Texas House Public Health Committee

April 5th , 2016

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Associate Vice Chancellor for Population Health
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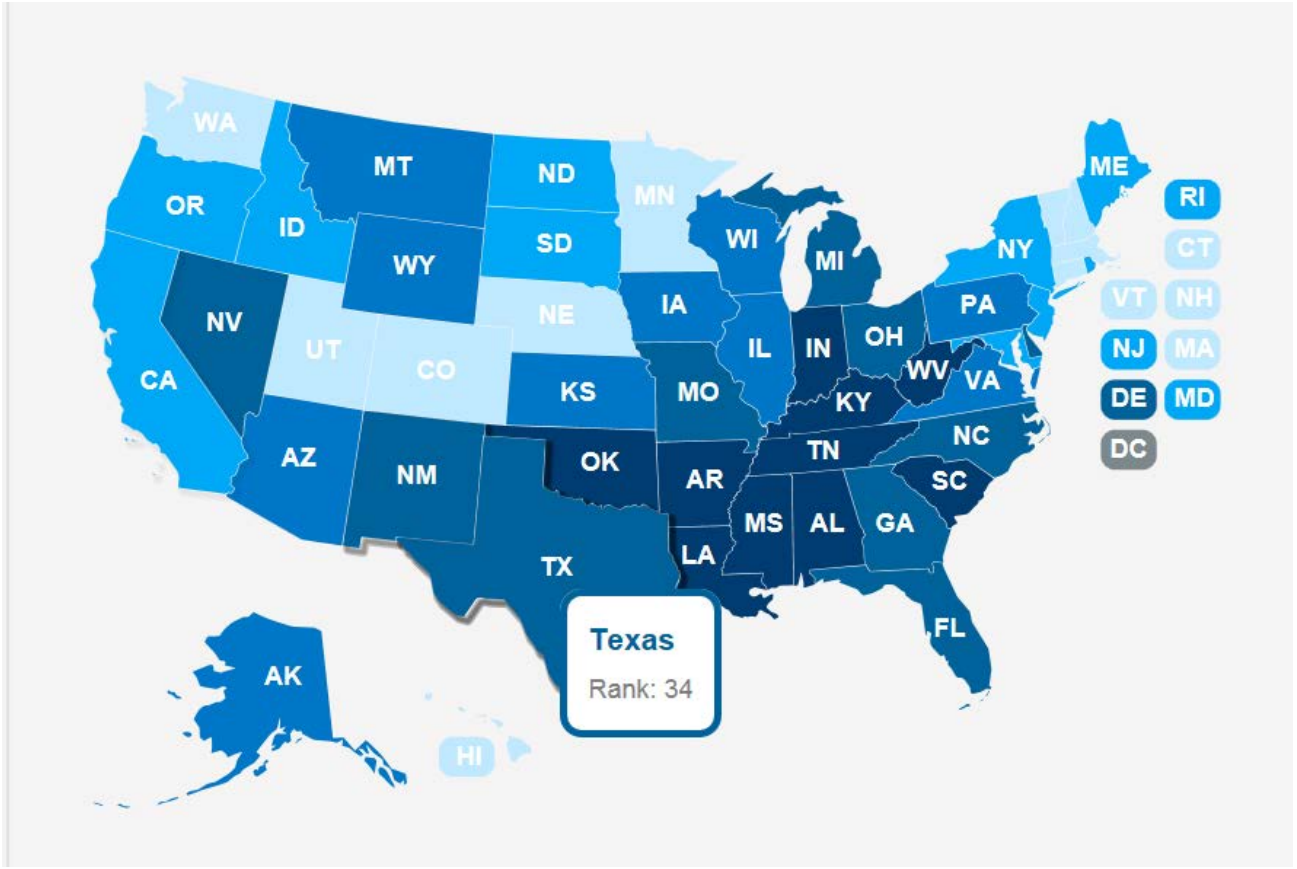
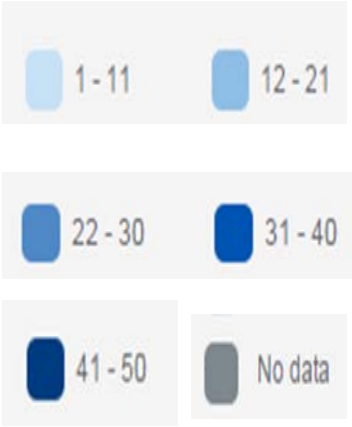
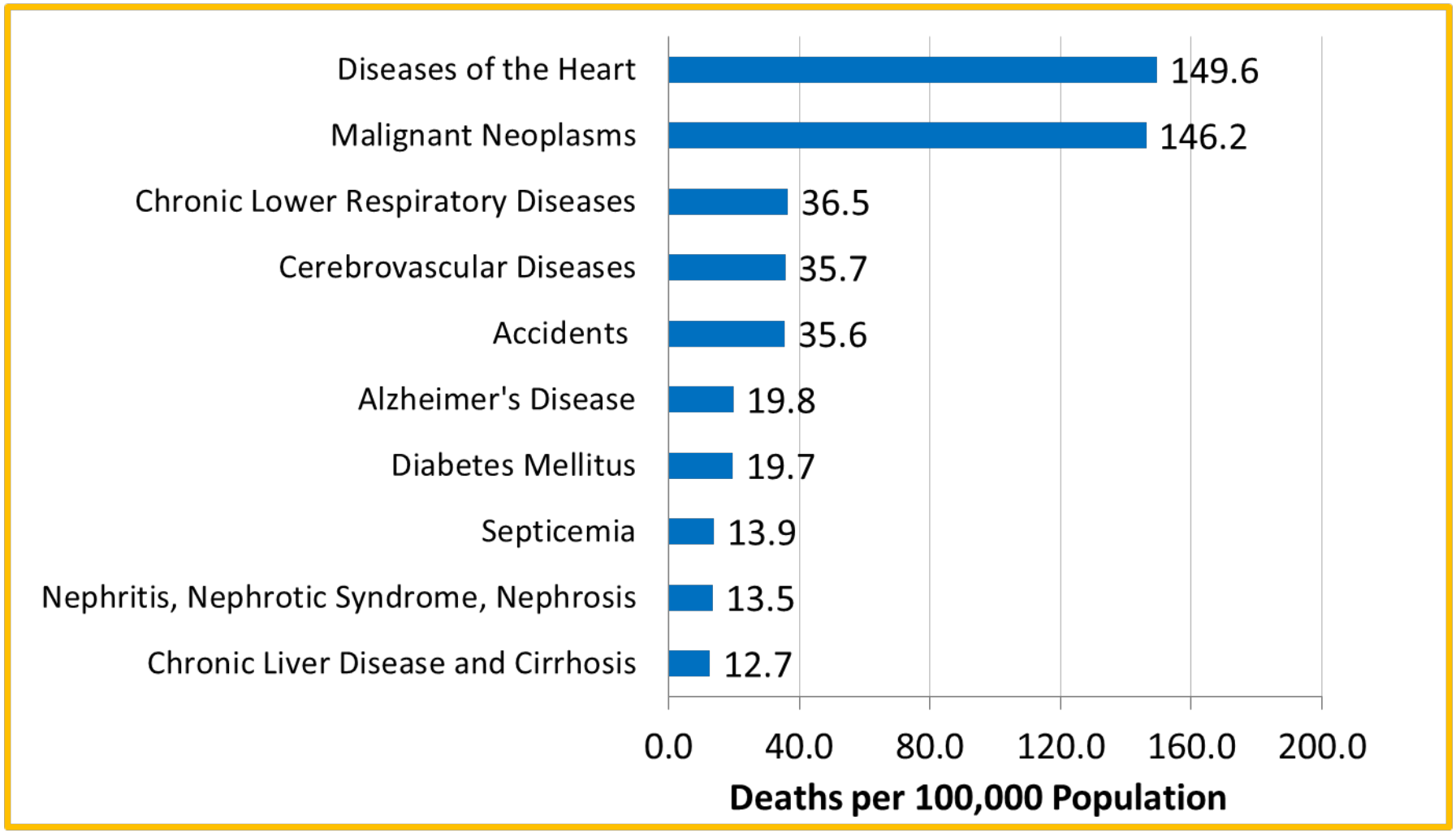
Overall State Health Rankings





