

Healthy Eating, Active Living (HEAL) Idaho



For more information about this plan, visit the
Idaho Physical Activity and Nutrition Program website at:
www.HEAL.dhw.idaho.gov

Nutrition and Physical Activity Framework Updated 2013



Safe Routes to School Nampa, Idaho



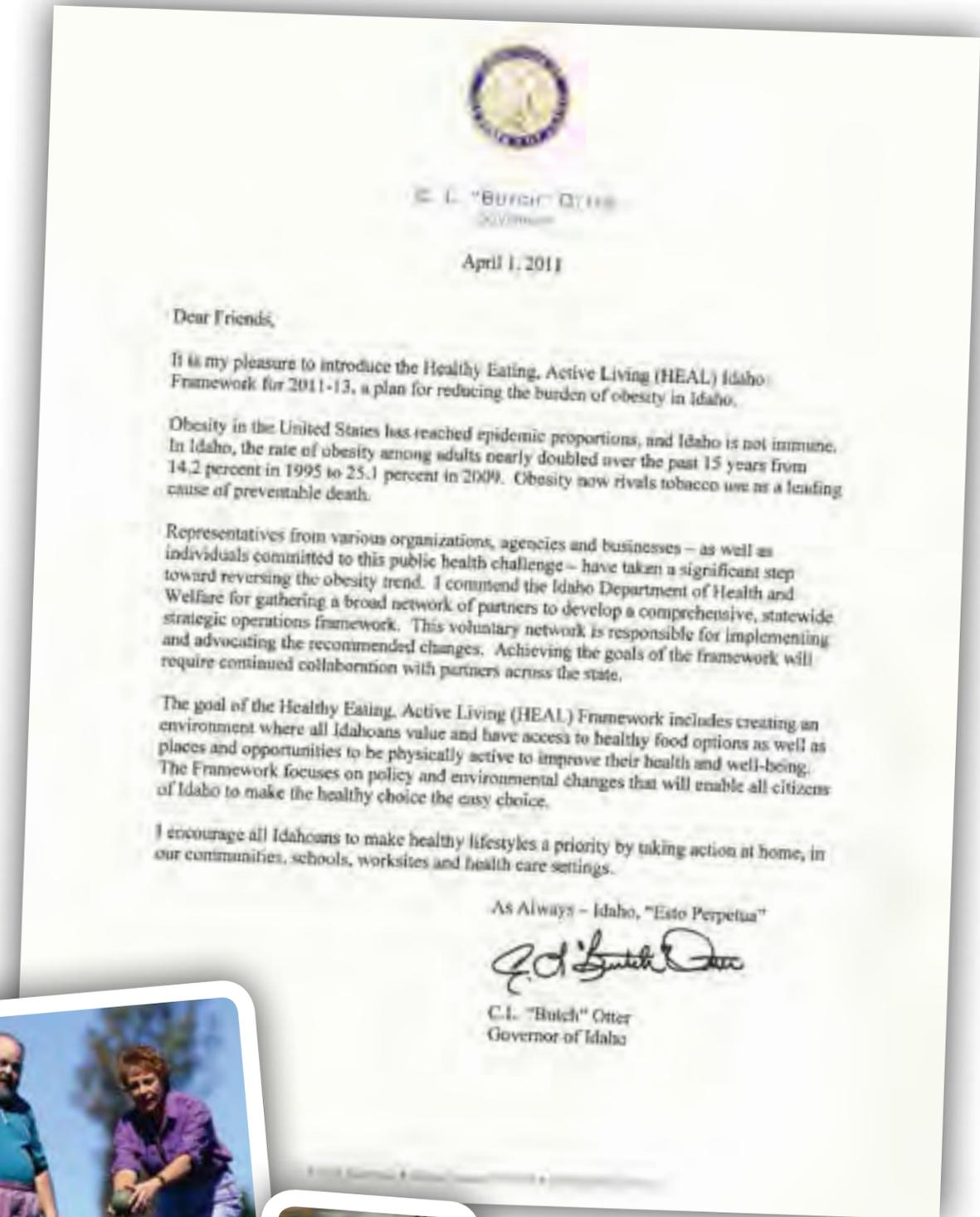
Walk to School Day is a national event that encourages kids and their parents to walk or bike to school as a method of changing community culture and creating safer environments for everyone.

Walking and bicycling to school enhances children's health due to the increased physical activity they receive. It also improves air quality and creates a safer environment by reducing the amount of cars on the road.

In Idaho, 47 events have been planned at elementary schools throughout the 2010-2011 school year. Ronald Reagan Elementary school in Nampa held their fourth Walk to School Day on October 14, 2010, and had almost 100% attendance.



*Information and photo retrieved from Kristi Watkins, Nampa Safe Routes To School Coordinator, October 2010 newsletter and www.walktoschool.org.



U Aim High Fitness & Nutrition



Thomas Aylward, 62, of Spirit Lake, Idaho, became a client of U AIM HIGH FITNESS & NUTRITION after volunteering at a local triathlon 18 months ago. At the time, Tom weighed 325 pounds, was unable to walk a block, did not know how to swim, and could not ride a bike, but he wanted to finish a triathlon. Through his training with U AIM HIGH, Tom lost 75 pounds, has run a 5K (3.1 miles), a 5 mile race, and a half marathon (13.1 miles). In June, 2010, he completed his first two sprint triathlons and in August, completed his first Olympic distance triathlon. He is signed up for the Ironman Coeur d'Alene in June, 2011. Tom is no longer taking his medications and has been give a clean bill of health from his physician. He has a new outlook on life and has become an inspiration to his community.



