</td>
<td>2.50 (1.60, 3.90)</td>
</tr>
<tr>
<td>Eley et al., 1994</td>
<td>2.50 (1.80, 3.40)</td>
</tr>
<tr>
<td>Cleveland et al., 2007</td>
<td>2.62 (1.28, 5.45)</td>
</tr>
</tbody>
</table>

Overall (I² = 72.7%, p = 0.000)
POST-DIAGNOSIS **Weight Gain** and Breast Cancer Death in Women with BMI < 25 at Diagnosis

![Bar chart depicting HR for breast cancer death based on weight gain categories.](image)

- **Maintain**
- **Gain < 2.0 kg/m²**
- **Gain > 2.0 kg/m²**

P trend < .01

Kroenke C JCO 2005
WEIGHT AND SURVIVAL IN EARLY-STAGE BREAST CANCER

Estimated Relative Risk of Adverse Event

- Distant Recurrence, \( p=0.0005 \)
- Death, \( p=0.0007 \)

BMI (kg/m²)

Goodwin et al, JCO 2002
Weight Change from Baseline to 3 years after diagnosis

Mean Weight Change = 1.7 ± 4.7 kg

- 32% Lost Weight: -2.8 ± 2.6 kg
- 68% Gained Weight: 3.9 ± 3.7 kg

n=514

Exercise Prescription for Cancer Survivors
US DHHS Physical Activity Guidelines

- **AVOID INACTIVITY**
- Aerobic: 150 minutes weekly moderate intensity activity
- Resistance: 2-3 times/week, each major muscle group
- Flexibility: stretch major muscle groups and tendons on days that other exercises are performed
Objectives/Goals of Exercise Prescription in Cancer Survivors

- Regain & improve
  - Physical Function
  - Aerobic Capacity
  - Strength
  - Flexibility
  - Psychosocial and cognitive function
- Improve body image and quality of life
- Improve body composition
- Reduce or delay recurrence or 2nd primary cancer
General Overview

- Avoid inactivity
  - risks of exercise must be balanced against risks of inactivity
- Return to normal daily activities as quickly as possible after surgery
- Continue normal activities and exercise as much as possible
  - during and after non-surgical treatments
<table>
<thead>
<tr>
<th>Population</th>
<th>Aerobic</th>
<th>Resistance</th>
<th>Flexibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>US PAGA</td>
<td>150 minutes/week of moderate-intensity activity or 75 minutes/week of vigorous-intensity activity or an equivalent combination</td>
<td>Muscle-strengthening activities of at least moderate intensity at least 2 days per week for each major muscle group</td>
<td>Stretch major muscle groups and tendons on days other activities are performed</td>
</tr>
<tr>
<td>Breast</td>
<td>Follow US PAGA</td>
<td>Start supervised &amp; progress slowly.</td>
<td>Follow US PAGA</td>
</tr>
<tr>
<td>Prostate</td>
<td>Follow US PAGA</td>
<td>Follow US PAGA</td>
<td>Follow US PAGA</td>
</tr>
<tr>
<td>Colon</td>
<td>Follow US PAGA</td>
<td>Follow US PAGA except with stoma (lower resistance, slower progression)</td>
<td>Follow US PAGA, avoid excess abdominal pressure if ostomy</td>
</tr>
<tr>
<td>Gynecologic</td>
<td>Morbidly obese may require addtl. supervision</td>
<td>Data not available for women with lower limb lymphedema</td>
<td>Follow US PAGA</td>
</tr>
<tr>
<td>Hematologic, no HSCT</td>
<td>Follow US PAGA</td>
<td>Follow US PAGA</td>
<td>Follow US PAGA</td>
</tr>
<tr>
<td>Hematologic, HSCT</td>
<td>Start with lighter intensity &amp; slower progression</td>
<td>Follow US PAGA. Resistance training may have particular benefits in this population</td>
<td>Follow US PAGA</td>
</tr>
</tbody>
</table>
POLL

QUESTION #2
F AS IN FAT:
HOW OBESITY THREATENS AMERICA’S FUTURE

Jeffrey Levi, PhD
Executive Director
C-Change/CCC Coalitions Webinar
October 17, 2013
OVERVIEW

• *F as in Fat* findings – a national snapshot

• A basis for hope – the groundwork laid, in part by the Affordable Care Act

• Compelling data about why we need to act and how we can make a difference in outcomes and cost
TWO DECADES IN THE MAKING (1990)

Percent of obese adults (Body Mass Index of 30+)
- 0.0 - 9.9%
- 10.0 - 14.9%
- 15.0 - 19.9%
- 20.0 - 24.9%
- 25.0 - 29.9%
- 30.0 - 34.9%

Map showing the distribution of obesity across the United States.
F AS IN FAT 2013: ANY PROGRESS?