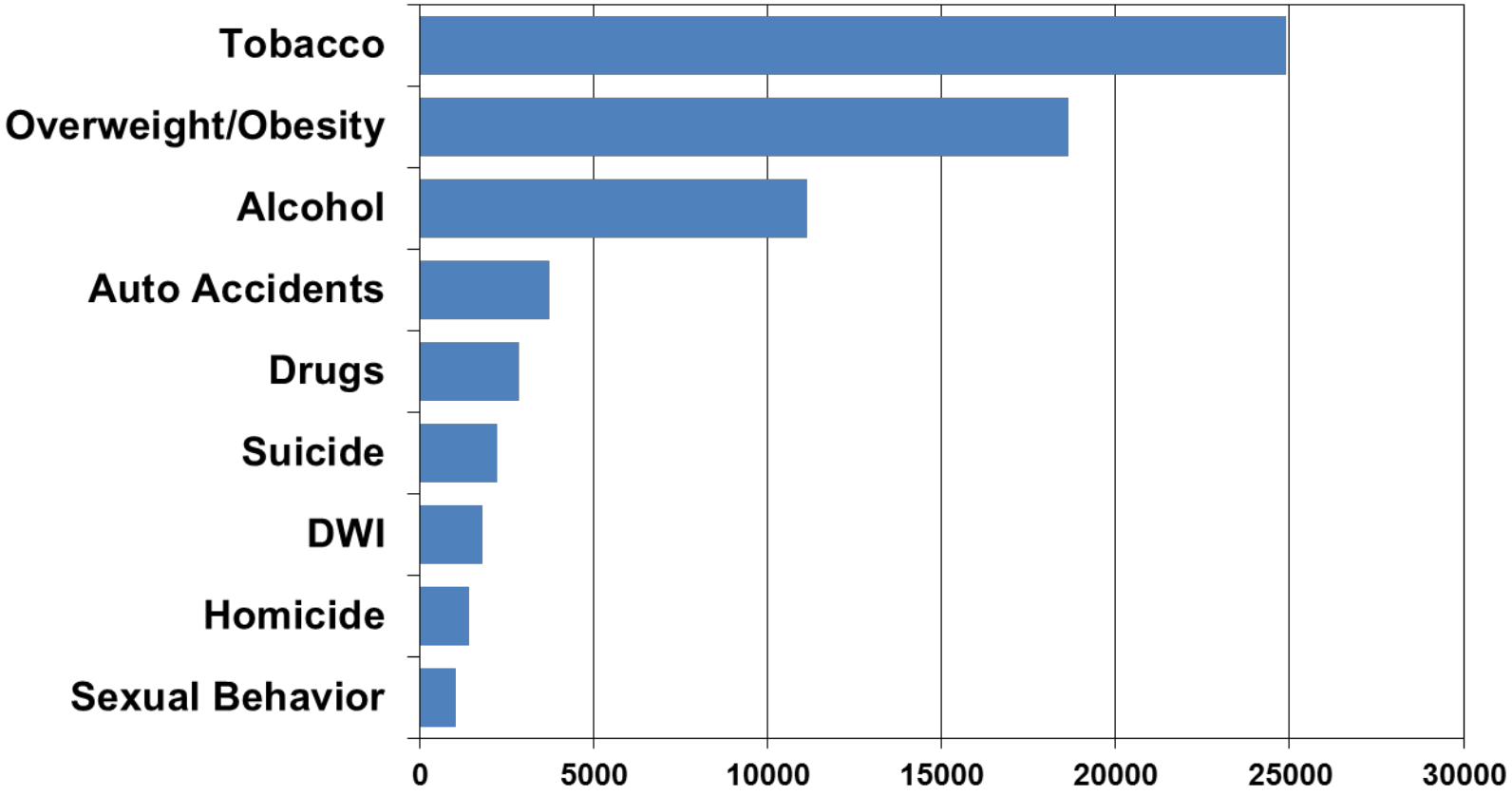
Source: America's Health Rankings,
United Health Foundation 2015 Annual Report