Melanie Patterson, 37, from Hayden, Idaho became a client of U AIM HIGH FITNESS & NUTRITION in January, 2010. A working mom with three children, she decided it was time to do something for herself. Melanie began taking small steps, such as changing her eating habits and becoming more active. She has found the athlete within – finishing her first half marathon (13.1 miles) in April, 2010.

Without knowing how to swim or bike, she trained for and completed five triathlons by September, 2010, finishing no less than second in her age group. Melanie's brightest accomplishment was inspiring her own children to finish their first triathlon.



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Acknowledgements

Listing of Individuals who Contributed to the Development of the Framework

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Kathy Browder, PhD, Department Chair, Health, Physical Education, Recreation, Dance, College of Education, University of Idaho

Helen Brown, RD, MPH, Health, Physical Education, Recreation, Dance, College of Education, University of Idaho

Adrean Casper, Director of Government Relations, American Heart Association

April Dunham, Program Manager, Heart Disease & Stroke Program, Idaho Department of Health and Welfare

Marilyn Edmondson, RN, SELECT Medical Network of Idaho, Inc.

Theresa Golis, Program Manager, Idaho Division of Professional-Technical Education

Mimi Hartman-Cunningham, RD LD CDE, Program Manager, Diabetes & Oral Health Programs, Idaho Department of Health and Welfare

Amaka Ikefuna, Health Specialist, Mountain States Early Head Start

Liisa Itkonen, Principal Planner, Transportation, Community Planning Association of Southwest Idaho

Carol Julius, RD, LD, Division Director, Southwest District Health

Terri Landa, MS, Health Solutions Prevention Services Manager, St. Luke's Regional Medical Center

Heidi Low, Idaho Director of Government Relations, American Cancer Society, Cancer Action Network

Mary T. MacConnell, Volunteer

Jaci McCormack, Nez Perce Tribe

Janice McGeachin, State Representative, District 32-A

Jack Miller, MHE, Coordinated Chronic Disease Section Manager, Idaho Department of Health and Welfare

Patti Moran, MHS, Cancer Prevention and Control Program, Idaho Department of Health and Welfare

Corinne Morgan, Board of Directors, Idaho Association of Health, Physical Education, Recreation and Dance

Mary Ann Reuter, Executive Director, Idaho Public Health Association

Suzette Robinson, Board of Directors, Idaho Parent Teacher Association Programs

Neva Santos, CAE, Executive Director, Idaho Academy of Family Physicians

LeeAnn Simmons, Executive Director, Idaho Voices for Children

Deanna Smith, Community Organizer, Idaho Smart Growth

Angela Spain, RD, LD, WIC Coordinator, Central District Health Department

Caile Spear, PhD, CHES, Health Promotion Program Coordinator, College of Education, Boise State University

Mary Thomsen, PacificSource Health Plans

Jessyca Tyler, RD, LD, Nutrition Programs Specialist, The Idaho Foodbank

Emily Waddoups, RD, LD, WIC Program, Idaho Department of Health and Welfare

Kendra Witt, PhD, MPH, Blue Cross of Idaho Foundation for Health, Inc.

Jackie Yarbrough, Agency Relations, The Idaho Foodbank

Laurel York Odell, Project Facilitator, Concepts in Writing, Inc.

Jody Zauha, Wellness Program Manager, State of Idaho

Anna Mae Florence, RD, LD, Child Nutrition Programs, State Department of Education

Caroline Keegan, RD, LD, School Marketing Director, Idaho Dairy Council

Crystal Wilson, Ed.S, MS, RD, LD, Health and Wellness Education Director, Idaho Dairy Council

Dana Zuckerman, Parent Nutrition Advocate

David Sperry, PhD, Public Health Idaho-North Central District

Ivie Smart, MHE, CHES, Respiratory Health Program Specialist, Idaho Department of Health and Welfare

Jamie Delavan, Cultural Liaison/Health Disparities Program Specialist, Idaho Department of Health and Welfare

Margaret Henbest, RN, MS, CPNP

Maureen Gresham, AICP, Bike and Pedestrian Coordinator, Idaho Transportation Department

Nancy Rush, RD, LD, Program Manager, Central District Health Department

Nicole Stickney, IPHH Outreach Coordinator, Mountain States Group, Inc.

Pam Catt-Oliason, Idaho Commission on Aging

Rhonda DeMers, PANT Coordinator, Coordinated School Health, State Department of Education

Sharlene Brown, Project Director, Retired & Senior Volunteer Program (RSVP), Mountain States Group, Inc.

Shawn Dunnagan, RD, Instructor, Community and Environmental Health, Boise State University

Stacy Beeson, RD, LD, St. Luke's Regional Medical Center

Winona Tindore, Northwest Band of Shoshone Nation

Karri Ryan, Wellness Consultant, Blue Cross of Idaho

Pat Stewart, Director, Coordinated School Health, State Department of Education

Jaime Harding, MHS, CHES, Community Health Program Manager, Central District Health Department

Rebecca Lemmons, MHS, Policy Analyst, Central District Health Department

Elke Shaw-Tulloch, MHS, Administrator, Division of Public Health, Idaho Department of Health and Welfare

Katie Lamansky, CHES, IPAN Health Program Specialist

Angie Gribble, MHS, IPAN Program Manager

Be Outside, Idaho!



