



**Metro Denver**

HEALTH & WELLNESS COMMISSION

Creating America's Healthiest Community

# MDHWC STRATEGIC PLAN: 2007-2012

*OUR RECIPE TO CREATE AMERICA'S  
HEALTHIEST COMMUNITY*

Adopted May 18, 2007



*Chair*

Barbara O'Brien  
Lieutenant Governor  
State of Colorado

May 18, 2007

*Co-Chairs*

Tom Clark  
Executive VP, Metro  
Denver Economic  
Development Corp.

It is with both a sense of urgency and optimism that the Metro Denver Health and Wellness Commission (MDHWC) release the *MDHWC STRATEGIC PLAN: 2007-2012 – Our Recipe to Create America's Healthiest Community*.

Dr. James O. Hill,  
PhD, Director,  
Center for Human  
Nutrition-UCDHSC

The MDHWC is a coalition of nearly 80 community leaders from the non-profit community, business, government, and education, with the vision of making the Metro Denver area America's healthiest community--and capturing the economic benefits of achieving that vision. With metro area residents comprising over 55 percent of Coloradans, achieving our vision will have a tremendous, positive impact on the state as a whole.

Mayor Karen Stuart  
City and County of  
Broomfield

Our mission is to promote policies and programs that support a culture of healthy eating and active living in schools, worksites, and communities. We are embracing small steps to bring about big change.

*Executive Director*  
Theresa M. Donahue

As a state, Colorado still boasts the lowest obesity rates in the nation. Similarly, we know that fewer Metro Denver area residents are overweight or obese than most other areas of the country. However, despite our low rates, obesity trends in Colorado and the Metro Denver area are moving in the wrong direction, and at a rate faster than some other areas of the country.

I am optimistic that we can turn these trends around for the good of our families and our economy given our relatively good health status, excellent parks and trails infrastructure, commitment to regional cooperation, understanding of the relationship between healthy lifestyles and economic prosperity, and the commitment of the many community leaders serving on the MDHWC.

Together, we can take many small steps and make big changes. Our physical, mental, social and economic health depends on it.

Sincerely,

A handwritten signature in black ink that reads "Barbara O'Brien".

Barbara O'Brien  
Lieutenant Governor  
MDHWC Chair

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# EXECUTIVE SUMMARY

## BACKGROUND

As a state, Colorado still boasts the lowest obesity rates in the nation. Similarly, fewer Metro Denver area residents are overweight or obese than most other areas of the country. However, despite our relatively low rates, obesity trends in Colorado and the Metro Denver area are moving in the wrong direction.

The percentage of adults in the Metro Denver area who were at a healthy weight has decreased by 9.2 percent between 1995 and 2005. In 2005, the percent of adults who were overweight or obese was 55 percent and almost 29 percent of Metro Denver area children ages 2 to 14 were at risk of being overweight or were overweight.

The impact of overweight and obesity on health and the cost of health are huge. They are directly linked with the three leading causes of death--heart disease, cancer and stroke--and ten of the top 15 costliest medical conditions. Obesity alone is estimated to cost Colorado \$874 million in related medical expenses.

Research shows that healthy eating and active living improves our overall health, quality of life, workplace productivity, and student performance, while lowering health costs and making the region more economically competitive.

In fact, in addition to higher academic performance, studies show that healthy eating and increased physical activity improves student test scores, increases student concentration, reduces disruptive behavior, lowers absenteeism and lowers depression.

In worksites, healthy-weight employees can decrease absenteeism and presenteeism (sick at work and under-performing), improve safety and morale, decrease health care costs (including short- and long-term disability and worker's compensation) as well as reduce the cost of replacement workers, overtime, and routine overstaffing. And, comprehensive, evidence-based worksite wellness programs produce well over a 5:1 return on every dollar invested.

That is why the Metro Denver Health and Wellness Commission (MDHWC), a coalition of nearly 80 community leaders led by Lieutenant Governor Barbara O'Brien and supported by dozens of local experts, has the vision of "Making Metro Denver America's Healthiest Community"--and capturing the economic benefits of achieving our vision.

Our mission is to promote policies and programs that support a culture of healthy eating and active living in schools, worksites, and communities. We are embracing small steps to bring big change.

We do not currently have the lowest rates of overweight and obesity among metro areas. Yet, we are well-positioned to be successful given our relatively good health status, excellent infrastructure of parks and trails, our commitment to regional cooperation, and the creation of the MDHWC, including our understanding of the relationship between healthy lifestyles and the economic prosperity of the region.

In collaboration with community partners, we will improve the health and wellness of residents, help individuals and businesses save money, and reap the related economic dividends of a healthy community. We acknowledge the importance of individual responsibility, and will focus on creating an

environment and culture that supports and rewards healthy lifestyle choices--making those healthy choices the norm.

To make Metro Denver America's Healthiest Community, the commission will focus its efforts on these three initiatives:

1. Healthy Schools and Early Childhood Programs
2. Healthy Worksites
3. Healthy Communities

Those three areas directly impact:

- Over 425,000 kindergarten through 12<sup>th</sup> grade students in our schools, and thousands of children in pre-kindergarten early childhood education and care programs.
- Over 1.3 million employees working for nearly 80,000 government, private, and nonprofit employers, and
- Over 2.6 million metro area residents affected by state and local government policies and programs.

The following initiatives and objectives are based upon MDHWC research and evaluation of evidence-based policies and programs, and input from hundreds of people across the Metro Denver area. Progress on implementation will be monitored and shared annually with the public and key stakeholders.

### **HEALTHIEST SCHOOLS AND EARLY CHILDHOOD PROGRAMS**

No Metro Denver school district currently achieves the physical activity, physical education, healthy foods, or nutrition education standards called for in our strategic plan. Our initiative includes in-school policies and programs, as well as after school and summer school activities, priorities highlighted by a recent study indicating that young children's body mass index was more likely to increase during the summer than during the school year.

Finally, in order to track our region's progress and giving our schools and

parents the data they need for appropriate wellness interventions, the plan calls for collecting and reporting aggregate-level fitness data for every school analyzed in relationship to academic performance.

*Key Objectives:*

- *Incorporate daily physical activity in all public school grades (pre-K through 12) by 2009.*
- *Incorporate physical education with qualified staff in all pre-K through 12th grades in public schools with funding appropriated by 2012.*
- *Ensure all children participate in a minimum of 50 hours of nutrition education annually by 2012.*
- *Secure sustainable resources to support and expand after school/summer activities by 2009.*
- *Establish that all food and beverages sold or otherwise available at school functions will meet or exceed criteria of the Alliance for a Healthier Generation by 2012.*
- *Promote physical activity and healthy foods in early childhood care and education programs by 2009.*
- *Collect and report aggregate-level data on students' fitness and the link to academic success in 100 percent of schools by 2012.*

### **HEALTHIEST WORKSITES**

The MDHWC will work with area employers, chambers of commerce, human resource associations and others to achieve aggressive objectives for comprehensive, evidence-based programs for larger employers, and effective healthy eating, active living wellness components for smaller employers. The plan also calls for researching and incorporating health insurance incentives as tools worksite wellness programs.

*Key Objectives:*

- *Comprehensive, evidence-based worksite wellness programs adopted by*

*all employers with 100 or more employees 2012.*

- *Worksite wellness programs incorporating incentives adopted by 2,000 small employers by 2012.*
- *Incorporate health insurance wellness incentives as part of a comprehensive worksite wellness initiative promoting healthy lifestyle choices by employees.*

## **HEALTHIEST COMMUNITIES THROUGH PUBLIC SECTOR POLICIES**

The strategic plan incorporates a broad range of objectives using public policies and programs, as well as community partnerships, to create an environment supporting physical activity and healthy eating. Research shows the link between community design, including access to parks and trails, and increased physical activity. Studies also show that local access to healthful foods, whether through farmers markets, neighborhood grocery stores and community gardens, increase healthy eating in lower income communities. The plan also focuses on the opportunity to curb the increasing costs of public health insurance, specifically Medicaid.

### **Key Objectives:**

- *Create communities that encourage more physical activity through public land use plans and policies, including the development of a transportation system supporting increased physical activity.*
- *Develop and adopt “Complete Streets” and safe intersection design standards by all local governments and the Colorado Department of Transportation by 2012.*
- *Achieve a fair allocation of state transportation system funding for infrastructure and improvements that benefit all users and support safe routes to schools.*
- *Support community driven initiatives (e.g. LiveWell Colorado partnerships) to identify community healthy eating, active*

*living priorities and implement policies and programs to achieve them.*

- *Increase availability and affordability of healthful foods, especially in underserved communities.*
- *Design and implement a pilot program that rewards participation in primary prevention and wellness programs among Medicaid enrollees in the Metro Denver area by 2009.*

## **COMMUNICATIONS AND MARKETING**

Sustaining the message, using our health status as an economic development tool, creating The Denver *Lifestyle Diet: A Formula for Healthy Living* as a brand, and celebrating our successes are essential to achieving our vision.

### **Key Objectives:**

- *Implement communications plan to support MDHWC strategic plan.*
- *Support other organizations launching broad-based social marketing campaigns.*
- *Hold annual awards event recognizing individuals and organizations that have led by example beginning in 2008*

**Acknowledgment of Financial Support:** The MDHWC Strategic Plan: 2007-2012 *Our Recipe For America’s Healthiest Community* could not have been developed without the generous support of the MDHWC’s Strategic Financial Partners: Colorado Department of Public Health and Environment, The Colorado Health Foundation, The Colorado Trust, Metro Denver Economic Development Corporation, Pfizer, Rose Community Foundation and other generous contributors.

## **BACKGROUND**

The Metro Denver Health and Wellness Commission strategic plan lays out our vision and mission. It incorporates objectives with aggressive targets and outlines strategies we will use to achieve them. Most importantly it identifies potential partners who will be key to achieving our vision. Although it is a five-year plan (2007-2012), we know it will take much longer to achieve our vision. We will annually evaluate our region's progress and refine the plan itself.

As a state, Colorado still boasts the lowest obesity rates in the nation. Similarly, fewer metro Denver area residents are overweight or obese than many other areas of the country. However, despite our relatively low rates, obesity trends in Colorado and the Metro Denver area are moving in the wrong direction.

The percentage of adults in the Metro Denver area who were at a healthy weight has decreased by 9.2 percent between 1995 and 2005. In 2005, the percent of adults who were overweight or obese was 55 percent and almost 29 percent of Denver Metro area children ages 2 to 14 were at risk of being overweight or were overweight.<sup>1</sup> Research shows that healthy eating and active improves our overall health, quality of life, workplace productivity, and school performance, while making the region more economically competitive.

### **Metro Denver Health and Wellness Commission**

These are the key reasons why the Metro Denver Health and Wellness Commission (MDHWC), a coalition of nearly 80 community leaders from government, non-profit organizations, business, and education, and both K-12 and higher education has the vision of Making the Metro Denver Area America's Healthiest Community. (See Appendix A--MDHWC Roster.)