Leading Causes of Death-Texas 2012



Data Source: Vital Statistics Unit, Center for Health Statistics, DSHS

Actual Causes of Death Shaped by Behavior



Source: Chronic Disease in Texas 2007,

Annual potentially preventable deaths based on average death rates for the three states with the lowest rates for each cause

Centers for Disease Control and Prevention
MMWR
Morbidity and Mortality Weekly Report
Weekly / Vol. 63 / No. 17
May 2, 2014

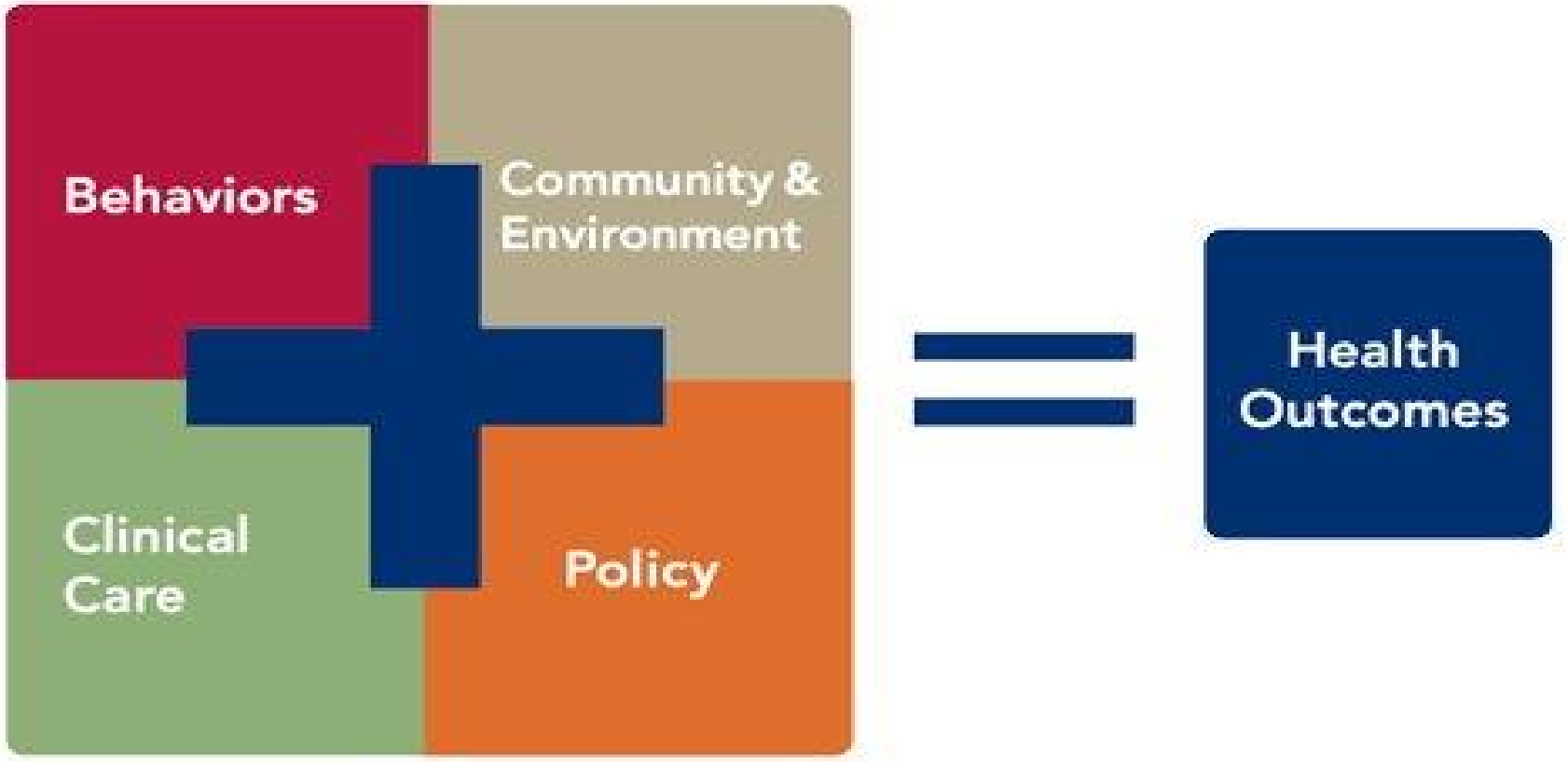
Potentially Preventable Deaths from the Five Leading Causes of Death — United States, 2008–2010

Paula W. Yoon, ScD[1], Brigham Bastian[2], Robert N. Anderson, PhD[2], Janet L. Collins, PhD[3], Harold W. Jaffe, MD[4]
(Author affiliations at end of text)

Potentially Preventable Deaths

	Observed	Expected	Potentially Preventable	Percent Preventable Texas	Percent Preventable United States
Heart Disease	19,939	12,683	7,256	36%	34%
Cancer	27,141	22,143	4,998	18%	21%
Chronic Lower Respiratory Disease	5,061	3,139	1,922	38%	39%
CVD/ Stroke	4,254	2,471	1,783	42%	33%
Unintentional Injury	7,612	4,551	3,061	40%	39%

How Do We Improve Health Outcomes?