Be Outside, Idaho! is a coalition of 150 diverse agencies and organizations united in the common cause of empowering all Idahoans to lead healthy lives by developing a sense of place in Idaho's outdoors. A growing body of research has drawn connections between the rise in childhood obesity, diabetes, depression, attention deficit disorders and pharmaceutical use with the decline in the amount of time children spend outdoors in nature.



On February 1, 2010, a Joint Resolution was passed by Governor Otter acknowledging the work Be Outside, Idaho! has done to get Idahoans outside and active from backyards to mountain tops. Be Outside, Idaho! partners such

as the Kiwanis Boys Choir, day cares, school groups and an Idaho storyteller were on hand at the Capitol Building in Boise for the day to share information and activities highlighting the importance of being outside and physically active.

Be Outside, Idaho! further promotes active living by participating in Idaho Family Reading Week, news stories highlighting individuals and communities outside, pilot projects in schools, created materials encouraging families to pursue healthier living for themselves and their children, and conducted outreach within the health care community to educate physicians about the impact of being outside on patients' health.

Background

Genuine solutions to the challenging problem of obesity require the concerted effort of many partners and collaborators. Healthy Eating, Active Living (HEAL) Idaho is a voluntary network of organizations, agencies, businesses and individuals committed to creating an environment where all Idahoans value and have access to healthy food options as well as places and opportunities to be physically active to improve their health and well-being.

In 2005, Idaho's Bureau of Community and Environmental Health (BCEH) conducted an Idaho Physical Activity and Nutrition Statewide Needs Assessment which served as the impetus for the development of a two-year action plan. The plan was intended to be a guide for executive and legislative efforts over the next two years (2006-2007). In continuation and expansion of this effort, the Idaho Physical Activity and Nutrition Program (IPAN) launched HEAL Idaho in the summer of 2010 to develop a comprehensive statewide strategic operations framework along with a network of stakeholders responsible for implementing and advocating the recommended changes. Over 50 representatives from businesses, state and local agencies, nonprofit organizations and the legislature came together to outline the framework and form the nucleus of the network.

Going forward, the HEAL Idaho Framework will serve as guide and benchmark for HEAL Idaho network activities and participants.



Kootenai Health Triathlon for Kids. Kootenai Medical Center.

HEAL Idaho Structure & Organization

HEAL Idaho is a voluntary network of organizations, agencies, businesses and individuals working together to create an environment where all Idahoans value and have access to healthy food options as well as places and opportunities to be physically active to improve their health and well-being. Network members share information and resources as well as participate in regional meetings and an annual statewide summit. Through these web-based and group activities, members have access to:

- Tools for grassroots organizing,
- National, state and community-based educational offerings,
- Funding resources and opportunities, and
- New partnerships for leveraging services and programs.

HEAL Idaho is facilitated by the Idaho Physical Activity and Nutrition (IPAN) Program in the Bureau of Community and Environmental Health, Idaho Department of Health and Welfare. As the facilitator, IPAN provides administrative support, communication coordination and fiscal management.

Members of HEAL Idaho have provided subject matter expertise, considered applications of goals and actions through their cultural lens, provided success stories and conducted hands-on work to generate the HEAL Idaho Framework. They provided information on current programs and activities that could be considered strengths and/or opportunities to be leveraged through a survey of stakeholder groups and representatives. They ensured that the framework featured the development of relationships, partnerships and capacity building that will support an environment to influence policy development, cultural change and the elimination of health disparities.

HEAL Idaho members participated in facilitated planning sessions where they developed and reviewed the strategic directives, goals, recommended actions and activities within the Framework. They assisted with the recruitment of community partners who came together in four regional meetings in southwestern (Meridian), southern (Twin Falls), eastern (Idaho Falls), northern (Coeur D'Alene) and north central (Lewiston) Idaho to generate specific activities and methods for leveraging resources at the local level. Collectively, network participants generated goals, recommended actions and activities that will produce a collaborative environment enabling partners statewide to work together to make healthier choices easier in their communities.

You are invited to become involved with HEAL Idaho. Contact BCEH@dhw.idaho.gov to request your membership or go online and become a friend of the Healthy Eating, Active Living (HEAL) Idaho Facebook page. Together, through networking, sharing of information, and leveraging of resources, we can achieve so much more than the sum of our individual efforts.



Kootenai Health Triathlon for Kids. Kootenai Medical Center.



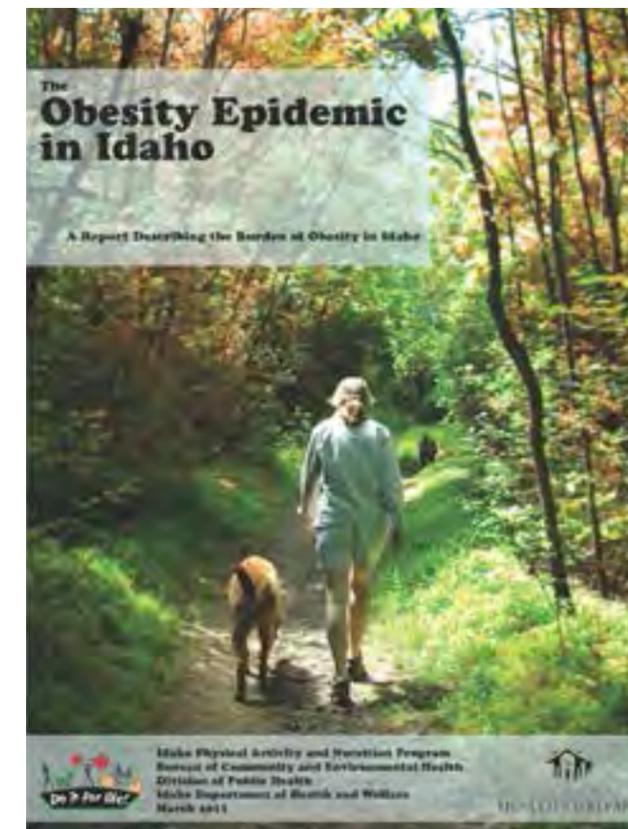
Triathlete Melanie Patterson of Hayden, Idaho.