• After three decades of increase, all state-by-state adult obesity rates (except one) remain statistically stable since last year’s report.
• We may be seeing some signs of progress.
• However, even stable rates are extremely high.
• Major geographic disparities persist.
• Future progress will require we examine what is working and bring these efforts to scale nationwide.
ADULT OBESITY TRENDS IN 2012

- Rates remained level in every state but Arkansas after three decades of increase.
- More than two-thirds (68.7%) of adults are overweight or obese.
A CAVEAT ON “EXTREME” OBESITY

• Extremely obese: BMI >= 40
  o Roughly 100 pounds or more above ideal body weight.

• Has grown significantly over time
  o 1976-1980, 1.4% adult prevalence
  o 2009-2010, 6.3% adult prevalence

• This subpopulation is most likely to have multiple chronic co-morbidities and incur the greatest level of health care spending.
DISPARITIES PERSIST IN 2012

- Of the states with the 20 highest adult rates, only Pennsylvania is not located in the South or the Midwest.
- Rates vary significantly by age; the Baby Boomer generation is particularly obese.
- Obesity rates vary significantly by education level and income.
- The gender gap however has essentially closed.
  - Ten years ago, women were significantly higher (33.4%) compared to men (27.5%)
However, rates for adult women vary wildly among different racial and ethnic groups.

**RACIAL/ETHNIC GAP EXISTS AMONG WOMEN:**
Prevalence of Obesity Among Women Age 20 and Older by Race and Ethnicity: 1988 to 1994 and 2009 to 2010
POSITIVE SIGNS IN PEDIATRIC OBESITY

• Rates have increased since 1989...

Obese Low-Income 2- to 4-Year-Olds, 1989
Obese Low-Income 2- to 4-Year-Olds, 2011
POSITIVE SIGNS IN PEDIATRIC OBESITY

• Significant decreases were seen in 18 states over the past year among low-income preschool-aged children (WIC data).

Source: CDC.gov
WHY DO WE SUSPECT PROGRESS?

• WIC data comes in addition to documented declines in New York City, Anchorage, Philadelphia, and other cities that have adopted comprehensive approaches to obesity prevention.

• Comes after initial steps to address problem:
  - Government
  - Industry
  - Personal behavior
OPPORTUNITIES WITHIN THE ACA

• Clinical coverage:
  o USPSTF on obesity counseling
  o Medicaid rule on covering community based programs and programs
  o ACOs and other reimbursement changes

• Prevention and Public Health Fund
  o Community Transformation Grants
    o Focus on social, environmental and policy change

• National Prevention Strategy
WHAT DOES THIS MEAN FOR HEALTH CARE COSTS?

• Estimates of added health care costs:
  o $147-$210 billion a year

• Lost productivity
  o $4.3 billion a year
Total Annual Child Health Care Expenses

<table>
<thead>
<tr>
<th></th>
<th>Medicaid</th>
<th>Private Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>$2,446</td>
<td>$1,108</td>
</tr>
<tr>
<td>Obese</td>
<td>$6,730</td>
<td>$3,743</td>
</tr>
</tbody>
</table>

Obesity-related Hospitalization Costs for Children and Youths

- 2001: $125.9 million
- 2005: $237.6 million

Annual Medical Claims per 100 Full-time Employees

<table>
<thead>
<tr>
<th></th>
<th>Healthy-weight</th>
<th>Obese</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$7,503</td>
<td>$51,091</td>
</tr>
</tbody>
</table>
WHAT’S THE POTENTIAL ROI?

- Urban Institute, TFAH, New York Academy of Medicine, Prevention Institute.
  - $5.60 return for every $1 invested in proven community based interventions *brought to scale*
Projected Obesity-Related Health Care Costs 2010 to 2030

Orange: If Obesity Continues to Rise on Its Current Trajectory
Blue: If BMI is Reduced by 1 Percent
Red: If BMI is Reduced by 5 Percent

Predicted BMI-related direct health costs; 0%, 1%, and 5% reduction in absolute BMI
FUTURE #1. THE STATUS QUO.