The Cost of Obesity

According to Healthy Kinder, Inc., an organization dedicated to promoting healthy lifestyles for children, the average lifetime cost of obesity is high – over half a million dollars for an obese child who remains obese throughout adulthood:

Shorter lifespan	$234,240
Cardiovascular disease	10,521
Cancer	1,794
Diabetes	3,482
Arthritis	1,871
Lower wages	291,214
Diet programs and gym memberships	6,603
Grand Total	**$532,057**

Source: http://www.healthykinderkids.org/Cost-of-Obesity.html

HEALTH COSTS OF OBESITY AND COSTS TO EMPLOYERS

- U.S. health care costs due to obesity doubled in less than a decade and account for 9.1 percent of annual health costs, or $147 billion.
- Average health care spending for obese individuals was $1,429 or 41.5 percent higher than that of normal-weight persons in 2006.
- Obesity accounts for 12.9 percent of private insurer costs.
- Obesity is now the leading cause of premature heart attacks.
- Individuals with a BMI greater than 35 represent 37 percent of the population but account for 61 percent of the costs due to excess weight.
- **Obesity cost Texas businesses $9.5 billion in 2009.**[3]

Gaining Costs, Losing Time: The Obesity Crisis in Texas, February 2011

EXHIBIT 11

Texas Business Costs Attributable to Obesity, 2009

Areas of Costs	Estimated Costs	Percent
Healthcare	$4,022,324,929	42.5%
Absenteeism	1,643,955,363	17.4
Presenteeism	3,469,229,333	36.7
Disability	321,813,719	3.4
Total Costs	**$9,457,323,345**	**100.0%**

Source: Texas Comptroller of Public Accounts.

SUSAN COMBS • *Texas Comptroller of Public Accounts*

Gaining Costs, Losing Time: The Obesity Crisis in Texas, February 2011

Obesity could cost Texas businesses **$32.5 billion** annually by 2030, if current trends in obesity and health care costs continue.

Gaining Costs, Losing Time: The Obesity Crisis in Texas, February 2011

Gaining Costs, Losing Time

Recommendations

1. Allow TEA to use student-level FitnessGram data to access the relationship between physical fitness and academic performance
2. Partner with the private sector, federal legislators, associations and other advocates to develop strategies to promote healthy eating and physical activity
3. Recognize schools for achievements and improvements in health and fitness
4. Improve nutritional and physical activity in early childhood programs, including support for the use of dietary guidelines in childcare settings
5. The Legislature should fund intervention grants for middle schools identified as " high risk" for obesity by incorporating FitnessGram data with obesity data system to be developed by the Comptroller's office

Gaining Costs, Losing Time

Recommendations

6. Urge Texas legislators to restore the high school PE graduation requirement to 1.5 credits
7. Urge Texas Legislators to expand middle-school physical education requirements
8. Encourage school districts to send parents a “fitness report card” based on FitnessGram data
9. Encourage schools to make facilities available before and after school for use by the school community and community-based organizations for intramural physical activity programs.
10. Urge Texas senators and representatives in the U.S. Congress to propose changes to the federal Supplemental Nutrition Assistance Program (SNAP), limiting or curbing the eligibility of unhealthy food items.

Gaining Costs, Losing Time

Recommendations

11. Encourage farmer's markets to accept SNAP benefits (food stamps/Lone Star Cards) as payment.
12. Encourage policies in cities and counties that encourage walking and bicycling for health, transportation and recreation.
13. The Cancer Prevention and Research Institute of Texas (CPRIT) should focus research grant funding on proposals that study the link between obesity and cancer, based on feedback and findings from the RFI issued in August 2010.
14. Create a task force of health care and insurance providers to determine ways in which their industries can provide obesity prevention and intervention services to patients and policyholders.
15. The state should encourage the restaurant industry to list calories and nutrition content on menu items.

The Guide to Community Preventive Services
THE COMMUNITY GUIDE
What Works to Promote Health

Community Preventive Services Task Force

Search

Home | Task Force Findings | Topics | Use The Community Guide | Methods | Resources | News | About Us

[Want to know what combination of interventions increase vaccination rates?](#)

See two new Community Preventive Services Task Force recommendations on this topic.

1 2 3 4

Task Force

2015 Meetings
October 28–29

2016 Meetings

Annual Reports to Congress

Text Size: S M L X

Get Email Updates

Submit your email address to g updates on The Community Gui topics of interest.

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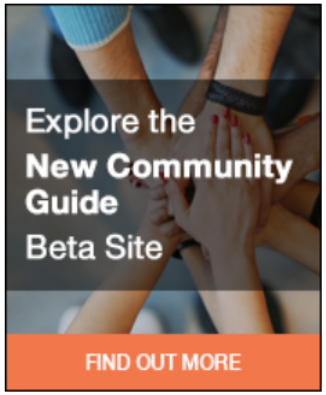
What's this?

Topics

Adolescent Health	Diabetes	Motor Vehicle Injury	Social Environment
Alcohol - Excessive Consumption	Emergency Preparedness	Nutrition	Tobacco
Asthma	Health Communication	Obesity	Vaccination
Birth Defects	Health Equity	Oral Health	Violence
Cancer	HIV/AIDS, STIs, Pregnancy	Physical Activity	Worksite
Cardiovascular Disease	Mental Health		



What is The Community Guide?