Burden of Obesity in Idaho

Adequate physical activity and healthy eating are essential ingredients for good health yet, too many Idahoans have poor eating habits and lead sedentary lives. Inactivity and poor food choices contribute significantly to the development of obesity, high blood pressure, heart disease, cancer and diabetes, the leading causes of disease and death among Idahoans.

In the past 20 years, the food environment has changed dramatically and parallels the increase in obesity rates. Advertisements and media messages, "super-sized" portions and promotional pricing encourage the consumption of foods high in calories, sugar and fat, and low in nutritional value. The abundance of fast-food restaurants, vending machines and convenience stores make the same poor food choices readily accessible.

At the same time people are encouraged to eat more, there are fewer opportunities to be physically active.



For example:

- Office jobs require hours of sitting;
- Elevators replace stairs;
- Physical education in schools has been reduced or eliminated completely;
- Televisions and computers are used extensively during leisure time;
- Motor vehicles are the primary means of transportation.

The intent of HEAL Idaho is to develop communities where the healthy choice is the easy choice:

To create an environment where all Idahoans understand, value and have access to healthy food options as well as places and opportunities to be active to improve their health and well-being.

Mountain States Early Head Start Play Group



Head Start and Early Head Start programs provide comprehensive child development, health, nutritional, social and other services to economically disadvantaged children and families, with a special focus on assisting children develop skills that will help them be successful in school. The Mountain States Group Early Head Start program in Coeur D'Alene facilitates playgroups with families and children ages 0 to 3 years old across four Head Start locations. They occur at the Early Head Start center and include a meal or snack, tooth brushing, free play, painting, art projects, songs, sand and water play, play dough and lots of other special activities. Children get to participate in new experiences, play with other children and learn new things. These activities include a focus on building lifelong habits to increase healthy eating and active living.

During playgroups, children are served a variety of age-appropriate foods to broaden their experiences. Families are able to enjoy nutritious meals together as a way to learn how to bring healthy and happy mealtime experiences to their own tables.

Playgroups also offer children the opportunity to explore and play outside, and engage in physical activity throughout playgroup time to have fun and promote good health.



Disparities in Health & Weight Status

Nutrition and physical activity are perceived differently across cultures within the state. Real changes in nutrition and physical activity behaviors cannot happen unless health promotion efforts are culturally competent. Five essential elements contribute to the ability of a system, institution or agency to become more culturally competent.

These include:

1. A value of diversity.
2. The capacity to assess the ability to serve diverse populations.
3. Knowledge, attitudes, and skills to deal effectively with the dynamics inherent when cultures interact.
4. Institutionalized cultural knowledge.
5. A service-delivery process that deals effectively with cultural diversity.

In recent decades, disparities in health have been well-documented across a broad range of medical conditions and for a wide range of groups. These differences have been noted in health outcomes such as quality of life and mortality; access to, quality and appropriateness of care; and the prevalence of certain conditions and diseases. The focus is to eliminate health disparities associated with physical inactivity, obesity, poor nutrition and related chronic disease whether these disparities are based on heritage, age, economic disadvantage or location.

The 2006 National Healthcare Disparities Report (NHDR) and the mid-course update of Healthy People 2020 report that health disparities have been reduced, although greater improvements are still needed.

Health disparity, or health inequity, refers to "large and persistent gaps in health status." The BCEH definition of health disparities refers to "the differences in disease risk, incidence, prevalence, morbidity, and mortality and other adverse conditions, such as inequities in access and delivery of health care, that exist among specific population groups in Idaho". Population groups may be based on race, ethnicity, age, gender, socioeconomic position, education level, occupation, immigrant status, sexual minority status, language, disability, homelessness, and geographic area of residence. Specifically, health disparities refer to those avoidable differences in health that occur among groups who have persistently experienced historical trauma, social disadvantage or discrimination, and systematically experience worse health or greater health risks than more advantaged social groups. Environmental and policy changes can help reduce health disparities in Idaho. Cultural competency is recognized as an important contributing factor in eliminating health disparities. The U.S. Department of Health and Human Services, Office of Minority Health (OMH) states, "Cultural competency is one of the main ingredients in closing the disparities gap in health care." The OMH defines cultural competence from an individual and organization perspective as having the capacity to function effectively within the realm of cultural beliefs, behaviors, and needs presented by consumers and their communities.

The HEAL Idaho Framework is intended for all who live, work and play in Idaho. It contains specific recommendations for schools and childcare providers; city, state and local governments; public and private work places; non-profit agencies and organizations; health care providers; transportation systems; city and urban planning units; state, county and local coalitions; and Idaho parents. HEAL Idaho will proceed with respect and awareness of differences in the way nutrition and physical activity are perceived and the way behavioral choices are made.



Tomando Control de su Salud training. Sage Community Resources. Garden City, Idaho.