<table>
<thead>
<tr>
<th>Related Disease</th>
<th>Projected Number of New U.S. Cases by 2030</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type 2 Diabetes</td>
<td>6,000,000 +</td>
</tr>
<tr>
<td>Coronary Heart Disease</td>
<td>5,000,000 +</td>
</tr>
<tr>
<td>Obesity-related cancers</td>
<td>400,000 +</td>
</tr>
</tbody>
</table>
FOR FURTHER INFORMATION

• The full text of *F as in Fat: How Obesity Threatens America's Future 2013* and many other interactive features are available at: www.FasinFat.org

• For county level data: www.countyhealthrankings.org

• For more on prevention and health reform: www.healthyamericans.org
EXAMPLE: WISCONSIN - IF WE TAKE ACTION

Obesity Health and Cost Savings

<table>
<thead>
<tr>
<th>Potential Health and Cost Savings by Top Obesity-Related Health Problems</th>
<th>2010 Number of Cases</th>
<th>Potential Cases Avoided by 2020 if BMI is Reduced by 5% (cumulative)*</th>
<th>Potential Cost Savings by 2020, if BMI is Reduced by 5% (cumulative)</th>
<th>Potential Cases Avoided by 2030 if BMI is Reduced by 5% (cumulative)</th>
<th>Potential Cost Savings by 2030, if BMI is Reduced by 5% (cumulative)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type 2 Diabetes</td>
<td>470,136</td>
<td>74,310</td>
<td>$1,442,000,000</td>
<td>147,935</td>
<td>$4,733,000,000</td>
</tr>
<tr>
<td>Obesity-Related Cancers*</td>
<td>89,046</td>
<td>4,341</td>
<td>$75,000,000</td>
<td>7,882</td>
<td>$187,000,000</td>
</tr>
<tr>
<td>Coronary Heart Disease &amp; Stroke</td>
<td>347,847</td>
<td>59,574</td>
<td>$1,968,000,000</td>
<td>123,717</td>
<td>$5,171,000,000</td>
</tr>
<tr>
<td>Hypertension</td>
<td>1,130,359</td>
<td>65,742</td>
<td>$286,000,000</td>
<td>114,692</td>
<td>$777,000,000</td>
</tr>
<tr>
<td>Arthritis</td>
<td>1,124,133</td>
<td>34,499</td>
<td>$377,000,000</td>
<td>66,542</td>
<td>$1,091,000,000</td>
</tr>
</tbody>
</table>
Healthy Beverages:
Community Solutions to Reduce Obesity and Obesity Related Cancers
Michelle Strangis, Minnesota Department of Health

Julie Ralston Aoki, Public Health Law Center
Setting the stage

Cancer Plan Minnesota

- Increase healthy eating
- Increase physical activity
- Increase number of people with healthy weight
Setting the stage

Key strategy: reducing consumption of sugary drinks

MDH Policy Brief on Sugar-Sweetened Beverages

http://mncanceralliance.org/policy-advocacy/sugar-sweetened-beverages
Why sugary drinks?

Consumption of sugar sweetened beverages has been associated with at least 20% of the increase in weight in the U.S. since 1977.
Promoting sustainable change

It is unreasonable to expect that people will change their behavior so easily when so many forces in the social, cultural, and physical environment conspire against change.
Statewide Network of Resources
Public Health Law Center
Building a Statewide Network

- Connect with key partners
- Create resources
- Collaborate
Statewide Network of Resources

Statewide Health Improvement Program (SHIP) at MDH
Hospital becomes first in Minnesota to stop selling sugar-sweetened beverages

St. Luke's Hospital in Duluth is planning to stop selling sugar-sweetened beverages at its main campus and all of its clinics.

It's the first hospital in Minnesota to take such action, according to Jamie Harvie of the Duluth-based Institute for a Sustainable Future, which advocates against sugary beverages.

Mark Branovan, St. Luke's director of hospitality, said the hospital made the decision because "there is that sugary-sweetened beverages are a significant contributor to obesity," the Duluth News Tribune reported. The ban is expected to start Nov. 1.