The Guide to Community Preventive Services is a free resource to help you choose programs and policies

ommunityguide.org/index.html

Obesity Prevention and Control: Interventions in Community Settings

Reviewed interventions include programs designed to reduce screen time, technology-based strategies, and interventions specific to worksite and school settings.

Task Force Recommendations and Findings

This table lists interventions reviewed by the Community Guide, with a summary of the Task Force finding (definitions of findings). Click on an underlined intervention title for a summary of the review, and where available, Research-tested Intervention Programs (RTIPs).

Behavioral Interventions that Aim to Reduce Recreational Sedentary Screen Time Among Children	Recommended August 2014
School-Based Programs	Insufficient Evidence October 2003
Worksite Programs	Recommended February 2007
Technology-Supported Multicomponent Coaching or Counseling Interventions	
To Reduce Weight	Recommended June 2009
To Maintain Weight Loss	Recommended June 2009

The Effectiveness of Worksite Nutrition and Physical Activity Interventions for Controlling Employee Overweight and Obesity

A Systematic Review

Laurie M. Anderson, PhD, MPH, Toby A. Quinn, MPA, Karen Glanz, PhD, MPH, Gilbert Ramirez, DrPH, Leila C. Kahwati, MD, MPH, Donna B. Johnson, PhD, Leigh Ramsey Buchanan, PhD, W. Roodly Archer, PhD, Sajal Chattopadhyay, PhD, Geetika P. Kalra, MPA, David L. Katz, MD, Task Force on Community Preventive Services

Abstract: This report presents the results of a systematic review of the effectiveness of worksite nutrition and physical activity programs to promote healthy weight among employees. These results form the basis for the recommendation by the Task Force on Community Preventive Services on the use of these interventions. Weight-related outcomes, including weight in pounds or kilograms, BMI, and percentage body fat were used to assess effectiveness of these programs.

This review found that worksite nutrition and physical activity programs achieve modest improvements in employee weight status at the 6–12-month follow-up. A pooled effect estimate of −2.8 pounds (95% CI=−4.6, −1.0) was found based on nine RCTs, and a decrease in BMI of −0.5 (95% CI=−0.8, −0.2) was found based on six RCTs. The findings appear to be applicable to both male and female employees, across a range of worksite settings.

Most of the studies combined informational and behavioral strategies to influence diet and physical activity; fewer studies modified the work environment (e.g., cafeteria, exercise facilities) to promote healthy choices. Information about other effects, barriers to implementation, cost and cost effectiveness of interventions, and research gaps are also presented in this article. The findings of this systematic review can help inform decisions of employers, planners, researchers, and other public health decision makers.

(Am J Prev Med 2009;37(4):340–357) Published by Elsevier Inc. on behalf of American Journal of Preventive Medicine

Increasing Physical Activity: Behavioral and Social Approaches

Behavioral and social approaches aim to increase physical activity by:

- Teaching behavior change skills
- Providing social support for people who are trying to begin or continue regular physical activity

Interventions may involve individual or group counseling, or the inclusion of friends and family.

Task Force Recommendations and Findings

This table lists interventions reviewed by the Community Guide, with a summary of the Task Force finding (definitions of findings). Click on an underlined intervention title for a summary of the review, and where available, Research-tested Intervention Programs (RTIPs).

Individually-Adapted Health Behavior Change Programs	Recommended February 2001
Social Support Interventions in Community Settings	Recommended February 2001
Family-Based Social Support	Insufficient Evidence February 2001
Enhanced School-Based Physical Education	Recommended December 2013
College-Based Physical Education and Health Education	Insufficient Evidence February 2001

Increasing Physical Activity: Environmental and Policy Approaches

Environmental and policy approaches are designed to provide opportunities, support, and cues to help people be more physically active. They may involve:

- The physical environment
- Social networks
- Organizational norms and policies
- Laws
- Public health professionals, community organizations, legislators, departments of parks, recreation, transportation, and planning, and the media

Task Force Recommendations and Findings

This table lists interventions reviewed by the Community Guide, with a summary of the Task Force finding (definitions of findings). Click on an underlined intervention title for a summary of the review, and where available, Research-tested Intervention Programs (RTIPs).

Community-Scale Urban Design and Land Use Policies	Recommended June 2004
Creation of or Enhanced Access to Places for Physical Activity Combined with Informational Outreach Activities	Recommended May 2001
Street-Scale Urban Design and Land Use Policies	Recommended June 2004
Transportation and Travel Policies and Practices	Insufficient Evidence February 2004
Point-of-Decision Prompts to Encourage Use of Stairs	Recommended June 2005

Diabetes

Task Force Recommendations and Findings

This table lists interventions reviewed by the Community Guide, with a summary of the Task Force finding (definitions of findings). Click on an underlined intervention title for a summary of the review.

Combined Diet and Physical Activity Promotion Programs to Prevent Type 2 Diabetes Among People at Increased Risk	Recommended July 2014
Case Management Interventions to Improve Glycemic Control	Recommended January 2001
Disease Management Programs	Recommended December 2000
Self-Management Education	
In Community Gathering Places - Adults with Type 2 Diabetes	Recommended March 2001
In the Home - Children and Adolescents with Type 1 Diabetes	Recommended March 2001
In the Home – People with Type 2 Diabetes	Insufficient Evidence March 2001
In Recreational Camps	Insufficient Evidence March 2001
In Worksites	Insufficient Evidence September 2000
In School Settings	Insufficient Evidence September 2000

Reducing Tobacco Use and Secondhand Smoke Exposure

Tobacco use is responsible for more than 430,000 deaths each year and is the largest cause of preventable morbidity and mortality in the United States (CDC).