The MDHWC is chaired by Lieutenant Governor Barbara O'Brien and co-chaired by Tom Clark, Executive Vice President of the Metro Denver Economic Development Corporation (MDEDC), Dr. James O. Hill, PhD, Director of the Center for Human Nutrition at the University of Colorado at Denver and Health Sciences Center, and Mayor Karen Stuart, City and County of Broomfield. MDHWC founding organizations include the Metro Mayors Caucus, MDEDC, and the Center for Human Nutrition and the Metro Denver Sports Commission. Creation of the MDHWC strategic plan has been supported by dozens of local experts serving on MDHWC committees.

The geographic scope of the MDHWC includes Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas and Jefferson Counties. The focus of the MDHWC is not only on improving health and wellness, but also on strengthening the metro area economy by taking advantage of the benefits of being a healthy region.

### **Vision and Mission of the MDHWC**

The vision of MDHWC is for the Metro Denver area to be America's healthiest community--and capture the economic benefits of achieving our vision. Our mission is to promote policies and programs that support a culture of healthy eating and active living in schools, worksites, and communities. We are embracing small steps to bring big change.

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<sup>1</sup> Colorado Department of Public Health and Environment

Given the rise in obesity rates across the country, being the healthiest community is not enough. So our additional goals are to flatten the obesity and overweight curve by 2012 and turn it around by 2017.

We are well-positioned to be successful given our relatively good health status, excellent infrastructure of parks and trails, our commitment to regional cooperation, and the creation of the MDHWC, including our understanding of the relationship between healthy lifestyles and the economic prosperity of the region.

The MDHWC will help create synergies by connecting community partners, educating regarding the challenges and opportunities, elevating the importance of the issues, measuring and reporting on our region’s progress, and promoting the strategies laid out in the strategic plan. As stated in The Colorado Trust’s new report evaluating obesity prevention, “Many factors contribute to successful weight loss, increased physical activity and improved nutrition, including the physical and social environments of communities and organizations, access to information and the policies, practices and norms within social and work settings.” Our plan addresses the complex, multi-component nature of the challenge facing us.

Vision:	<ul style="list-style-type: none"> <li>○ Be America’s healthiest community</li> </ul>
Mission:	<ul style="list-style-type: none"> <li>○ Increase healthy eating and active living</li> <li>○ Create the culture and infrastructure to support healthy lifestyle choices</li> </ul>
Strategic Priorities:	<ul style="list-style-type: none"> <li>○ Create healthy schools, worksites, and communities</li> <li>○ Market health and wellness accomplishments to achieve economic benefits</li> </ul>
Guiding Principles and Values:	<ul style="list-style-type: none"> <li>○ Support entrepreneurial and voluntary approaches before government mandates</li> <li>○ Embrace small steps to bring big change</li> <li>○ Acknowledge personal responsibility</li> <li>○ Measure progress to ensure accountability</li> <li>○ Incorporate research and best practices</li> <li>○ Build on and support existing resources and partnerships</li> <li>○ Seek positive change for <b>all</b> metro area residents</li> </ul>

## IMPACTS AND OPPORTUNITIES

### Health and Wellness, and Quality of Life

Every week new studies emerge which highlight the connections between healthy eating and active living--the two behaviors directly impacting our weight--and our health and quality of life. For example, researchers at National Jewish Medical and Research Center recently found that being overweight or obese increases the odds of developing asthma the next year by about 50 percent and that the more overweight a person is, the greater the risk of developing

asthma.<sup>2</sup> The three leading causes of death are heart disease, cancer, and stroke--and all are caused by overweight and obesity. Diabetes and Alzheimer's disease ranked sixth and seventh, are also directly linked to overweight and obesity.<sup>3</sup> According to the U.S. Department of Health and Human Services (HHS), obese adults have a 50 to 100 percent increased risk of premature death compared to adults of healthy weight.

Physical activity levels and diet can directly influence people's ability to carry out even the most basic social and physical activities.<sup>4</sup> Being overweight or obese increases your chances of hypertension, type 2 diabetes, cancer, heart disease, stroke, gallbladder disease, osteoarthritis, sleep apnea, asthma, back problems, gallstones, liver disease, incontinence, dyslipidemia, and periodontal disease.<sup>5 6</sup>

From the positive perspective, healthy eating and active living can reduce our risks of those diseases and health conditions. People who enjoy participating in physical activity on a regular basis benefit by lowering their risk of developing coronary heart disease, stroke, type 2 diabetes, high blood pressure, and colon cancer by 30 to 50 percent, according to the HHS. Increased physical activity in 20 to 60 year olds has been shown to reduce the risk of Alzheimer's as older adults.<sup>7</sup>

However, we are seeing alarming levels children at risk of overweight and obesity and early symptoms of disease previously seen only in adults, for example, high blood pressure, early symptoms of hardening of the arteries, and type 2 diabetes.<sup>8</sup> Recent research indicates that obesity in girls can triple the risk of asthma as an adult.<sup>9</sup>

For older adults, good nutrition<sup>10</sup> and physical activity help maintain the ability to live independently. Physically active older adults can delay the onset of arthritis symptoms<sup>11</sup>, help control joint swelling and pain associated with arthritis, reduce the risk of falling and fracturing bones, reduce symptoms of anxiety and depression and foster improvements in feelings of well-being, reduce blood pressure in some people with hypertension, and delay reduction in mental

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<sup>2</sup> Allstetter, William, "Excess Weight Estimated to Cause More Than 250,000 New Asthma Cases Each Year in U.S.", *National Jewish Medical and Research Center*, <http://www.nationaljewish.org/news/y2007/obesity-asthma.aspx> (January 29, 2007).

<sup>3</sup> Centers for Disease Control and Prevention, National Center for Health Statistics, <http://www.cdc.gov/nchs/fastats/lcod.htm>, accessed April 2, 2007.

<sup>4</sup> Haomiao Jia, PhD, "The impact of obesity on health-related quality-of-life in the general adult US population", *Journal of Public Health* 27:2 (April 2005), 156-164.

<sup>5</sup> "Overweight and Obesity", Division of Nutrition and Physical Activity, National Center for Chronic Disease Prevention and Health Promotion, <http://www.cdc.gov/nccdphp/dnpa/obesity/index.htm>, accessed March 2007.

<sup>6</sup> Karels, A., Cooper, B. "Obesity and its role in oral health", *The Internet Journal of Allied Science and Health Practice* 5: 1 (January 2007), (<http://ijahsp.nova.edu/>)

<sup>7</sup> Robert P. Friedland, Thomas Fritsch, Kathleen A. Smyth, Elisabeth Kossi, Alan J. Lerner, Chien Hsiun Chen, Grace J. Petot, and Sara M. Debannes, "Patients with Alzheimer's disease have reduced activities in midlife compared with healthy control-group members", *Proceedings of the National Academy of Sciences of the United States of America* 98(6) (2001), 3440-3445.

<sup>8</sup> Stephen R. Daniels, "The Consequences of Childhood Overweight and Obesity", *The Future of Children* 16:1 (Spring 2006) 47-67.

<sup>9</sup> "Childhood obesity triples women's adult asthma risk", *ScienceAlert* (29 March 2007) <http://www.sciencealert.com.au/news/20072903-14653-2.html> (March 2007)

<sup>10</sup> "Nutrition and Older Adults", Kathleen A. Meister, American Council on Science and Health, Health Issues, Posted January 1, 1998—not sure where this came from

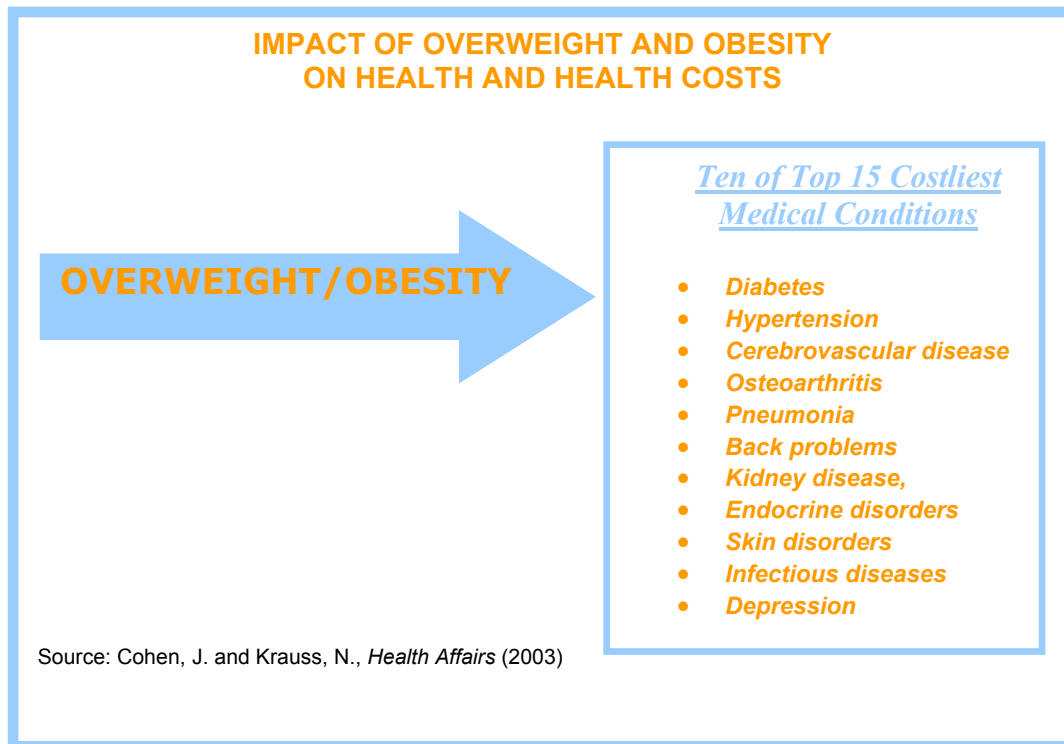
<sup>11</sup> Kristiann C Heesch, Yvette D Miller, Wendy J Brown, "Relationship between physical activity and stiff or painful joints in mid-aged women and older women: a 3-year prospective study", *Arthritis Research & Therapy* (2007) <http://arthritis-research.com/content/9/2/R34>, accessed March 2007.

acuity, along with reducing other health risks.<sup>12</sup> And, for adults with Alzheimer's disease, physical activity delays deterioration in their ability to do daily physical activities.<sup>13</sup>

We know that the health status of groups within Colorado and the Metro Denver area differ based upon race, ethnicity, socio-economic status and other factors. According to the Colorado Department of Public Health and Environment Office of Health Disparities, Latinos, African Americans, and American Indians in Colorado are all disproportionately affected by diabetes. In its *Racial and Ethnic Disparities in Colorado 2005*, the office noted that "[d]iabetes is the ninth leading cause of death in Colorado. In Colorado, the death rate of diabetes is statistically highest in the Latino and African American populations... at close to twice the state average rate...."

## Financial and Economic

The economic costs of obesity are also staggering: Overweight and obesity have a direct link to ten of the top 15 costliest medical conditions,<sup>14</sup> and related health costs exceed those associated with tobacco use.<sup>15</sup> Obesity is estimated to have cost \$874 million (\$1,710 per person) in obesity-related medical expenses in Colorado alone.<sup>16</sup>



<sup>12</sup> *Surgeon General's Report on Physical Activity and Health*

<sup>13</sup> "Exercise Program in Nursing Home Residents with Alzheimer's Diseases: A One-Year Randomized Controlled Trial." *Journal of the American Geriatrics Society* 55:2 (February 2007).