Orchard's Elementary Pumpkin Project

The University of Idaho Extension Nutrition Program's 'Building a Healthy Me' curriculum was taught throughout the 2009-2010 school year to the Orchard's Elementary 4th grade. At the same time, Lewis-Clark State College Latina Sorority took over management of the annual 'Save the Pumpkin' community event and partnered with Orchard's 4th graders to grow pumpkins for donation to the event. Each student received a Science/Health notebook to encourage participatory action learning by allowing the students to document the experience in their own words. They also participated in a fun hands-on activity of making pots out of recycled newspapers. These pots were planted with pumpkin seeds and left with the students in their classrooms to observe and record the growth process.



In May, students took their first field trip to Modie Park to plant the pumpkin patch. The students learned about drip irrigation, using mulch to conserve water, how to properly transplant vegetables, and enjoyed a healthy snack and got their memorabilia 'pumpkin project' water bottle. The students were invited to attend three summer workdays, one each month that school is out, to check their pumpkins progress, weed the patch, and water. In November, students returned as 5th graders to the patch to harvest and collect the pumpkins for donation to the annual 'Save the Pumpkin' event. Before donating the pumpkins the students got to decorate them to showcase in their classrooms.

The 5th graders' final step in this project involved preparing a presentation on the entire project to give to the patrons of the Orchard's Senior Meal Site while serving pumpkin pies they made from scratch! Many of the students mingled throughout the lunch making casual conversation with the elders. Everyone left smiling.

Social-Ecological Model

Interventions to promote physical activity, healthy eating and reduce disease risk have almost always focused on changing individual behavior. However, the environment also has enormous impact on the ability to change behavior. The HEAL Idaho Framework is based on the Social-Ecological Model which integrates personal and environmental change agents (McLeroy, Bibeau, Steckler & Glanz, 1988). The model describes how health promotion includes not only individual behavior change but also organizational, community, and environmental change, policy development, and economic supports.

At the center of the model is the individual with their awareness, knowledge, attitudes, and behaviors. This is the foundation of change, but there are external forces at play, represented by the subsequent layers of the model. In order to facilitate individual behavior change, it is important to address the external forces. The HEAL Idaho Framework is designed to change the organizational, community, and public policy layers of the model. Changing these layers will lead to an environment where individual behavior change is easier and can be sustained long-term.



Goals & Recommended Actions



The Centers for Disease Control and Prevention (CDC) recommends obesity prevention strategies that focus on five highly preventable risk factors – **calorie imbalance, insufficient fruit and vegetable consumption, physical inactivity, lack of adequate breastfeeding and increased screen-time and sedentary behaviors.** These recommendations provide the base for the HEAL Idaho Framework which is meant to be used as a guide for program and policy development across the state.

Purpose

To create an environment where all Idahoans understand, value and have access to healthy food options as well as places and opportunities to be physically active to improve their health and well-being.

Vision

All Idahoans have access to healthy food options, active lifestyles, and improved personal health and wellness supported by a coordinated statewide infrastructure.

Benchmarks of Success

- Idaho children and adults report an increase in physical activity and healthy eating that promotes health and well-being.
- Recommended dietary and physical activity guidelines are followed by Idaho's children and adults to achieve healthy weight and prevention of chronic disease.
- The infrastructure is in place that supports all Idahoans' ability to eat healthy foods and be physically active.
- Healthy eating and active living efforts in Idaho are sustainable and utilize coordinated approaches.



Courtesy of the Idaho Dairy Council.

Shadow Butte Elementary Success Story



Shadow Butte Elementary School's Coordinated School Health Team received a mini-grant from the Idaho Chapter of Action for Healthy Kids to build a walking path. Work began the last week of May 2010. Shadow Butte is located five miles outside of downtown Emmett in a rural, agricultural setting. Due to the location of the school, many families live 20+ miles out of town and would need to travel to access any recreation opportunities in the community. The walking path provides families with a local alternative for walking and/or running. They currently have an "Active Feet" program that involves staff and students. Staff and students are encouraged to walk or run around the boundary of the playground fence. For every five miles completed, a small plastic foot is awarded to be placed on a necklace. Currently 78% of students and 53% of staff are participating. The "Active Feet" program has been so successful with staff and students alike that the program now awards tokens for increasing fruit and vegetable consumption, drinking more water and taking steps to improve their mental health.

In 2010, Shadow Butte students and staff logged 2,515 miles in the Active Feet Program. This compares to 5,960 miles for all of last year. Shadow Butte students and staff are well on their way to surpassing last year's number. The Coordinated School Health Team has also implemented a Lifelong Wellness Program for staff with four components: exercise, mental health, healthy foods, and health promotion. Shadow Butte has also held "Biggest Loser" contests in 2010 and 2011 involving staff and community members.



Lapwai (Nez Perce) Students On the Move Again

With the support and guidance from the Nez Perce Coordinated School Health Program, Lapwai Elementary School has begun making healthy changes for students and their environment.

The Lapwai Elementary School Health Council was determined to address concerns with the playground area outside. Although there is a large grassy area, there was not a sufficient amount of space for games like four square, hop scotch, jump rope or other blacktop games. Not all students could participate or be actively involved at recess. Often, students would stand around having nothing to do, setting in motion the beginning of unhealthy behaviors. The School Health Council felt this needed to be among the first areas of concern to be addressed.

There was a large area surrounding the school that contained bark for landscaping. Many times the bark created unwanted distraction and presented a safety concern for students and staff. With assistance from the Nez Perce Coordinated School Health Program and school maintenance personnel, the bark was removed and replaced with concrete. This added additional play area to the playground and eliminated the distraction and safety concern regarding the bark.

The added cement was stenciled with three separate four-square areas, one hop scotch area and created more space for jump rope, ball games and blacktop activities. Lapwai Elementary also purchased additional jump ropes, four square balls, basketballs and footballs.