In Best Practices for Comprehensive Tobacco Control Programs, the Centers for Disease Control and Prevention (CDC) recommends statewide programs that combine and coordinate community-based interventions that focus on the following areas.

1. Preventing initiation of tobacco use among youth and young adults
2. Promoting quitting among adults and youth
3. Eliminating exposure to secondhand smoke, and
4. Identifying and eliminating tobacco-related disparities among population groups

Task Force Recommendations and Findings

This table lists interventions reviewed by the Community Guide, with a summary of the Task Force finding (definitions of findings). Click on an underlined intervention title for a summary of the review, and where available, Research-tested Intervention Programs (RTIPs).

Interventions	Outcomes Addressed	Task Force Finding
Community Education to Reduce Secondhand Smoke Exposure in the Home	Secondhand Smoke Exposure	Insufficient Evidence February 2000
Comprehensive Tobacco Control Programs	Secondhand Smoke Exposure Cessation Initiation	Recommended August 2014
Incentives and Competitions to Increase Smoking Cessation Among Workers		
When Used Alone	Cessation	Insufficient Evidence June 2005
When Combined with Additional Interventions	Cessation	Recommended June 2005
Internet-Based Cessation Interventions	Cessation	Insufficient Evidence December 2011
Interventions to Increase the Unit Price for Tobacco Products	Cessation Initiation Health Disparities	Recommended November 2012
Mass Media - Cessation Contests	Cessation	Insufficient Evidence May 2000
Mass-Reach Health Communication Interventions	Cessation Initiation	Recommended April 2013
Mobile Phone-Based Cessation Interventions	Cessation	Recommended December 2011
Quitline Interventions	Cessation	Recommended August 2012
Reducing Out-of-Pocket Costs for Evidence-Based Cessation Treatments	Cessation	Recommended April 2012
Smoke-Free Policies	Secondhand Smoke Exposure Cessation Initiation	Recommended November 2012

Worksite-Based Incentives and Competitions to Reduce Tobacco Use

A Systematic Review

Kimberly D. Leeks, PhD, MPH, David P. Hopkins, MD, MPH, Robin E. Soler, PhD, Adam Aten, MPH, Sajal K. Chattopadhyay, PhD, the Task Force on Community Preventive Services

Abstract: The *Guide to Community Preventive Service* (*Community Guide*) methods for systematic reviews were used to evaluate the evidence of effectiveness of worksite-based incentives and competitions to reduce tobacco use among workers. These interventions offer a reward to individuals or to teams of individuals on the basis of participation or success in a specified smoking behavior change (such as abstaining from tobacco use for a period of time). The review team identified a total of 26 published studies, 14 of which met study design and quality of execution criteria for inclusion in the final assessment. Only one study, which did not qualify for review, evaluated the use of incentives when implemented alone. All of the 14 qualifying studies evaluated incentives and competitions when implemented in combination with a variety of additional interventions, such as client education, smoking cessation groups, and telephone cessation support. Of the qualifying studies, 13 evaluated differences in tobacco-use cessation among intervention participants, with a median follow-up period of 12 months. The median change in self-reported tobacco-use cessation was an increase of 4.4 percentage points (a median relative percentage improvement of 67%). The present evidence is insufficient to determine the effectiveness of incentives or competitions, when implemented alone, to reduce tobacco use. However, the qualifying studies provide strong evidence, according to *Community Guide* rules, that worksite-based incentives and competitions in combination with additional interventions are effective in increasing the number of workers who quit using tobacco. In addition, these multicomponent interventions have the potential to generate positive economic returns over investment when the averted costs of tobacco-associated illnesses are considered. A concurrent systematic review identified four studies with economic evidence. Two of these studies provided evidence of net cost savings to employers when program costs are adjusted for averted healthcare expenses and productivity losses, based on referenced secondary estimates.

(Am J Prev Med 2010;38(2S):S363–S374) Published by Elsevier Inc. on behalf of American Journal of Preventive Medicine

Reducing Tobacco Use and Secondhand Smoke Exposure: Smoke-Free Policies

Task Force Finding

The Community Preventive Services Task Force recommends smoke-free policies to reduce secondhand smoke exposure and tobacco use on the basis of strong evidence of effectiveness. Evidence is considered strong based on results from studies that showed effectiveness of smoke–free policies in:

- Reducing exposure to secondhand smoke
- Reducing the prevalence of tobacco use
- Increasing the number of tobacco users who quit
- Reducing the initiation of tobacco use among young people
- Reducing tobacco-related morbidity and mortality, including acute cardiovascular events

Economic evidence indicates that smoke-free policies can reduce healthcare costs substantially. In addition, the evidence shows smoke-free policies do not have an adverse economic impact on businesses, including bars and restaurants.

Read the full Task Force Finding and Rationale Statement for details including implementation issues, possible added benefits, potential harms, and evidence gaps.

Economic Evidence

Eleven studies were included in the economic review, of which two assessed cost-effectiveness, one measured cost-benefit, and eight considered benefits only (costs-averted). All monetary values are reported in 2011 U.S. dollars.

- Cost per quality-adjusted life year (QALY) gained: $1,138 (1 study)
- Cost per life year saved (LYS): $8,803 (1 study)
- Estimated net savings that would result from a U.S nationwide smoke-free policy ranged from $700 to $1,297 per person not currently covered by a smoke-free policy (1 study)
- One year healthcare costs averted: median estimate of $409,000 per 100,000 persons (range of values: $148,000 to $1.6 million; 5 studies)
- Annual healthcare costs averted over five or more years: median estimate of $1.1 million per 100,000 persons (range of values: $0.15 million to $4.8 million; 3 studies)
- Annual smoking-related costs averted for multi-unit housing in the state of California, including averted cleaning, repair, maintenance, and other costs: $18 million (1 study)

The economic impact of smoke-free policies on hospitality establishments (restaurants, bars, hotels, tourist venues, gaming establishments) was also considered using evidence from a systematic review published in 2008 (Scollo & Lal, 158 studies, search period 1988 – January 2008) combined with more recent evidence (21 studies, search period January 2008 – July 2012).