>Click here to read more about why St. Luke's decided to end sales of sugar-sweetened beverages.
HEALTHY BEVERAGES IN HEALTHCARE TOOLKIT

- Guide
- Fact sheets
- Case studies

http://www.publichealthlawcenter.org/search/node/healthy%20healthcare
Healthcare Can Lead the Way
Making the Healthy Choice the Easy Choice

The Policy, Systems, and Environmental Change Approach

Sickly Sweet
Why the Focus on Sugary Drinks

Although many factors influence rates of obesity and overweight, sugary drinks play a significant role. Some argue that singling out one type of food is not appropriate because any candy can be consumed in moderation. The fact is, however, that sugary drinks are no longer consumed as a special treat. Instead, they have become a regular and large contributor of daily calories to our diet. This is why efforts to reduce sugary drinks consumption are widely supported by public health experts.

Consumption of Sugary Drinks

Almost all of the sugar that Americans consume comes from added sugars (sugars added to food during processing, preparation, or at the table), and these added sugars account for about 16% of all the calories in the U.S. diet.5 Less than half of these added sugars come from sugary drinks such as soda, energy drinks, sports drinks, and “fruit” drinks (see Figure 1), prompting experts at the Institute of Medicine to identify sugary drinks as the single largest contributor of calories and added sugars to the U.S. diet.

While sugary drink consumption varies by age, sex, income, race and ethnicity, on any given day about half of the U.S. population consumes a sugary drink and 29% consumes more than one.6 Makes consume

Healthy Beverage Programs, Healthy Bottom Lines
Taking steps to eliminate the availability of sugary beverages within a facility is consistent with the premise that healthy options won’t sell as healthy ones. Healthy vending programs and in-schools indicate that the trend of sugary drinks rarely come to pass. The experiences and lessons learned suggest that while these may be an assessment period, overall revenue remains strong. These experiences indicate that trends embrace the sale of healthier – particularly water and 100% juices.

Implementing these changes have high costs. This series includes case studies of the experiences of two Massachusetts that implemented healthy beverage without hurting beverage sales or revenue. After implementing a healthy beverage Saint Elizabeth’s Hospital reported a 30% increase in healthy beverage sales, and an increase in the previous year. As viewed

Healthy Beverage Hot Spots
Identifying and Utilizing the Institutional Access Points

A key step in developing an effective healthy beverage program is to conduct an assessment of the beverage environment in the organization. An organizational assessment provides important information about where, how, and what drinks are available within a healthcare facility. In general, beverages are offered through five types of locations or access points:

- Retail Cafeterias
- Vending Machines
- Catering/Procurement for meetings and events
- Patient Services
- Outpatient contracted food/beverages (such as Au Bon Pain, Dunkin’ Donuts, McDonald’s)

Each location presents unique opportunities and challenges. The assessment results — and the greater understanding of the beverage access points gained through the assessment — enable healthcare facilities to refine policies and procedures to support healthier beverage options.
Working with Partners
MAKING SUSTAINABLE CHANGES

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Making sustainable changes

“By phasing out the sale of soda and other sugar-sweetened beverages, the health care facilities in Northeastern Minnesota are saying they prioritize good health—before, as well as after, people are sick. They are offering inspired leadership for other hospital and health care systems, their patients, staff, and the entire community.”

Edward P. Ehlinger, MD, MSPH, Commissioner, Minnesota Department of Health (editorial published in the Duluth Herald Tribune)
What can coalitions do?

• Identify critical partners

• Bring coalition resources to your partners to enhance their work.

• Think strategically about the role of the coalition: an independent coalition can be an effective messenger on sensitive topics.
Partners and resources

- MN Cancer Alliance members
- MDH (Community Transformation Grant Staff and Local Grantees; MDH Chronic Disease Programs; Office of State Health Improvement Initiatives; Collaboration Initiative and Commissioner’s Office; Oral Health Unit)
- University of Minnesota, School of Public Health
- Public Health Law Center
- Institute for a Sustainable Future/Commons Health Care Network
- Blue Cross Blue Shield of Minnesota Center for Prevention
- Local Public Health Departments
- Minnesota Hospitals
- Minnesota office of the American Heart Association and the Minnesotans for Healthy Kids Coalition
- MN Department of Education
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