<sup>14</sup> Cohen, J. and Krauss, N. 2003. "Spending and Service Use Among People With the Fifteen Most Costly Medical Conditions, 1997." *Health Affairs* 22, (2):129-138.

<sup>15</sup> Sturm, R. 2002. "The Effects of Obesity, Smoking, and Drinking on Medical Problems and Cost. Obesity Outranks Both Smoking and Drinking in its Deleterious Effects on Health and Health Costs." *Health Affairs* Mar-Apr;21(2):245-53.

<sup>16</sup> Eric A. Finkelstein, Ian C. Fiebelkorn and Guijing Wang. "State-level estimates of annual medical expenditures attributable to obesity", *Obesity Research* 12:18-24 (2004)

Obesity and overweight conditions contribute as much as \$93 billion to health care costs in the United States, according to studies reviewed by the National Business Group on Health (NBGH). Researchers have found that obese people who reach 65 years of age have much larger annual Medicare expenditures than non-obese people. For the period between 1996 and 1998, a 15 percent increase in annual per capita Medicare spending is attributable to being overweight, and a 37 percent increase is attributed to being obese.<sup>17</sup>

NBGH concluded that U.S. companies are paying \$13 billion per year for their share of the \$93B cost. That translates into 39 million lost workdays, 239 million days where work activity is restricted, 90 million sick days and 63 million visits to physicians, along with \$8,720 per year per claimant in obesity-related employer disabilities costs.<sup>18</sup> Costs to employers encompass:

- Increased absenteeism
- Increased presenteeism (sick at work and under performing)
- Increased overtime and routine overstaffing
- Increased short- and long-term disability claims
- Increased worker's compensation costs
- Reduced safety
- Lower morale
- Increased costs of health care coverage.

Once again, from the flip side, increasing even moderate physical activity could reduce direct medical costs in the U.S. by nearly \$77B, and employers would benefit by up to a:

- 32 percent reduction in short-term sick leave
- 55 percent reduction in health costs and
- 52 percent increase in productivity.<sup>19</sup>

Finally, research shows that worksite wellness programs have produced savings of well over 5 dollars for every one dollar invested.<sup>20</sup>

## Academic Performance

Healthy eating and physical activity, even at the expense of academic hours in the classroom, have been shown to improve academic performance and students' test results. Benefits include:

- Higher academic performance
- Increased concentration
- Reduced disruptive behavior
- Lower absenteeism
- Lower depression.<sup>21</sup>

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<sup>17</sup> "Prevention Makes Common Cents" *U.S. Department of Health and Human Services* (September 2003) <http://aspe.hhs.gov/health/prevention/>, accessed March 2007.

<sup>18</sup> "Efforts Are Growing to Trim the Fat from Employees --and Employers' Health Care Costs", Knowledge@Wharton, <http://knowledge.wharton.upenn.edu/signup.cfm?CFID=4938935&CFTOKEN=31086637&jsessionid=9a30c8bd6489d316d2f3> (November 1, 2006), accessed March 2007.

<sup>19</sup> "Physical Activity Fundamental To Preventing Disease", *U.S. Department of Health and Human Services* (June 20, 2002) <http://aspe.hhs.gov/health/reports/physicalactivity/>, accessed March 2007.

<sup>20</sup> Larry S. Chapman, "Meta-Evaluation of Worksite Health Promotion Economic Return Studies", *The Art of Health Promotion* (July/August 2005), (<http://www.commonwealthnorth.org/>).

<sup>21</sup> "The Role of Sound Nutrition and Physical Activity in Academic Achievement", *Action for Healthy Kids* (2004), (<http://www.actionforhealthykids.org/>).

A recent four-year elementary school initiative that incorporated physical activity and a nutritious breakfast for all students resulted in several health and performance improvements. The school moved from passing only two of the state indicator proficiency tests to passing all five. The increase in students passing the five tests ranged from 11 percent on the citizenship test to 29 percent on the science test. There was a slight increase in attendance and a 58 percent reduction in discipline referrals. Finally, there were sixty-seven percent fewer school nurse visits.<sup>22</sup>

## **OUR RECIPE FOR THE HEALTHIEST COMMUNITY: OBJECTIVES AND STRATEGIES**

### **Overview**

To be America's Healthiest Community, the strategic plan focuses its efforts on three initiatives:

- Schools and Early Childhood Programs
- Worksites
- Communities

Those three areas directly impact:

- Over 425,000 kindergarten through 12<sup>th</sup> grade students in our schools, and thousands of children in pre-kindergarten early childhood education and care programs
- Over 1.3 million employees working for nearly 80,000 government, private, and nonprofit employers, and
- Over 2.6 million metro area residents affected by state and local government policies and programs.

Each of those initiatives provide an opportunity to reach entire families, not just children or working adults. We are working to change cultural norms and the physical environment of our community, not simply move a handful of strategies forward.

The following strategic priorities are based upon MDHWC research and evaluation of evidence-based policies and programs, and input from hundreds of people across the metro Denver area (see Appendix B--Summary of Public Feedback on Draft Strategic Priorities). The MDHWC strategic plan incorporates objectives with aggressive targets and outlines strategies to achieve them, and most importantly identifies potential partners who will be key to their success.

Although it is a five-year plan (2007-2012), we know it will take much longer to achieve our vision. We will annually evaluate our region's progress and refine the plan itself.

## **HEALTHIEST SCHOOLS AND EARLY CHILDHOOD PROGRAMS**

Summary: Getting daily physical activity (PA) and healthful foods into our schools and early childhood education and care programs are critical objectives in our plan for the future health of our children and adolescents. The strategic plan also calls for physical education (PE) and nutrition education for every student to develop the knowledge and skills needed for lifelong physical activity and healthy eating. (Physical activity is movement of any type--playing sports, taking the stairs, walking to school--whereas physical education can include physical activity but

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<sup>22</sup> "Nutrition, Physical Activity Boost School Performance Four-Year Program Improves Test Scores, Discipline, Attendance", *American College of Sports Medicine* (June 1, 2006).

also assesses student knowledge, motor and social skills, and provide instruction.) None of our public school districts currently achieve the standards called for in those MDHWC objectives.

MDHWC objectives also focus on after school and summer school activities, including healthy eating, for low-income students, priorities highlighted by a recent study indicating that young children's body mass index (BMI) was more likely to increase during the summer than during the school year.<sup>23</sup> Finally, in order to track our progress and give our schools and parents the data they need for appropriate wellness interventions, the plan calls for collecting and reporting aggregate-level fitness data for every school analyzed in relationship to academic performance.

- **OBJECTIVE 1A** - *Incorporate 60 minutes of daily age appropriate, moderate to vigorous physical activity in all public school grades (pre-K through 12) by 2009.*
  - **STRATEGY 1A.1** - Develop an education package and outreach plan for school districts, boards, administrators and staff, including PA as part of PE classes, academic classes, fitness breaks, recess and other opportunities by 2008.
  - **STRATEGY 1A.2** - Identify leaders and partners to begin implementing outreach plan by 2008.

Rationale: Nationally, obesity rates in children have tripled in the past four decades. Fewer children are physically active and PE opportunities have decreased, e.g. only 14 percent of children are walking or biking to school and minutes of school recess, PE and PA have decreased. The American Academy of Pediatrics and the U.S. Department of Health and Human Services recommend a minimum of 60 minutes of moderate to vigorous daily PA for children and adolescents. Physically active children perform better academically, learn better, have a lower incidence of high blood pressure, obesity, diabetes, asthma and cardiovascular disease, reduced stress, anxiety and depression, behave better in the classroom, and have improved concentration and memory. And we know that play is important to healthy brain development in young children. Yet, no school districts in the metro area meet the PA and PE recommendations incorporated in the MDHWC strategic plan.

- Primary Beneficiaries: Children and adolescents in grades pre-K through 12, parents and school staff, administrators and school boards.
- Key Decision Makers: State and local school boards, school district administrators, school principals, classroom teachers, school building accountability committees, state legislators
- Potential Partners: Local PTAs/PTOs, public health professionals/organizations, health care providers/organizations, chambers of commerce, insurance companies and HMOs, professional sport franchises, police and fire departments, physical educators, non-profit education and public health organizations, colleges and universities, teachers' organizations, media/marketing industry, coordinated school health teams, school nurses, school-based health centers

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<sup>23</sup> T Paul T. von Hippel, PhD, Brian Powell, PhD, Douglas B. Downey, PhD and Nicholas J. Rowland, MA "The Effect of School on Overweight in Childhood: Gain in Body Mass Index During the School Year and During Summer Vacation", American Journal of Public Health 97:4 (April 2007) 696-702.

- Resource Needs: Staff training regarding age-appropriate physical activities, funding for equipment, facilities
- Resources Available: 20-30 minutes of daily recess in preK-6 in some metro elementary schools, other physical activities during the day, and intramural/after school programs in our schools, existing curriculum
- Potential Barriers/Obstacles to Success: Lack of knowledge regarding links between PA and academic performance, No Child Left Behind/CSAP pressures and requirements, facilities for activities, lack of funding for professional development and tools
- **OBJECTIVE 1B** - *Incorporate age-appropriate physical education (PE) with qualified staff in all pre-K through 12th grade in public schools with funding appropriated by 2012, including all elementary students participating in at least 150 minutes of physical education per week, all middle school students in at least 225 minutes of physical education per week, and requiring two credits (equivalent to two years) of physical education for high school graduation.*
  - **STRATEGY 1B.1** - Work with school districts, Colorado Department of Education and other partners to secure ideas, design, and recommendations (i.e. best practices) by 2008 for rescheduling the school day to accommodate daily PE.
  - **STRATEGY 1B.2** - Develop communications and information package regarding the link between PA and academic performance, other benefits and tools and resources by July 2007.
  - **STRATEGY 1B.3** - Create plan to educate key leaders, including legislators, school boards, business leaders, parents and others, and begin implementing by 2008.
  - **STRATEGY 1B.4** - Identify champions among local school boards, legislators, business community and others by March 2008.
  - **STRATEGY 1B.5** - Analyze cost of implementation by October 2007.
  - **STRATEGY 1B.6** - Provide PE assessments annually on student report cards to benefit students and parents and ensure district/school accountability, by fall semester 2008.
- Rationale: PE incorporates education regarding lifelong PA, not just current PA encompassed in Objective 1A. Colorado is one of a few states without state PE requirements. (See other rationale under Objective 1A.)
- Primary Beneficiaries: Children and adolescents in grades pre-K through 12, along with parents and school staff, administrators and boards, and the broader community
- Key Decision Makers: State and local school boards, school district administrators, principals, school building accountability committees, state legislators, teachers, state legislators, coordinated school health teams
- Potential Partners: local PTA/PTOs, public health professionals/organizations, health care providers/organizations, chambers of commerce, insurance companies and HMOs,

professional sport franchises, police and fire departments, physical educators, non-profit education and public health organizations (e.g. Rocky Mountain Center for Health Promotion and Education), colleges and universities, teachers' and administrators' organizations, media/marketing industry, local physical therapy and physiology majors to help with fitness testing