With the added space and equipment all students not have the opportunity to play, be active and build relationships with other children at recess. The students no longer stand around with nothing to do. They all have access to working equipment and activities that were not previously available. With the support and guidance from the Nez Perce Coordinated School Health Program, students at Lapwai Elementary are becoming more healthy and active every day.



Priority Areas of Focus

Infrastructure/Capacity Building

GOAL 1

Develop and maintain an active, engaged network of partners working together, investing resources and expertise to create a healthy eating, active living Idaho.

Recommended Actions:

- Create, maintain and leverage partnerships and coalitions that implement effective strategies to promote healthy eating and active living.
- Leverage national initiatives, campaigns and messaging for statewide and local change.
- Increase opportunities for state and local funding through collaboration and leveraging of resources.
- Increase support from policy makers, the public, government, the private sector, hospitals, health care providers, and other community service organizations to be engaged in community coalitions that influence healthy eating and active living.
- Increase opportunities for HEAL Idaho members to inform and share strategies in order to strengthen partnerships and the capacity of each member.
- Co-sponsor community-wide campaigns and events, and integrate messages promoting healthy eating and active living.
- Conduct local and statewide events and activities that recognize employers, schools, individuals, communities and coalitions engaging in best practice programming for individual, organizational, community, and environmental behavior change and/or policy development,
 - Prioritize events and activities that address the elimination of health disparities and integrate cultural competencies.
- Support integration of healthy eating and active living messages into existing public health and quality of life campaigns.
- Engage grassroots organizations that demonstrate success in other public health issues (e.g., tobacco control) to provide training and participation in population-based healthy eating and active living promotion campaigns.
- Integrate activities and recommendations of other strategic plans that support HEAL Idaho (e.g., transportation, city development, statewide chronic disease plans, etc.)



Infrastructure/Capacity Building

GOAL 2

Enact policies throughout Idaho that support healthy eating and active living.

Recommended Actions:

- Engage in advocacy to elevate the priority of healthy eating and active living in public policy.
- Build statewide support of policy initiatives through –
 - A) grassroots activities;
 - B) media advocacy; and,
 - C) engagement of legislative and policy level decision makers.
- Educate and encourage local, state, tribal and national organizations and decision makers that can impact public health to collaboratively engage in policy development and advocacy.
 - Develop the case for supporting economic, social and personal benefits of healthy eating and active living for policy, practice and research.
- Ensure policies account for disparate populations and eliminate health disparities.
- Use the most current version of federal guidelines as a foundation for advocacy and policy development (2010 USDA Dietary Guidelines for Americans, Physical Activity Guidelines for Americans Midcourse Report, and Healthy People 2020.).
 - Develop and disseminate shared messages emphasizing economic, social and personal benefits of healthy eating and active living.
- Identify and recruit key policy makers and other community champions to lead and model promotion of healthy eating and active living.
- Identify and counter unproductive policies which do not support healthy eating and active living.



Global Gardens Booth at the Capitol City Market, Boise, Idaho.



Mobile Recreation Van activities through Boise Parks and Recreation Davis Park, Boise, Idaho.

GOAL 3

Establish a statewide system to report, monitor and evaluate healthy eating and active living programs and initiatives.

Recommended Actions:

- Identify and reduce gaps in healthy eating and active living surveillance data for children, youth and adults, and share the information with partners and stakeholders.
- Increase the capacity of agencies, organizations, local communities, tribes and systems to collect, maintain, analyze and report health data to increase understanding of the burden of inactivity and poor nutrition of Idaho residents.
- Disseminate the findings of assessments, evaluation and data collection.
- Support health departments, educational institutions/agencies and community organizations to in assessing barriers to physical activity and healthy food choices.
- Utilize data in program planning, advocacy efforts, as well as local and statewide media campaigns.



Fit and Fall Proof™ Class Heatherwood Retirement Center, Boise, Idaho.

Nutrition

GOAL 1

Increase the availability and consumption of low-calorie, nutrient dense foods and beverages.

Recommended Actions:

Build Capacity

- Work with partners to increase availability of healthy foods in all segments of communities (e.g. community gardens, farmers markets, cooperative buying groups, retailers, food banks, etc.).
- Identify and recognize schools, worksites, tribes and communities implementing policies and best practices that support access to low calorie, nutrient dense foods.
- Establish regional and local food planning mechanisms, such as food policy councils to set priorities to increase access to low-calorie, nutrient dense foods.

Environmental Change

- Support food assistance program efforts to provide healthy food options and healthy eating information.
- Provide point-of-purchase nutrition information the availability of point-of-purchase nutrition information and programs in retail establishments such as supermarkets, restaurants and fast food outlets.
- Provide healthy foods and beverages in worksite cafeterias, break rooms and vending machines.
- Provide healthy foods and beverages at meetings and workshops.
- Provide healthy foods in school cafeterias, break rooms, and vending machines.
- Establish state and local guidelines for offering healthy food at public gatherings, events and activities.
- Provide lower sodium food options (e.g. increase accessibility and competitive pricing) in worksites and government institutions.

- Implement farm-to-institution (schools, businesses, public agencies, etc.) programs.

- Showcase schools with policies and practices applying portion-size, calorie and nutrient standards to all food and beverages sold, served or offered before and during the school day.

- Provide incentives for the production, distribution, and procurement of food from local farms in the local jurisdiction.

- Provide incentives to food retailers to locate in or offer healthier food and beverage choices in underserved areas.

- Initiate school gardens initiation of school gardens.