- Smoke-free policies did not have an adverse economic impact on the business activity of restaurants, bars, or establishments catering to tourists; some studies found a small positive effect of these policies.

PEERS AGAINST TOBACCO

TOBACCO RESEARCH & EVALUATION TEAM
THE UNIVERSITY OF TEXAS AT AUSTIN

Texas College Policy Database

Policies obtained by:

- **Looking on school website**
- **Phone calls to *each* campus**
- **Confirmed copy of each policy**

Campuses include:

- **46 Private Colleges/Universities**
- **60 Public College/Universities**
- **100 Community College Campuses (65 different policies)**

Updates:

- **Annual updates**
- **Last update fall 2015**

PEERS AGAINST TOBACCO

TOBACCO RESEARCH & EVALUATION TEAM
THE UNIVERSITY OF TEXAS AT AUSTIN

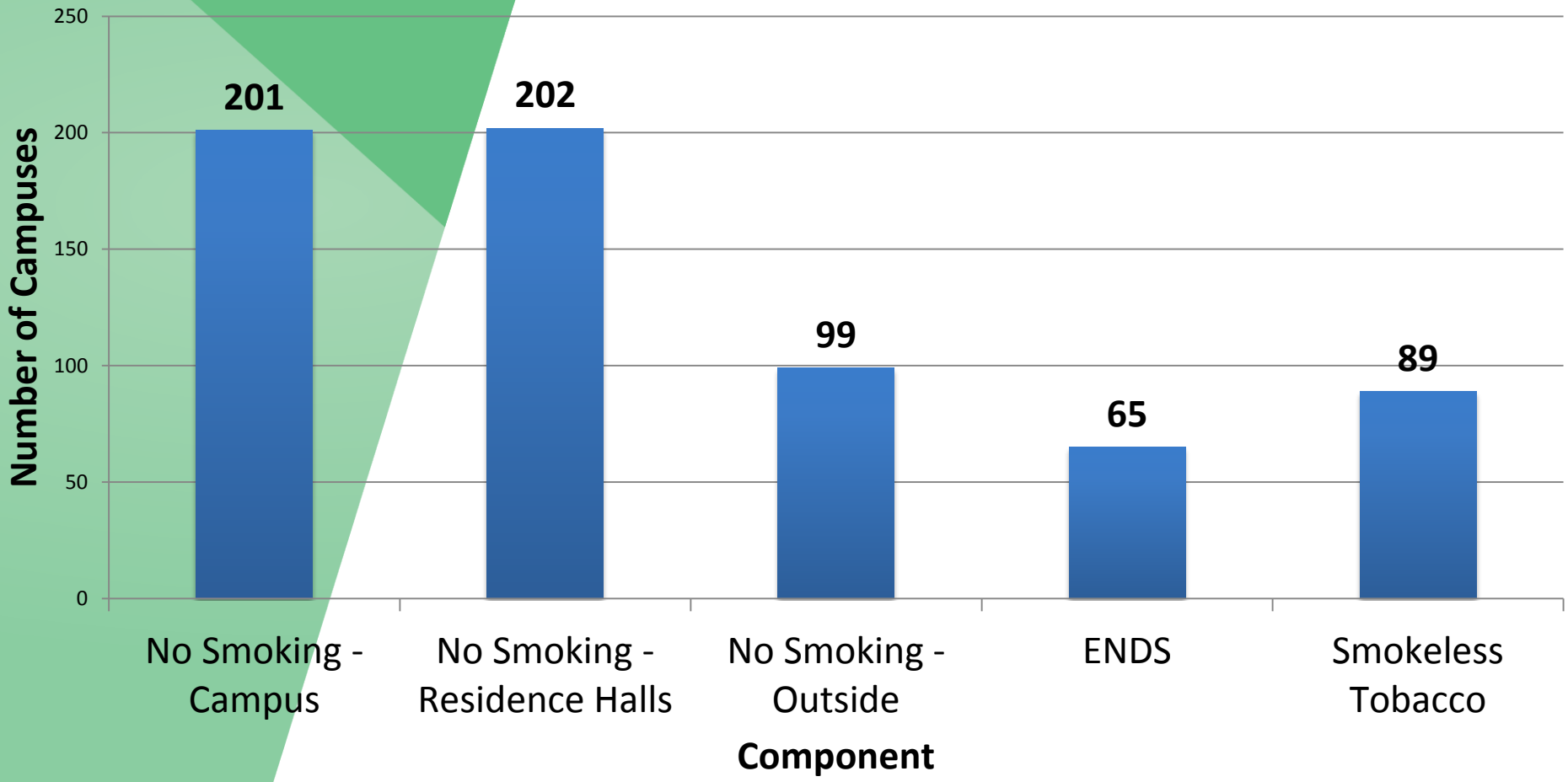
Policy Scale

Policy Component	Points (0 or 1)
Smoking is prohibited in buildings on campus	1
Smoking is prohibited in residence halls and/or dorms	1
Smoking is prohibited on campus property (i.e. designated outdoor areas, including parking lots)	1
Use of ENDS is prohibited on campus	1
Use of smokeless tobacco is prohibited on campus	1
Policy Rating (5 = Ideal Campus Policy)	**Total: 5**