- Resource Needs: Qualified PE teachers, staff development, funding for curriculum and equipment, facilities
- Resources Available: Existing curriculum, programs and facilities
- Potential Barriers/Obstacles to Success: Funding, competing time interests, lack of qualified PE teachers, resolving differing perspectives on licensure/training requirements for PE teachers, lack of facilities for activities, lack of knowledge regarding links between PE and academic performance, lack of understanding of benefits of PE beyond PA, No Child Left Behind/CSAP pressures and requirements, no current state PE requirement in Colorado
- **OBJECTIVE 1C** – *Ensure that all children participate in a minimum of 50 hours of nutrition education annually, including nutrition education in classrooms, cafeterias, after school programs, on school menus, and provided to parents and caregivers by 2012.*
  - **STRATEGY 1C.1** - A sequential planned nutrition curriculum, as described above, that meets the needs of the students and families will be developed.
  - **STRATEGY 1C.2** - Nutrition education materials and resources for all grade levels will be provided for students, teacher and school foodservice and nutrition personnel.
- Rationale: The U.S Department of Education recognizes that a minimum of 50 hours of preK-12 nutrition education per year is required to impact students' attitudes and behaviors. The USDA Healthy Eating Index study shows that the more nutrition information individuals have regardless of age, socio-economic status or ethnic background, the better their overall diet. Studies show that when nutrition education is coordinated between the classroom and the cafeteria, the school meal food consumption from all food groups increases. The USDA Women, Infants and Children (WIC) program (which requires a nutrition education component for benefits) has documentation of the importance of nutrition education to overall health of the child and family. All school district wellness policies are required to have a goal for implementing nutrition education and a plan for measuring implementation. Coordinating, supporting and building upon the district wellness policy goals and implementation plan would help achieve these objectives.
- Primary Beneficiaries: Pre-K through 12th grade students, teachers, parents, community
- Key Decision Makers: State and local school boards and school district administrators (superintendents, principals, student health director, nutrition service director), PTAs/PTOs, parents, classroom teachers, legislators
- Potential Partners: Metro Denver District Wellness Policy Implementation and Evaluation Coordinators, after school program coordinators, PTA/PTO's, insurance companies and

HMOs, Colorado USDA Team Nutrition program, Colorado USDA Food Stamp Nutrition Education Program, Colorado Action for Healthy Kids State Team, Colorado Dietetic Association, Colorado Farm to School Program, Colorado School Nutrition Association, faith-based organizations, non-profits, state and local public health departments, Greater Denver School Food Service Directors, Harvest of the Month program, local colleges, junior colleges and universities

- Resource Needs: Funding, student teachers or dietetic interns (either hours for internship or minimum wage), effective practice and reinforcement of aligned prek-12 nutrition curriculum with core subjects' platform, nutrition content, skills for core subject matter, trained classroom educators, staff development
- Resources Available: Fully utilize USDA Nutrition Education Programs funds and resources, existing curriculum
- Potential Barriers/Obstacles to Success: Funding, competing time interests, lack of qualified teachers, No Child Left Behind/CSAP pressures and requirement
- **OBJECTIVE 1D** - *Secure sustainable resources and partnerships to support and expand after school/summer activities, including physical activities and healthful snacks, both school- and community-based by 2009.*
  - **STRATEGY 1D.1** - Design and conduct public information/promotional campaign around the need for PA and healthy snacks for school age children: design campaign in 2007; conduct campaign in 2008.
  - **STRATEGY 1D.2** - Collaborate with the Colorado After School Network (CAN) to incorporate approximately 10 minutes per hour of PA and snacks that meet or exceed the Alliance for a Healthier Generation's Beverage and Competitive Food Guidelines in their network's after school programs by 2008.
  - **STRATEGY 1D.3** - Secure sustainable sources of funding and fully utilize existing resources to ensure all low income children in the Denver Metro area have access to quality age appropriate PA and USDA child nutrition programs during non school hours by 2009.
  - **STRATEGY 1D.4** - Garner support from Governor's office, key legislators, and foundations to facilitate the development of a comprehensive funding package during 2007 and 2008 for PA for school age children in after school settings.
- Rationale: Children watch too much TV, and spend hours playing video games and on the computer. Schools are not required to offer PE, a recent study found that the young children body mass index was more likely to increase during the summer than during the school year.
- Primary Beneficiaries: Pre-K through 12<sup>th</sup> grade students
- Key Decision Makers: Legislators, community based organizations (CBO's), philanthropic community, parents, Colorado After School Network (CAN), school administrators

- Potential Partners: CAN, Children's Health Foundation and other foundations, United Way
- Resource Needs: Funding for public information/promotional campaign, Print and electronic media partner(s)
- Resources Available: CAN is currently working on developing comprehensive funding package; Children's Health Foundation, other local foundations, Colorado Action for Healthy Kids, Colorado Department of Public Health and Environment/Colorado Physical Activity and Nutrition Program (COPAN)
- Potential Barriers/Obstacles to Success: Limited funding sources; lack of support on part of CBO's to incorporate PA due to resource, staffing, or facility limitations
- **OBJECTIVE 1E** - *Establish that all food and beverages sold in cafeterias and school vending machines or otherwise available at school functions will meet or exceed age-appropriate guidelines and food and beverage recognition criteria of the Alliance for a Healthier Generation as follows: meet Bronze Level by 2008, Silver Level by 2010 and Gold Level by 2012.*
  - **STRATEGY 1E.1** - Educate school board members and superintendents at the CASE and CASB conferences and through discussions with boards and administrations.
  - **STRATEGY 1E.2** - Promote renegotiating vendor contracts prior to renewal or, at least, a commitment to incorporate upon renewal by fall 2008, and incorporating the Alliance guidelines and implementation timetable into all district wellness policies or implementation plans by 2012.
  - **STRATEGY 1E.3** - Enroll every metro Denver school into the Alliance for a Healthier Generation program by 2012.
- Rationale: Schools come in contact with 95 percent of all children ages 5-17. Meals, beverages, and snacks served at school provide one third to one half of many students' daily nutritional needs. The risk factors for obesity are complex and multifaceted. Foods at school are not only to blame for obese and overweight children. However, vending machines, ala carte items, fundraiser food items, food at school parties and food at school stores are prevalent in schools and provide frequent access to foods of minimal nutritional value. The foods offered at schools can be a learning tool and provide many opportunities to engage students in healthy eating. Implementation across the metro districts can provide consistent definitions for standards for all foods offered (a requirement for each district wellness policy). The consistency could make it easier for vendors to provide products for the districts in the metro Denver area. Although school districts have been concerned about losing revenue by providing healthier beverages and snacks, many studies show that revenues can actually increase with healthier choices. In addition, school may provide healthful options, yet food and beverages offered by booster clubs and brought into schools by parents are unhealthy. Finally, schools are also worksites, so healthy schools promote the health of school employees that can save public funds.

- Primary Beneficiaries: Pre-K through 12th grade students with the entire school community benefiting
- Key Decision Makers: Parents, school purchasing agents, parents, school administrators, superintendents, school nutrition directors, child nutrition directors, and wellness policy monitors, and school health staff
- Potential Partners: Colorado Department of Education, USDA, State School Board, state government leaders, city leaders, community leaders, beverage companies, beverage suppliers, Colorado Association of School Boards, Colorado Student Nurses Association, Greater Denver Food Service Council, Colorado Vending Council, Colorado Parent and Teacher Association, Colorado Action for Healthy Kids and Colorado Connections for Healthy Schools, Alliance for a Healthier Generation, Farm to School, Denver Urban Garden, Colorado Association of School Executives, Distributed Education Clubs of America, Colorado High School Activities Association, American Heart Association
- Resource Needs: staff training and time for implementation, computer access, implementation guide that provides consistent information to all districts
- Resources Available: Alliance for a Healthier Generation, including some resources free to any school registered with the Alliance
- Potential Barriers/Obstacles to Success: Parents may oppose or find it difficult to comply with healthful food guidelines when they bring foods into schools. Districts want to make money on vending and they may think that the change in product will decrease the profits. Districts are in snack and beverage contracts that may last up to 10 years that do not follow the guidelines. Districts may not be aware the need to make these changes to improve student performance and achieve other benefits of healthful foods in schools. There are no regulatory requirements that districts incorporate these changes in the vending and non-meal foods. Distributed Education Clubs of America and booster programs run many food programs and do not adhere to nutritional standards or USDA school meal guidelines.
- **OBJECTIVE 1F** - *Support and promote age-appropriate physical activity and healthful foods in early childhood care and education programs, including incorporating in child care regulations and standards supported by other organizations, e.g. Qualistar, by May 2009.*
  - **STRATEGY 1F.1** - Work with CDPHE, Colorado Department of Human Services, Colorado Department of Education and other partners to develop and begin to use consistent messages for young children by June 2008.
  - **STRATEGY 1F.2** - Revise and identify resources to distribute COPAN early childhood best practices and other materials, including user-friendly, ready-to-use materials for child care providers by June 2008.
  - **STRATEGY 1F.3** - Support train the trainer programs for Head Start, child care providers and others, including providing such training to all Head Start programs and licensed large child care centers by 2009.

- **STRATEGY 1F.4** - Use media partnerships to heighten public awareness and provide tools through their web sites regarding the importance of healthy eating and activity infants and toddlers beginning in 2008.
  - **STRATEGY 1F.5** - Incorporate Head Start BMI data into MDHWC youth monitoring strategy by 2008.
  - **STRATEGY 1F.6** - Encourage developmentally appropriate PA per the National Association for Sport and Physical Education Guidelines for Infants, Toddlers and Preschoolers beginning in 2007.
  - **STRATEGY 1F.7** - Encourage PE and nutrition training among early care providers.
- Rationale: Eating habits learned early in life last a lifetime. Teaching healthy eating and PA in the early child hood setting impacts the child and entire family. Nutrition and PA impacts health care disparities and disease states can be addressed for families through the child care setting. Early childhood setting is an ideal location to reach young families to begin behavior change in healthy eating and PA to impact healthy life style behavior.
  - Primary Beneficiaries: Infants preschool age, school age and young families, and extended families
  - Key Decision Makers: Legislators, federal, state and local regulatory agencies and programs (e.g. U. S. Department of Agriculture Women, Infants and Children (WIC) and Child and Adult Care Food Program (CACFP), Denver Department of Environmental Health/Board of Environmental Health, Colorado Department of Human Services), early child care providers including Head Start and Early Head Start, Colorado Department of Human Services, Denver Department of Environmental Health, Joint Council on Early Childhood Education
  - Potential Partners: Local organizations (e.g. Arapahoe County Early Childhood Council, Denver Association of Family Child Care, Early Care and Education Council of Boulder County, Joint Council on Early Childhood Education, Metro Denver Head Start Coalition), health care providers, local and state public health departments, LiveWell community partnerships, America on the Move - Colorado, child care health consultants, Head Start Colorado Association, school wellness program staff, state and national foundations (e.g. Robert Wood Johnson, Piton, The Colorado Trust), HHS Head Start Technical Assistance Group, Colorado Department of Human Services, Denver Department of Environmental Health, QualiStar, WIC, CAN, individual Head Start, Early Head Start organizations and other child care providers, nurse family partnership programs and other child care providers
  - Resource Needs: Cost of train the trainer materials to address participants' knowledge, impact knowledge acquisition, modify attitudes, and assess and change behavior. Training staff. Cost of revising and developing train the trainer and other key materials and tools, funding for early care providers' professional development
  - Resources Available: CDPHE/COPAN and other organizations have developed materials and resources including best practices tools.