- Support farmers market programs making low-calorie, nutrient dense foods more accessible and available to disadvantaged populations.

- Organize farmer's markets at worksites and or establish Community Supported Agriculture partnerships with local farmers.

- Increase the capacity of worksites, schools and others to keep low calorie, nutrient dense foods and beverages fresh through education and infrastructure support.

Advocate, Adopt and Implement Policies

- Advocate for state and federal funding to ensure all educational institutions have resources (e.g. facilities, equipment, staff) to provide quality food choices.

- Increase the number of employers enacting worksite wellness policies to increase staff access to healthy foods and physical activity opportunities.

- Increase advocacy for nutrition policies by health care providers as well as other employers.
- Employers adopt policies ensuring healthy food options are available on-site such as cafeteria and vending machine options.
- Support the Department of Education as well as individual district and school development, adoption and implementation of policies requiring all food to meet or exceed current USDA Dietary Guidelines for Americans and all serving sizes to be age appropriate.

Individual Education through Communication

- Provide lifelong learning about where food comes from, and how choices affect personal health and the viability of local farms.
- Educate and encourage families to make healthy choices for family meals.
- Support and assist with promotion of community and home gardens.

GOAL 2

Decrease the availability and consumption of less healthy foods and beverages.

Recommended Actions:

Environmental Change

- Increase access to healthy food and beverage alternatives.
- Limit access of high calorie, low nutrient foods

Advocate, Adopt and Implement Policies

- Support initiatives, including taxation, that reduce the amount of high sugar and sodium snacks and drinks.
- Build grassroots support for local and state policies on nutrition standards for school vending machines.
- Institute smaller portion sizes in public venues.
- Adoption of policies by schools and childcare settings prohibiting fundraising activities and the marketing of food and beverages not supporting a healthful diet as defined by the USDA Dietary Guidelines for Americans.

Individual Education through Communication

- Educate about the association between consumption of low-nutrient, sweetened beverages and obesity.
- Promote research on the negative effects of low-nutrient foods and beverages and students' ability to learn.
- Increase awareness of the personal health implications of consuming low nutrient foods and beverages.
- Promote the economic benefits to reduced consumption of low-nutrient foods (e.g. fewer sick days, reduced health care costs, etc.).
- Discourage consumption of sugar-sweetened beverages.



Nutrition

GOAL 3

Decrease food insecurity in Idaho.¹

Recommended Actions:

Build Capacity

- Increase funding for food assistance programs.
- Increase access to food assistance programs.
- Increase partnerships among agencies representing disparate & economically disadvantaged populations.
 - Create new and diverse partnerships to increase the reach of interventions.
 - Support the development of local and statewide food policy councils.²

Environmental Change

- Expand farmer’s markets and local food efforts.
- Increase the number of individuals, families and communities that grow their own food.

- Implement the use of Electronic Benefit Transfer (EBT) point-of-purchase machines at farmer’s markets for Supplemental Nutrition Assistance Program (SNAP), Women, Infants and Children (WIC) and senior nutrition benefits.

Individual Education through Communication

- Increase awareness and referrals of low-income families and other disparate populations to food assistance programs through health care settings, worksites, schools and other human service organizations.
- Decrease perceived social stigmas associated with the acceptance of food assistance.
- Provide individual education about providing and preparing food on a budget.

Courtesy of the Idaho Foodbank.



Global Gardens, the first booth to accept food stamps at the Capitol City Market, Boise, Idaho.

¹ Food insecurity is defined as not having both physical and economic access to food that meets people’s dietary needs as well as their food preferences.

² Food policy councils include, but are not limited to representation from chefs, farmers/growers, faith-based organizations, hunger-relief groups, education, land use professionals, volunteer groups, insurers, etc.

GOAL 4

Increase breastfeeding initiation, duration and exclusivity in supportive environments in accordance with American Academy of Pediatrics guidelines.

Recommended Actions:

Build Capacity

- Develop and increase awareness and utilization of existing resources.
- Work with public health and community partners to provide education regarding the benefits of breastfeeding, and promote breastfeeding as the norm.
- Promote and provide education for medical, allied health care professionals and patients about the importance of nutrition during pregnancy and lactation.

Environmental Change

- Pre-natal, women’s health care and birthing facilities provide breastfeeding-friendly peer counseling.

- Pre-natal, women’s health care and birthing facilities provide lactation support, breast pumps (when needed) and education.
- Assist health care settings, childcare facilities and worksites to provide supportive environments for breastfeeding.
- Provide awareness about implementing the use of International Board of Lactation Consultant Examiners (IBCLC) certified counselors.
- Recognize, encourage and support replication of innovative and best practices, especially those eliminating health disparities and integrating cultural competencies.

Advocate, Adopt and Implement Policies

- Adoption of breastfeeding-friendly policies in all birthing facilities”
- Implement policies and incentive programs for employers to provide breastfeeding-friendly worksites.

Individual Education through Communication

- Promote and encourage the importance of breastfeeding and good nutrition during pregnancy and breastfeeding.



Physical Activity

GOAL 1

Increase physical activity among children and adults to meet recommended guidelines.

Recommended Actions:

Build Capacity

- Implement an integrated approach to increased physical activity.
- Health care professionals assess patient's physical activity and discuss ways to make progress toward meeting the Physical Activity Guidelines for Americans
- Health care systems and payers make physical activity a priority and develop comprehensive approaches to physical activity promotion.

Environmental Change

- Create referral services to community-based physical activity programs and resources.
- Create partnerships between parks and recreation departments and after-school programs.