PEERS AGAINST TOBACCO

TOBACCO RESEARCH & EVALUATION TEAM
THE UNIVERSITY OF TEXAS AT AUSTIN

Number of Campuses meeting each Policy Component (*N*=206)



UT Eliminate Tobacco Use Initiative

- **Representatives from each of UT System's 14 institutions met On February 22-23, 2016 at an "Eliminate Tobacco Use Summit" to discuss creating a system-wide tobacco-free culture.**
- **Summit participants collectively shared: tobacco control policies, public education and prevention programs, and cessation services**
- **Representatives developed their own comprehensive plans to bring back to their institutional campus leadership.**
- **By inventorying available resources, UT System academic and health institutions identified areas to take collective action toward measurable reductions in the tobacco burden in Texas.**
- **The UT institutions will continue to convene and work together on addressing tobacco policies, prevention and cessation.**
- **Since the summit one of the three UT institutions not yet tobacco free has announced they will be tobacco free by September 2016**

Wellness Programs for State Agencies

State Employees Health Behaviors and Conditions Mirror Texas as a Whole

- **20% smoke**
- **66 % are overweight or obese**
- **28% do not exercise or routinely get physical activity**
- **10% have diabetes**
- **27% have high blood pressure**
- **38%have high cholesterol**

State Agency Worksite Wellness, DSHS, November 2014

Impact on States Healthcare Expenditures

- **Medical expenditures for an obese employee in the US are estimated to be 42% higher than a person of healthy weight.**
- **Each employee that smokes costs his/ her employer an extra $3,383 per year**
  - **$1,760 in lost productivity**
  - **$1,630 in additional medical costs**

State Agency Worksite Wellness, DSHS, November 2014

“Texas Model Wellness Program”

- **Criteria**
  1) **Shown to be effective, or strong promise for success**
  2) **Cost-effective to implement**
  3) **Feasible to implement within a public agency**

- **Priority objectives**
  - **Increasing usage of preventive screenings and services**
  - **Improving tobacco prevention and cessation**
    - **Smoke-free campus policy implemented by HHS in FY 2015**
  - **Increasing physical activity**
  - **Increasing healthy eating**
  - **Improving stress management**
  - **Supporting nursing mothers**

Level of Wellness Program Development

- **60 of 140 wellness liaisons/coordinators responded (43%)**
- **74% agencies have a wellness policy in place**
- **59% have a wellness council**
- **62% have a wellness plan**
- ***60% report their agencies have no wellness budget, 20% have budget under $1,000/year***

State Agency Worksite Wellness, DSHS, November 2014

Table 1. Prevalence of Wellness Policy Provisions among Agencies

Provision	Percent of Agencies
3 x 30 minutes/week for physical activity	62%
Permission to attend wellness education opportunities	59%
Leave incentive (eight hours) to complete health risk assessment (HRA) and physician visit	48%
Creation and operation of a wellness council	47%
Designated senior-level support for wellness activities	31%

Note: n=60 responding state agencies

State Agency Worksite Wellness, DSHS, November 2014

Table 2. Prevalence of Suggested Programming among Agencies

Programming	Percent of Agencies
Increase physical activity	91%
Support health risk assessments/screenings	86%
Support stress management	82%
Support breastfeeding	82%
Increase healthy eating	60%
Support tobacco cessation	58%

Note: n=60 responding state agencies

State Agency Worksite Wellness, DSHS, November 2014

Table 3. Most Commonly Implemented Programming

Programming	Percent of Agencies
Increase Physical Activity	
Allowing time during the workday for physical activity	67%
Providing on-site fitness classes	49%
Support Health Risk Assessments (HRA)/Screenings	
Providing flu vaccination clinics	71%
Providing incentives for completion of HRA	47%
Support Stress Management	
Providing education/resources addressing stress	53%
Educating managers on referring staff to services	49%
Compressed work week schedule or telecommuting	47%
Support Breastfeeding	
Providing a private, comfortable room for breastfeeding	78%
Meet/Exceed Texas Mother-Friendly Worksite criteria	42%
Increase Healthy Eating	
Farm-to-work program	40%
Increasing availability of healthy foods in cafeterias	26%
Tobacco Cessation	
Establishing a smoke-free or tobacco-free campus policy	42%
Promoting telephone counseling	22%

Note: n=60 responding state agencies

State Agency Worksite Wellness, DSHS, November 2014

Table 5. Staff utilization of wellness benefits/services from 2012-2014

Benefits/Services	Percent of Staff
Leave incentive (eight hours) for HRA	20%
Available exercise time (3 x 30 min/week)	20%
On site health screenings	19%
Physical activity programs	19%
Employee Assistance Program	14%
Healthy eating programs	9%
On site massage therapy	8%
Stress management counseling	6%
Tobacco cessation services	1%
Breastfeeding facilities	1%
I have not used any of these services	46%

Note: n=12,903 responding state employees

2014 Worksite Wellness Advisory Board Recommendations to DSHS

1. **Identify wellness activities to define "participation" in the Building Healthy Texans State Agency Wellness Program**

2. **Prohibit tobacco use on all state-owned and leased properties**

3. **Identify DSHS team to work with ERS to:**

   a) **Support USPSTF A&B and US Advisory Council on Immunization Practices (ACIP) recommendations**

   b) **Study potential savings to provide generic disease meds at zero out-of-pocket expense to state employees**

4. **ERS will share aggregated health claims data annually with the Statewide Wellness Coordinator and state agency wellness staff .**

5. **Provide agencies with a listing of community/statewide partners that could provide USPSTF A&B recommended services and screenings on-site at wellness fairs or clinics.**

6. **In support of Government Code Chapter 664, agencies should devote a minimum percent of an FTE (according to agency size) to planning, implementing, and evaluating wellness activities.**

QUESTIONS?