- Potential Barriers/Obstacles to Success: The early childhood system is not as structured as the public school system, especially child care facilities that are not part of Head Start. Some early child care providers may believe that changing physical activities and foods could adversely impact their business, e.g. if parents were not educated regarding and supportive of healthy eating and PA and took business elsewhere. Health care providers may be reluctant to identify children as overweight and/or do not have time to assist family in addressing issues of overweight children. Conflicting priorities within the early childhood education. Limited staff training and resources in early childhood education. Difficulty in incorporating nutrition and PA into existing curriculum.
- **OBJECTIVE 1G** - *Collect and report aggregate-level data on students' fitness, and link it to their academic success, in 30 percent of schools by 2008, 60 percent by 2010, and 100 percent by 2012.*
  - **STRATEGY 1G.1** - Establish a standardized protocol to collect fitness data, including who would collect data, when and the specific grade level by 2008.
  - **STRATEGY 1G.2** - Incorporate information regarding the protocol and the benefits of collecting fitness data in MDHWC materials and outreach activities by 2008.
- Rationale: We need baseline and ongoing data regarding student fitness levels to enable schools, school districts, and parents determine what wellness interventions are necessary. Local school boards and administrators will have baseline data for developing policy and curriculum to improve the fitness level of students. Components of fitness could include body mass index (BMI), cardiovascular and muscular endurance, flexibility and strength and incorporates objective fitness standards. The Denver Public School District, Aurora Public School District and Jefferson County School District have already begun tracking fitness in some grades.
- Primary Beneficiaries: Children and adolescents in grades 5-12, with parents and school staff, administrators and school boards as beneficiaries.
- Key Decision Makers: School administrators, local school boards, PE coordinators and other health services staff, school wellness policy committees or coordinated school health committees, state legislature, Colorado State Board of Education
- Potential Partners: Metro area PE coordinators, Colorado Department of Education, Colorado Association for Physical and Health Education Recreation and Dance, Colorado Action for Healthy Kids, Colorado Connections for Healthy Schools, local PTAs, Colorado PTA, Cooper Institute, MicroFit
- Resource Needs: Trained staff, testing equipment/program, testing equipment, computer equipment/staff, funding for ongoing data collection, personnel and software for analysis of fitness and academic performance
- Resources Available: Depends upon fitness test selected

- Potential Barriers/Obstacles to Success: Funding, additional teacher/staff training time, no current requirement for districts to test fitness levels, lost instructional time due to testing, validity of results if teachers/staff are not properly trained on the testing protocol
- **OBJECTIVE 1H** - Develop and begin implementation of evaluation plan for ongoing monitoring of performance measures by 2008, including a “report card” to be presented to parents, teachers, school boards.
  - **STRATEGY 1H.1** - Identify data sources and develop collection processes in concert with research and other community partners by October 2007.
  - **STRATEGY 1H.2** - Secure resources and commitments to create school health and wellness report card by 2008.
- Rationale: The MDHWC must establish clear measures and processes to evaluate and report its progress in achieving its vision, mission, goals and objectives. We must also provide the results to the public and key stakeholders to ensure accountability in implementing the strategic plan.
- Potential Partners: Colorado Children’s Coalition, local schools and school districts, school nutrition and PE coordinators, Colorado Department of Education, colleges and universities, research organizations, funders
- Resource Needs and Available: Varies based upon research needed
- Potential Barriers/Obstacles to Success: Funding, data sources willing and able to provide information

## HEALTHIEST WORKSITES

Summary: The MDHWC will work with area employers, chambers of commerce, human resource associations and others to achieve aggressive objectives for comprehensive, evidence based programs for larger employers and effective healthy eating, active living wellness components for smaller employers. The plan also calls for researching and incorporating health insurance incentives as a tool in worksite wellness programs where employers provide health insurance. The program framework will be the Wellness Councils of America (WELCOA) framework but one objective of the plan is to assess how to most efficiently and effectively use their framework. Finally, public policies providing effective employer incentives will be explored and leadership in worksite wellness recognized.

- **OBJECTIVE 2A** - *Promote and facilitate establishment of comprehensive, evidence-based worksite wellness programs, incorporating the Wellness Councils of America (WELCOA) seven benchmarks by all employers with 100 or more employees, including all city and county governments and school districts, by June 2012.*
  - **STRATEGY 2A.1** - Develop and/or identify educational and marketing materials, including CEO-level materials by August 2007.

- **STRATEGY 2A.2** - Develop and begin implementing employer outreach strategy with lead organizations and partners by August 2007.
  - **STRATEGY 2A.3** - Sponsor CEO summit and worksite wellness conference in partnership with the Colorado Business Group on Health in October 2007, and other events targeting decision-makers.
  - **STRATEGY 2A.4** - Begin working with research organizations, colleges and universities regarding related research and evaluation needs and opportunities by September 2007.
- Rationale: Although fewer than three percent of metro area employers have 100 or more employees, their worksites could encompass 75 percent of our area employees. Comprehensive, evidence-based worksite wellness programs have well over a 5:1 return on investment. Each health risk factor (i.e. physical inactivity, poor nutrition, tobacco use, high blood pressure, overweight) adds approximately \$1,500-\$3,500 in excess claims cost.
  - Primary Beneficiaries: Adults and their families are targeted and employers and taxpayers are beneficiaries
  - Key Decision-Makers: CEOs, business owners, non-profit boards of directors, college and university boards, elected officials, city and county managers, school administrators
  - Potential Partners/Lead Organizations: Metro Mayors Caucus, Metro Area County Commissioners, Denver Regional Council of Governments, Governor/Lieutenant Governor, chambers of commerce, large employers, colleges and universities, local school boards, Rocky Mountain Center for Health Promotion and Education and other non-profit organizations
  - Resources Needed: Depending upon the number of larger employers that already have comprehensive worksite wellness programs, the cost is approximately \$150 to \$450 per employee but with a positive return on investment in a year and more over time.
  - Resources Available: Many larger employers already have comprehensive or components of comprehensive worksite wellness programs in place. Employers, CDPHE/COPAN, America on the Move - Colorado, and other government or non-profit worksite wellness resources.
  - Potential Barriers/Obstacles to Success: Lack of knowledge of benefits, multi-location worksites, up-front costs of investment, changing leadership within organizations over time, cannot measure health risk of small businesses/other employer organizations, staffing to implement programs
- **OBJECTIVE 2B** - *Promote and facilitate the establishment of new worksite wellness programs incorporating the WELCOA physical activity and nutrition incentive programs by 500 employers with 99 or fewer employees by June 2009, 750 more employers by June 2011, and an additional 750 employers by June 2012.*
    - **STRATEGY 2B.1** - Develop and/or identify educational and marketing materials by 2008.

- **STRATEGY 2B.2** - Develop and begin implementing employer outreach strategy with lead organizations and partners by 2008.
- **STRATEGY 2B.3** - Develop and test on a pilot basis comprehensive, evidence-based worksite wellness programs for small employers and other challenging groups, e.g. service workers, encouraging employees to make healthy lifestyle choices related to healthy eating and active living by June 2009.
  - Rationale: It is more difficult to demonstrate the return on investment to small employers and others due to employee turnover, inability to realize impact on health insurance expenditures, and other factors. Yet, Colorado is a small business state and there are other financial benefits to all employers, e.g. reduced workers compensation and presenteeism costs, and health and wellness benefits to all employees.
  - Primary Beneficiaries: Working and retired adults, working adolescents and their families, employers and taxpayers
  - Key Decision-Makers: CEOs, business owners, non-profit boards of directors and executives, college and university boards and administrators, elected officials and city/county managers
  - Potential Partners: Metro Mayors Caucus, Metro Area County Commissioners, small business organizations, chambers of commerce, Colorado Nonprofit Association, Colorado Department of Public Health and Environment, Colorado Association of School Executives, Colorado Association of School Boards
  - Resources Needed: Multi-million dollars (minimum \$45 per employee plus other staff support) depending upon number of employees with a positive return on investment
  - Resources Available: employers, CDPHE/COPAN, America On the Move - Colorado, and other government or non-profit worksite wellness resources.
  - Potential Barriers/Obstacles to Success: Employer buy-in to wellness programming, lack of funding and staffing to support health and wellness in small businesses, difficulty in identifying employers ready to incorporate health and wellness into their operations
- **OBJECTIVE 2C** - *Determine how the MDHWC will utilize the WELCOA model by June 2008.*
  - **STRATEGY 2C.1** - Evaluate MDHWC needs with respect to products and services provided through WELCOA, including evaluating membership, Well Cities recognition, local well council program, etc., and determine MDHWC WELCOA-based program and timeline.
    - Rationale: The WELCOA blueprint addresses how employers can systematically implement wellness programs using an evidence-based, proven method: gaining management support, creating a wellness team, collecting data, creating an operating plan, choosing interventions, creating a supportive environment, and evaluating programs. WELCOA provides supporting materials, incentive programs, data collection

tools, professional development and continuing education information, links to other resources, health promotion research, etc. In addition, WELCOA nationally recognizes organizations and communities for implementing worksite programs based on specific criteria. WELCOA also offers a small business (50 or less employees) application and award program to assist these organizations in reaching their goals and being rewarded for their efforts. The MDHWC needs to explore how it and area employers can most cost effectively and efficiently utilize the WELCOA framework including metro area and employer membership, resources, recognition programs and WELCOA/MDHWC branding opportunities.

- Key Decision-Makers: MDWHC and MDHWC committees
- Potential Partners: CDPHE/COPAN, other worksite wellness professionals and experts
- Resources Needed: MDHWC and other partners time, information from WELCOA
- Resources Available: MDHWC and other partners time, information from WELCOA
- Potential Barriers/Obstacles to Success: potentially limited detailed information available to non-members regarding WELCOA; potentially limited number of local worksite wellness vendors using or supporting the WELCOA framework; early stages of implementing strategic plan may not provide necessary MDHWC information regarding our future needs
- **OBJECTIVE 2D** - *Analyze, provide and advocate for effective employer incentives, including community recognition and public sector incentives.*
  - **STRATEGY 2D.1**– Research reward and recognition programs for worksites in Colorado, other states and nationally and design MDHWC metro area program and advocate for appropriate public sector incentives.
  - Rationale: Employers may not be motivated to implement worksite health promotion programs only through return on investment or societal goals alone, especially when an investment returns are not immediate or readily apparent. Public recognition as one of the healthiest organizations in which to work, along with other benefits to the employer, will help gain commitment from employers to actively participate. Other employer financial incentives may be appropriate and needed to achieve the full benefits to the metro area.
  - Potential Partners: Colorado Business Group on Health, National Council of State Legislatures, National Governors' Association, Western Governors' Association, Colorado Governor's Office, state legislators, Colorado Physical Activity and Nutrition Program Worksite Task Force, Colorado Department of Public Health and Environment, Denver Metro Chamber of Commerce
  - Resources Needed: The staffing, materials and other resources will vary based upon the specific employer/CEO incentive programs, conferences, and other events. The cost of any public policies providing employer incentives will also depend upon the specific incentives provided.

- Resources Available: MDHWC partners can provide research support for potential incentives.
- Potential Barriers/Obstacles to Success: Funding for incentives, rewards and recognition
- **OBJECTIVE 2E** - *Incorporate use of health insurance wellness incentives as part of a comprehensive worksite wellness initiative promoting healthy lifestyle choices by employees (see Objective 2A).*
  - **STRATEGY 2E.1** - Complete a literature review by December 2007 on evidence-based best practices using wellness incentives as a tool for promoting participation in self-care and wellness classes and to investigate the impact of these incentive programs on the pricing of health insurance premiums.
  - **STRATEGY 2E.2** - Complete an inventory of health insurance products sold in the metro Denver region that incorporate wellness incentives by December 2007.
  - **STRATEGY 2E.3** - Convene a meeting with representatives of metro Denver area health plans to brainstorm current status, research, opportunities and interest in conducting a wellness-oriented health insurance pilot (including a rigorous evaluation) for state employees by August 2007.
  - **STRATEGY 2E.4** - Determine need for additional research on the relationship between health insurance product design and employee productivity based upon strategies 2E.1-2E.3 by March 2008.
  - **STRATEGY 2E.5** - Incorporate all findings and a set of recommendations from strategies 2E.1-2E.4 into MDHWC worksite wellness promotion initiatives by March 2008.
- Rationale: Presently, we have little accumulated knowledge about the wellness-oriented health insurance products that are being marketed in the Metro Denver area. There is growing evidence that financial incentives such as reduced co-payments for participation in a health risk assessment will increase employee participation in health promotion activities. To fully understand the link between health insurance offerings, participation in wellness programs and their ultimate impact on health, the fact-finding noted in these objectives is necessary before incorporating an insurance objective in the MDHWC worksite wellness initiative.
- Primary Beneficiaries: Metro Denver area employees and employers
- Key Decision-Makers: MDHWC, health plans, the state and private employers
- Potential Partners: State of Colorado Department of Personnel and Administration and Department of Public Health and Environment, insurance carriers, Colorado Business Group on Health, local colleges and universities, the MDHWC Insurance Committee members.
- Resources Needed: Funds and in-kind resources to complete insurance product inventory, best practice review and related research and access to administrative data.

- Resources Available: Data from data stewards (state, private insurers and employers), potential support from colleges, universities and research organizations
- Potential Barriers/Obstacles to Success resistance by data stewards to share data considered proprietary, inability to secure adequate funding and/or in-kind support
- **OBJECTIVE 2F** - *Develop and begin implementation of evaluation plan for ongoing monitoring of performance measures by 2008.*
  - **STRATEGY 2F.1** - Identify data sources and develop collection processes in concert with research and other community partners by September 2007.
  - Rationale: The MDHWC must establish clear measures and processes to evaluate and report its progress in achieving its vision, mission, goals and objectives. We must also provide the results to the public and key stakeholders to ensure accountability in implementing the strategic plan.
  - Potential Partners: Universities and colleges, other research organizations, local chambers and other employer organizations, CDPHE, Colorado Department of Public Administration, Colorado Business Group on Health, Metro Mayors Caucus, Metro Area County Commissioners
  - Resource Needs and Available: Varies based upon research needed
  - Potential Barriers/Obstacles to Success: Funding, data sources willing and able to provide information

## HEALTHIEST COMMUNITIES

Summary: The Healthiest Communities initiative incorporates a broad range of objectives focused on using public policies, as well as community partnerships to make the metro Denver area America's healthiest community. Objectives include incorporating health and wellness components into local land use plans governing development, adopting state and local "Complete Street" and street safety standards and funding related improvements to support active living, and improving low-income residents' access to healthful foods. It also focuses on the opportunity to curb the increasing costs of public health insurance and improve health through a Medicaid pilot program promoting primary prevention and wellness in the metro Denver area.

- **OBJECTIVE 3A** – *Create communities that encourage more physical activity through public land use plans and policies, including the development of transportation system supporting increased physical activity.*
  - **STRATEGY 3A.1** - Encourage local governments to adopt public health regulations and objectives promoting physical activity whenever they amend comprehensive plans and land use codes, so at least 30 percent of local governments have adopted such language by 2010 and 100 percent by 2012.

- **STRATEGY 3A.2** - Conduct baseline research on existing policies and practices in the metro area and best practices across the U.S. by August 2007, and develop best practices guide and self-assessment tool for local policy makers by 2008.
  - **STRATEGY 3A.3** - Partner with the Metro Mayors Caucus and Metro Area County Commissioners to create a memorandum of understanding for adoption incorporating best practices for adoption by local governments by 2008.
  - **STRATEGY 3A.4** - Create communications plan by spring 2008 to educate key decision-makers, including state and local officials, foundations and the public regarding best practices and the relationship between planning and developing environments supporting physical activity impact health and wellness and the economy.
  - **STRATEGY 3A.5** - Work with partners to identify state and other grant funding supporting local planning and implementation activities by spring 2008.
  - **STRATEGY 3A.6** - Foster increased collaboration among public health, planning and transportation officials by hosting joint meetings and sharing information regarding best coordination practices, e.g. Tri-County Health Department planning activities.
- Rationale: Research shows the link between community design, including access to parks and trails, and increased physical activity. For example, research shows that even people who dislike being active are more active when they live in compact, walkable areas, and that children living close to parks and their school were more physically active.<sup>24</sup> Increased walking/biking also reduces automobile traffic.<sup>25</sup> The City and County of Broomfield was the first in the nation to incorporate a public health component in its strategic plan.
  - Primary Beneficiaries: General population
  - Key Decision-Makers: Mayors, city councils, county commissioners, city and county managers, transportation system users
  - Potential Partners: DRCOG, Metro Mayors Caucus, Metro Area County Commissioners, city councils, Colorado Counties Inc., Colorado Municipal League, local public health departments, Colorado Department of Transportation, Colorado Department of Public Health and Environment, Colorado Department of Local Affairs, local planning departments, Colorado Chapter of the American Planning Association, AARP, Homebuilders Association of Metro Denver, environmental groups, Bicycle Colorado, Colorado Walks, RTD, Transit Alliance, developers, transit-oriented development

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<sup>24</sup> Ben Harder , “Weighing in on City Planning: Could Smart Urban Design Keep People Fit and Trim?”, *Science News Online* 171 (January 20, 2007), <http://www.sciencenews.org/articles/20070120/bob9.asp>, accessed March 2007.

<sup>25</sup> “Understanding the Relationship Between Public Health and the Built Environment”, *U.S. Green Building Council (USGBC), the Congress for the New Urbanism (CNU), and the Natural Resources Defense Council (NRDC)* (May 2006). [http://www.cnu.org/aboutcnu/index.cfm?formAction=initiative\\_detail&initiative\\_id=55](http://www.cnu.org/aboutcnu/index.cfm?formAction=initiative_detail&initiative_id=55), accessed March 2007.

organizations, Rocky Mountain Land Use Institute, National Association of City and County Health Officials

- Resources Needed: Research staff time, developing and distributing guide
- Resources Available: Gates Foundation infrastructure grants, local government tax incentive programs for active community developments, national leaders within metro area, local nonprofit expertise
- Potential Barriers/Obstacles to Success: Funding for updating local government plans, timing regarding planned amendments to comprehensive plans and land use codes, individuals and organizations who are opposed to these policies for economic or other reasons
- **OBJECTIVE 3B** - *Develop and adopt “Complete Streets” and safe intersection new construction and reconstruction design standards by all local governments and the Colorado Department of Transportation by 2012.*
  - **STRATEGY 3B.1** - Work with local and state traffic engineers to develop a model set of standards by June 2008.
  - **STRATEGY 3B.2** - Provide information supporting adoption of the model package to local and state decision-makers by August 2008.
  - Rationale: The first step towards safe transportation options is to have governments adopt standards for use in new developments and street reconstruction. This is essential to provide safe travel for pedestrians and bicyclists that the MDHWC is promoting to address our growing obesity problem. During the period between 1994-95 and 2002-03, the Denver through north Front Range “Pedestrian Danger Index” measuring the rate of pedestrian deaths relative to how much people walk in the area increased by 40 percent.<sup>26</sup> According to CDPHE, each year, an average of 81 individuals are killed and 439 are hospitalized for injuries sustained as a pedestrian in Colorado with adults ages 75 and older have the highest hospitalization rate for pedestrian-related injuries. The percentage of older adults is projected to more than double in the metro area over the next 20 years.
  - Primary Beneficiaries: General population, especially older adults, children, and people with disabilities
  - Key Decision-Makers: Mayors and city councils, county commissioners, Colorado Transportation Commission, local and state traffic engineers, transportation system users

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<sup>2626</sup> Michelle Ernst, “Mean Streets 2004: How Far Have We Come?”, *Surface Transportation Policy Partnership*(November 2004), (<http://www.transact.org/library/>).

- Potential Partners: DRCOG, Metro Mayors Caucus, Metro Area County Commissioners, city councils, local public health departments, local transportation departments, Colorado Department of Transportation, Colorado Department of Public Health and Environment, Colorado Department of Local Affairs, AARP and other older adults organizations, environmental groups, Bicycle Colorado, Colorado Walks, RTD, Transit Alliance, developers, transit-oriented development organizations, Rocky Mountain Land Use Institute, National Association of City and County Health Officials, Colorado Children's Campaign and other children safety advocates, Cross Disability Coalition and other advocates for people with disabilities
- Resources Needed: Best practices information
- Resources Available: Best practices information available through local and national potential partners
- Potential Barriers/Obstacles to Success: competing objectives of decision-makers, timing of adoption of standards with new development and reconstruction opportunities, individuals and organizations who are opposed to these policies for economic or other reasons
- **OBJECTIVE 3C** - *Achieve a fair allocation of state transportation system funding for infrastructure and improvements that benefit all users, including those most vulnerable-- children, older adults, and persons with disabilities, and supporting safe routes to schools.*
  - **STRATEGY 3C.1** - Provide information to the Governor's Blue Ribbon Panel regarding the importance of balanced transportation funding to benefit all users beginning summer and fall 2007.
  - **STRATEGY 3C.2** - Meet with legislative leadership regarding the importance of balanced transportation funding to benefit all users beginning fall 2007.
  - Rationale: State funding of "Complete Streets" and transit is needed to encourage active transportation, both on state roads and highways as well as local roads and streets and through transit systems. Historically, Colorado has been one of just five states where no state transportation funds went to any alternative transportation other than roads. SB1 was recently passed to steer 10 percent of surplus funds available for transportation to go to alternatives but that does not come close to meeting the demand for expanded transit, bike lanes and paths, well designed sidewalks, etc.
  - Primary Beneficiaries: General population, especially older adults, children, and people with disabilities
  - Key Decision-Makers: Colorado Transportation Commission, Governor's Blue Ribbon Panel, legislators, transportation system users
  - Potential Partners: Colorado Department of Transportation, DRCOG, Metro Mayors Caucus, city councils, Metro Area County Commissioners, local public health departments, local transportation departments, AARP and other older adults organizations, environmental groups, Bicycle Colorado, Colorado Walks, RTD, Transit Alliance, developers, transit-oriented development organizations, Rocky Mountain Land

Use Institute, National Association of City and County Health Officials, Colorado Children's Campaign and other children safety advocates, Cross Disability Coalition and other advocates for people with disabilities

- Resources Needed: Reallocation of state funds, full allocation of the 10 percent of SB 1 funds, and significant additional dollars
- Resources Available: Up to ten percent of state general fund dollars, federal grant funds
- Potential Barriers/Obstacles: Political opposition to shifting funds from other transportation uses
- **OBJECTIVE 3D** - *Support community driven initiatives (e.g. LiveWell Colorado partnerships) where local residents and businesses collaborate with nonprofits and government agencies to identify community priorities and implement policies and programs to achieve them.*
  - **STRATEGY 3D.1** - Ensure ongoing communications between the MDHWC and LiveWell Colorado partnerships by including LiveWell Colorado coordinators on key committees, through updates to the MDHWC from LiveWell initiatives on lessons learned.
  - **STRATEGY 3D.2** - Identify areas of synergies for grassroots promotion and identification of potential public policies and revisions to the MDHWC strategic plan through periodic planning meetings of the LiveWell Executive Committee and MDHWC staff beginning summer 2007, and regular communications among metro area partnerships and the MDHWC.
  - **STRATEGY 3D.3** - Utilize web sites to share information, data, and provide information on strategies that communities are implementing, including accessing LiveWell Colorado tools with link from MDHWC web site by July 2007 and searching community strategies on LiveWell web site by November 2007.
- Rationale: It is important to support and build on the knowledge of the community-based initiatives that are currently taking place through initiatives like LiveWell Colorado (previously known as Thriving Communities and COPAN Communities) and Steps to a Healthier U.S. Based on the *Community Guide* published by the Centers for Disease Control and Prevention and other evidence-based resources, including the Institute of Medicine's *The Future of Public Health in the 21<sup>st</sup> Century* and Policy Link's *Reducing Health Disparities Through a Focus on Racial and Ethnic Health Disparities 2003*, multi-sectoral approaches that cross various levels of prevention are needed to address the complex nature of obesity. Additionally because many of these community initiatives have been in existence for several years they have unveiled potential metro-wide and state policy issues. These communities are also potential grass root partners to support MDHWC goals and centers for obtaining resident and local input. Finally, it is necessary for our state and metro area initiatives to share consistent goals across various agencies in order to leverage resources and impact of our financial and human energy.
- Primary Beneficiaries: The target is the general population within communities interested in addressing healthy eating and active living through community-based initiatives in their regions/neighborhoods. The region as a whole can benefit, including the MDHWC benefiting from the knowledge learned through these community-based initiatives.

- Key Decision-makers: LiveWell Executive Committee, community coalitions and their coordinators
- Potential Partners: LiveWell Executive Committee, community coalitions and their coordinators, local businesses and business organizations, America On the Move - Colorado, local public health departments
- Resources Needed: Need a formal communications plan and schedule to maximize benefits to all coalitions and partners
- Resources available: LiveWell Colorado initiative is funding community-based initiatives and resources, e.g. LiveWell web site
- Potential barriers/obstacles: Continuous need for communication and utilizing expertise and resources to balance the knowledge as represented on the MDHWC commission
- **OBJECTIVE 3E** - *Increase availability and affordability of healthful foods, including whenever possible, locally grown fresh produce, e.g. providing incentives to grocery stores to locate in and offer healthful, affordable food choices in underserved communities; and community-supported farmers markets and community gardens.*
  - **STRATEGY 3E.1** - Research and identify best practices and resources, for example zoning code amendments, financial incentives, and innovative financing, to promote the MDHWC farmers markets, community garden, neighborhood grocery stores with healthful foods, and food pantry/congregate site strategies by 2008.
  - **STRATEGY 3E.2** - Educate the public and policy makers regarding best practices and resources through MDHWC, local government and other web sites, other government communications, schools and libraries by June 2008.
  - **STRATEGY 3E.3** - Increase the number of farmers' markets by educating local officials regarding benefits and related zoning issues, and support local efforts to enable the use of food stamps at all markets by November 2008.
  - **STRATEGY 3E.4** - Expand the number of community gardens by incorporating them within all local parks plans by 2010, and identifying and educating about any local zoning issues to be addressed throughout the metro area by 2012.
  - **STRATEGY 3E.5** - Promote new neighborhood grocery stores and fresh produce sold in new and existing neighborhood stores by exploring and educating about innovative, success models by 2009.
  - **STRATEGY 3E.6** - Convene meeting and/or workshop by June 2008 to create synergies among businesses and nonprofit organizations promoting healthful foods through food pantries and congregate eating sites.
- Rationale: Studies have shown that local access to healthful foods, whether through farmers markets, neighborhood grocery stores and community gardens, have increased healthy eating in lower income communities. Community gardens also provide opportunities for active living.

- Primary Beneficiaries: Low-income residents, although the general population can benefit
- Key Decision-Makers: Varies by strategy but includes business owners, elected officials, planning, parks and community development officials, financial institutions, and nonprofit executives and boards working on these issues
- Potential Partners: U.S. Department of Agriculture, Colorado Restaurant Association, Colorado Anti-Hunger Network, Metro Mayors Caucus, city councils, Metro Area County Commissioners, Denver Urban Gardens, Slow Food, Urban Farm, Policy Link, other national organizations and funders, grocery stores, faith-based organizations, other non-profit advocacy and service organizations, local public health departments, local parks and recreation agencies, local planning departments
- Resources Needed: Sites for new neighborhood stores, community gardens and farmers markets; financial research for stores; funding for additional EBT machines to allow food stamps use at farmers markets
- Resources Available: Federal tax credits, foundation grant funds, university and college research capacity
- Potential Barriers/Obstacles to Success: some strategies involve complex zoning and/or financing issues, need organizations willing and able to take lead
- **OBJECTIVE 3F** - *Design and implement a pilot program that rewards participation in primary prevention and wellness programs among Medicaid enrollees in the Metro Denver area by 2009. The Medicaid pilot should account for eligibility group differences (i.e., children, low-income parents and working age individuals with disabilities).*
  - **STRATEGY 3F.1** - Complete literature review of best practice models for Medicaid by September 2007.
  - **STRATEGY 3F.2**- Secure funding and voluntary participation by a health plan or plans to conduct the pilot by September 2007.
  - **STRATEGY 3F.3** - Form an expert panel to design a pilot program and an evaluation team to evaluate the pilot by December 2007.
  - **STRATEGY 3F.4** - Begin implementation of the pilot by July 2008.
  - **STRATEGY 3F.5** - Develop and begin implementing pilot by January 2009.
- Rationale: There is increasing evidence that incorporating incentives for healthy behavior into a health insurance product can reduce overall health care costs. Presently, the Colorado Medicaid program does not have an explicit policy goal related to promoting health and personal responsibility by Medicaid enrollees. The goal of the pilot would be to improve health status and reduce overall health care costs incurred by participants in the pilot.
- Primary Beneficiaries: A subset of Medicaid enrollees representing all major eligibility categories (children, low-income parents, people with disabilities and the elderly) that

live in the Metro Denver Area, a potentially broader group of enrollees post-pilot, Colorado taxpayers, and private businesses in the Metro Denver area that pay a surcharge due to the cost-shifting from publicly-funded programs to employer-sponsored insurance.

- Key Decision-Makers: Colorado Department of Health Care Policy and Financing (HCPF)
  - Potential Partners: HCPF, insurance carriers, panel of Medicaid experts, evaluation team
  - Resources Needed: Data from HCPF, expert panel to design pilot, evaluation team to evaluate pilot, funding for pilot, including research and analysis
  - Resources Available: Data-sharing agreements with HCPF
  - Barriers/challenges: Not able to find a health plan willing to participate in pilot; not able to garner the resources necessary to fund the pilot; insufficient enrollment by Medicaid enrollees to provide a fair test of the pilot
- **OBJECTIVE 3G** - *Develop and begin implementation of evaluation plan for ongoing monitoring of performance measures by 2008.*
    - **STRATEGY 3G.1** - Identify data sources and develop collection processes in concert with research and other community partners by October 2007.
    - Rationale: The MDHWC must establish clear measures and processes to evaluate and report its progress in achieving its vision, mission, goals and objectives. We must also provide the results to the public and key stakeholders to ensure accountability in implementing the strategic plan.
    - Potential Partners: Universities and colleges, other research organizations, local chambers and other employer organizations, Colorado Department of Public Administration, Colorado Business Group on Health, Colorado Department of Public Health and Environment, Colorado Department of Transportation, DRCOG, Metro Mayors Caucus, Metro Area County Commissioners, local public works and planning departments, non-profit organizations (varies based upon individual objectives)
    - Resource Needs and Available: Varies based upon research needed
    - Potential Barriers/Obstacles to Success: Funding, data sources willing and able to provide information

## COMMUNICATIONS AND MARKETING

Summary: The success of the MDHWC will depend upon our ability to market and inform the public and decision-makers about our efforts through the media and other communication tools, to support other organizations' social marketing campaigns, to recognize individuals and

organizations leading by example in implementing the strategic plan, and to developing a brand, The Denver *Lifestyle* Diet to sustain our momentum over time.

- **OBJECTIVE 4A** - *Develop and begin implementing communications plan including media, web site, email and other tools to support implementation of the strategic plan and marketing the MDHWC's work by August 2007.*
  - **STRATEGY 4A.1** - Create process for identifying opportunities to work with our media partner, CBS4 Fit4Colorado, and other media outlets.
  - **STRATEGY 4A.2** - Work with MDHWC volunteers to periodically evaluate the MDHWC web site in supporting the MDHWC's initiatives beginning in June 2007.
  - **STRATEGY 4A.3** - With the Communications Committee and others, evaluate (and periodically reevaluate) how to best use email and other technology tools to support the MDHWC by July 2007.
  - **STRATEGY 4A.4** - Incorporate MDHWC branding into the communications plan based upon concept development timeline.
  - **STRATEGY 4A.5** - Develop and market The Denver *Lifestyle* Diet: A Formula for Healthy Living brand, which will focus on nutrition, physical activity, mental/emotional vitality, and community, starting with a rollout in October 2007.
- Rationale: Effective, visible communications are essential to elevating the importance of the MDHWC's mission, maintaining knowledge of and enthusiasm about it, and using the public and key stakeholders to help ensure accountability for implementing the plan. It is also the key to using our status as a healthy community in economic development marketing efforts to support a healthy economy.
- Key Decision-Makers: Media, MDHWC
- Potential Partners: Marketing/communications/information technology experts, media
- Resources Needed: Staff time and expertise for implementation, software or other costs depending upon communications plan, brand development and marketing resources
- Resources Available: Communications Committee, CBS4 partnership, other media interest, local access cable stations
- Potential Barriers/Obstacles to Success: Funding
- **OBJECTIVE 4B** - *Support other organizations and coalitions in developing and launching broad-based social marketing campaigns in 2008.*
  - **STRATEGY 4B.1** - Join and coordinate with existing social marketing development group(s) relative to implementing MDHWC strategic plan messaging.
- Rationale: Social marketing is the use of marketing techniques to promote positive behavioral change, in our case, promoting healthy eating and active living. Social

marketing has proven to be an effective tool. It is very expensive to analyze and determine target audience and message, as well as implement the marketing campaign. Other groups, e.g. LiveWell Colorado, have begun exploring a statewide social marketing campaign that provides the MDHWC an opportunity to collaborate to support the work of multiple partnerships and organizations.

- Primary Beneficiaries: To be determined based upon campaign
- Key Decision-Makers: Other partnerships and organizations leading the creation of a campaign
- Potential Partners: Same partnerships and organizations, media
- Resources Needed: Marketing consultants, creative materials, marketing materials, funds for research and evaluation
- Resources Available: LiveWell Colorado founders, other organizations exploring campaign
- Potential Barriers/Obstacles to Success: Funding limitations, difficulty in measuring effectiveness of these types of social marketing campaigns
- **OBJECTIVE 4C** - *Hold annual awards event recognizing individuals and organizations that have led by example in promoting the MDHWC's Healthiest Schools/Early Childhood Program, Healthiest Worksites, and Healthiest Communities initiatives, including leaders from business, non-profit organizations, government and education.*
  - **STRATEGY 4C.1** - Develop a process for identifying and selecting individuals and organizations that are leading by example by September 2007 and select by March 2008.
  - **STRATEGY 4C.2** - Secure underwriters and venue and have event committee in place for first event by January 2008.
  - **STRATEGY 4C.3** - Plan and implement successful event by June 2008.
  - Rationale: A key to successfully implementing the plan is energizing and rewarding those who lead by example. This also provides an opportunity to highlight the MDHWC and our sponsors.
  - Primary Beneficiaries: Award winners, media and other sponsors, MDHWC
  - Key Decision-Makers: MDHWC
  - Potential Partners: Media, and business, nonprofit and government organizations
  - Resources Needed: Awards, event costs including staffing
  - Resources Available: CBS4 and other media partners
  - Potential Barriers/Obstacles to Success: None expected

# Appendix A

**Tom Clark, Co-Chair**

**Lieutenant Governor Barbara O'Brien, Chair**

**Dr. James O. Hill, PhD, Co-Chair**

**Mayor Karen Stuart, Co-Chair**

## MDHWC MEMBERS

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External Relations  
Colorado Permanente Medical  
Group, PC

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Director, Health & Disability  
Benefits  
Qwest Communications

Mr. Hank Baker  
Senior VP of Marketing  
Forest City Stapleton

Ms. Darlene Barnes  
Regional Director  
USDA

Mr. Mark Barnes  
Principal  
Brownstein Hyatt & Farber, P.

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Recreation Manager  
Wheat Ridge Parks and  
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Ms. Kieann Brownell  
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GoCakeGo.com

Ms. Sheila Bugdanowitz  
President and CEO  
Rose Community Foundation

Mayor Steve Burkholder  
City of Lakewood

Mr. Tom Clark  
Executive Vice President  
Metro Denver Economic  
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Corporation

Mr. Rob Cohen  
Board Chair  
Denver Metro Chamber of  
Commerce

Ms. Judy Cooper  
Curriculum Coordinator  
Jefferson County Schools

Dr. Bridget Coughlin, Ph.D.  
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Department of Health  
Sciences and Curator, DMNS

Mr. Thomas Currigan  
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Pediatrician-in-Chief, The  
Children's Hospital, and  
Chairman, Department of  
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Ms. Dede de Percin  
Executive Director  
Colorado Consumer Health  
Initiative

Ms. Susan Downs-Karkos  
Senior Program Officer  
The Colorado Trust

Mr. Gregory D. Feasel  
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Business Operations  
Colorado Rockies

Mayor Ken Fellman  
City of Arvada

Dr. Andy Fine, M.D.  
Private Practice

Ms. Susan Garcia MA, RD  
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Adams 12 School District

Ms. Monica Garcia-Pleiman  
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Vice Chancellor for External  
Affairs  
University of Colorado at Denver  
and Health Sciences Center

Ms. Sue Glass  
Executive Director  
American Diabetes Association  
(CO)

Mr. Jim Goddard  
President and CEO  
9Health Fair

Mayor Ronald Goodner  
Town of Edgewater

Dr. Pamela Hanes, Ph.D.  
President and CEO  
Colorado Health Institute

Mayor Larry Harte  
City of Glendale

Ms. Kirsten Helgeland  
Local Store Marketing  
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Mayor John Hickenlooper  
City and County of Denver

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Center for Human Nutrition,  
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Mr. Scott Hysler  
Lifestyle and Programs Director  
Pulte Homes

Mr. Grant Jones  
Executive Director  
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Dr. Frank Kim, Ph.D.  
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Asian Pacific Development Center

Mr. David Lack  
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House of Delegates of the  
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Ms. Maya Leon-Meis  
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Voice Productions International

Mr. J. Madden  
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Greenwood Athletic Club

Mr. Bob Malte  
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Lieutenant Governor  
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Mr. Jeff Olson  
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Well Nourished Worldwide

Ms. Rachel Oys  
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Ms. Linda Pryor  
Director, Government  
Relations & Public Affairs  
Pfizer

Mayor Randy Pye  
City of Centennial

Mr. Kevin Reese  
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Zaring/Cioffi Entertainment

Ms. Karen Reinertson  
President  
Front Range Community  
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Mr. Mark Renn  
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Colorado Business Council

Dr. Michael Salem, M.D.  
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Mr. Steve Sander  
President  
Sander Kenney Marketing

Mr. Richard Scharf  
President & CEO  
Denver Metro Convention &  
Visitors Bureau

Mr. Brooksy Smith  
CEO  
123Fit

Mr. Greg Sonzogni  
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Promote It International

Mr. Stephen L. Stieneker  
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Counsel  
Kroenke Sports Enterprise

Ms. Stephanie Stevens  
Executive Director  
Colorado Parks & Recreation  
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Mayor Karen Stuart  
City and County of Broomfield

Mr. John Swartout  
Executive Director  
Great Outdoors Colorado

Mr. Gary Thorson  
Deputy Director  
Colorado State Parks

Mr. Andre von Hall  
General Manager  
Denver Athletic Club

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Colorado Cancer Coalition

Ms. Sandra Walters, RN  
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Andre Center for Breast Cancer  
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Ms. Anne Warhover  
President and CEO  
The Colorado Health Foundation

Mr. Richard Weil  
CFE, President, COO  
Nick-N-Willy's Franchise  
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Mr. Pete West  
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Dr. Andrea Wieland, Ph.D.  
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International Center for  
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Ms. Suzanne Arkle Wilson  
President  
Zann & Associates, Inc.

Mr. John Wright  
Executive Director  
Asian Chamber of Commerce

Dr. Phil Zeitler, M.D.  
Assistant Professor  
UCDHSC

## Appendix B

### COMMUNITY FEEDBACK ON MDWHC STRATEGIES Summary from Town Hall Meetings and Online Survey

In February 2007, the MDHWC adopted a set of draft priorities that were presented to the community for public input during five regional townhall meetings, as well as via a web-based online survey. The draft priorities included strategies in three focus areas-- worksites, schools/child care facilities, and public sector policies and programs. Questions presented within the online survey, and during the town hall meetings, focused on obtaining feedback on health and wellness priorities in each priority area, as well as reasons why they feel people in general are physically inactive and choose to eat unhealthy. A total of 142 people responded to the online survey and 260 participated in the town hall meetings. Not all participants responded to every question.

#### **Demographic Make-up of Participants**

Eighty-three percent of participants were Caucasian (non-Hispanic). The race/ethnicity of others was: African American (7%), Hispanic/ Latino (4%), Asian/ Pacific Islander (2%), American Indian (1%), and Other (2%).

Thirty-six percent of participants live in Denver County compared with 21% from Jefferson County, 18% Arapahoe County, 8% Douglas County, 5% Broomfield County, 4% Adams County, 3% Boulder County and 4% elsewhere.

When asked what was their primary perspective when providing feedback, the largest group, participants identified their perspective as follows:

- 21% - health providers/public health professional
- 14% - nonprofit organization representative
- 13% tied as educators or government employee/elected official
- 11% - community member
- 6% tied as business person or parent
- 5% tied as employee or advocate
- 4% - employer
- 3% - student.

Considering that perspective the largest percentage again represented Denver County (31%) with 15% of participants tied as representing Jefferson County or multiple counties..

#### **Barriers to Physical Activity and Healthy Eating**

Physical Activity: "Lack of time" (28%) and "not a priority for individuals"(28%) tied as the top two reasons people are not physically active according to people at the town hall meetings. "Lack of knowledge" was a distant third with 9% of the vote. When asked to identify the three top barriers, 74% of online survey respondents named "lack of time", 38% said "not a priority at worksites", and 37% said "lack of social support."

Healthy Eating: The number one reason why people do not eat healthy is a "preference for less healthful foods", according to 29% of town hall participants "Affordability of produce/nutritious foods" was identified by 17% as the second largest reason for not eating healthy foods, followed by 16% who believe it is "not a priority at home". Those were also the top vote recipients, in the same order, for online survey respondents.

## **Top Strategic Priorities**

In each of the three focus areas, the MDHWC had identified two or more priority strategies in the February draft. Each participant was asked to rank their top health and wellness priorities in schools, worksites, public sector (local government and state government).

**Schools/Child Care Facilities:** By far the top strategy in this focus area was “incorporate K-12 PE, physical activity, and nutrition education” with 73% choosing it as their top priority. Twelve percent selected “food and beverages meet or exceed healthy standards”, and as their top priority with “secure funding to maintain and expand after school physical activity” receiving 7% of the top priority votes.

**Worksites:** Of the two worksite MDHWC strategies, 62% of participants identified “comprehensive worksite wellness programs, including senior management support, targeted interventions, incentives, supportive environment, etc” as their top worksite priority.

**Public Sector-Local Government:** Forty-eight percent identified “land use plans and policies, including transportation funding, supporting active community environments” as their number one choice in this category. “Community-driven initiatives with targeted policies and programs” was second at 24% and “access to healthy and affordable food” was third with 15% of the first place votes.

**Public Sector-State Government:** Thirty-eight percent selected “develop and adopt “Complete Streets” standards, e.g. sidewalks, bicycle lanes” as their top choice, “pilot program to encourage healthy lifestyles for Medicaid recipients” received 24% of first place votes and “transportation funding to benefit pedestrians, bicycles, wheelchairs, strollers” was third with 23% of first place votes.