- Improve access to public-private recreational facilities in communities with limited recreational opportunities through:
 - Reduced costs for participating in programs and/or use of facilities;
 - Increased operating hours;
 - Co-location of schools and public private recreation facilities;
 - Availability of child care;
 - Joint use agreements
- Programs and facilities where people work, learn, play and worship provide easy access to safe and affordable physical activity opportunities.

- Expand the use of school facilities as recreation sites for community members.

Individual Education through Communication

- Disseminate current best practice guidelines to promote physical activity in high-risk populations that address primary, secondary and tertiary prevention.
- Educate medical, allied health care professionals and patients about the prevention of obesity including effective techniques for motivating patients to make lifestyle changes.
- Medical, allied health care professionals educate their patients about healthy lifestyle choices that prevent and reduce obesity.
- Support inclusion of culturally appropriate patient education materials and counseling for physical activity by health care providers.



GOAL 2

Increase the quality and quantity of physical education and activity opportunities in all schools and childcare settings.

Recommended Actions:

Build Capacity

- Support resource allocation for adequate and safe equipment and facilities in all educational and childcare settings.
- Recognize, encourage and support replication of innovative and best practices, especially those eliminating health disparities and integrating cultural competencies.

Environmental Change

- Provide access to and opportunities for high quality, comprehensive physical activity programs anchored by physical education best practices in preK-12 educational settings that are inclusive, safe and developmentally and culturally appropriate that:
 - Teach skills that promote lifelong physical activity;
 - Increase time that students are actively involved in physical education at school;
 - Train teachers in physical education and enhance the training of physical education teachers.

- Provide access to opportunities for physical activity before and after school.
- Early childhood education settings for children ages 0-5 years facilitate physical activity.
- Schools provide access to physical activity opportunities (i.e. joint use agreements).

Implement Policies

- Advocate for state and federal funding to ensure all educational institutions have resources (e.g. facilities, equipment, staff) to provide quality physical activity programming.
- Implement recess before lunch policies and practices in schools
- Develop and implement state and

school district policies requiring school accountability for the quality and quantity of physical education and physical activity programs.

- Implement requirements for preK-12 standards-based physical education that address state standards, curriculum time, class size and employment of certified highly qualified physical education teachers in accordance with national standards and guidelines such as those published by the National Association for Sport and Physical Education (NASPE).
- Implement local, state and national standards that emphasize provision of high levels of physical activity in physical education i.e., those recommended by the National Association for Sport and Physical Education (NASPE).
- Develop and implement state-level policies requiring school districts to report on the quality and quantity of physical education and physical activity programs.

- Implement policies mandating daily active recess time for all elementary schools.
- Implement policies clearly defining physical activity components for early childhood program providers.

Individual Education through Communication

- Conduct coordinated events and opportunities for students to walk or bike to and from school.
- Disseminate and provide education demonstrating the link between physical activity during the day and academic performance.
- Incorporate the use of physical movement throughout the day.



Physical Activity

GOAL 3

Increase adoption of and participation in workplace wellness programs.

Recommended Actions:

Build Capacity

- Identify, summarize and disseminate best practices, models and evidence-based physical activity interventions in the workplace.
- Recruit key business and industry leaders to play central roles in influencing their peers.
- Educate business and industry leaders regarding their role as positive agents of change to promote physical activity and healthy lifestyles within the workplace and in their communities, giving particular consideration to efforts targeting disparate populations.
- Increase awareness and understanding among business, agency and organization managers about the benefits of wellness (e.g., decreased sick leave, decreased absenteeism, increased productivity and improved morale).
- Support and promote active commuting to and from work.

Environmental Change

- Develop specific worksite wellness approaches appealing to worksites that employ large numbers of disparate populations.
- Provide showers, bike racks, lockers, breaks and other amenities to support physical activity at the workplace.
- Create an expectation and culture of employees getting up and moving.

Advocate, Adopt and Implement Policies

- Employers identify and implement key policies and activities to support physical activity in the workplace.



Mobile Recreation Van activities through Boise Parks and Recreation, Davis Park, Boise, Idaho.

GOAL 4

Decrease sedentary screen-time (e.g. television, gaming systems and computers) among all Idahoans.

Recommended Actions:

Capacity Building

- Promote recognition of and awards for innovative uses of interactive technology to increase physical activity.
- Ensure data gathering on screen-time reflects changes in technologies.

Environmental Change

- Provide opportunities to replace sedentary behaviors, such as watching television, with physical activity.
- Identify and increase utilization of resources that increase physical activity during screen-time, such as interactive technologies.

Individual Education through Communication

- Promote American Academy of Pediatrics (AAP) recommendations for:
 - Limiting children's television time to no more than one or two hours of quality programming per day.
 - Removing television sets from children's bedrooms.
 - Discouraging television viewing for children younger than two years and encouraging more interactive activities such as talking, playing, singing and reading together.
- Promote statewide and local participation in Unplugged Week with Be Outside Idaho.
 - Assist with the implementation of Unplugged Week.
- Develop and promote an awareness campaign to educate parents and caretakers about the relationship between screen-time and obesity.



Physical Activity

GOAL 5

Support the development and implementation of community plans including mixed-use designs that promote physical activity for all ages.

Recommended Actions:

Build Capacity

- Educate the planning community about the value of including the public health perspective into community design, and participate at their tables when possible.
- Integrate “active” transportation elements into land-use, transportation and community design plans.
- Adopt strategies and infrastructure to improve access to safe and secure parks, recreation, fitness and sports facilities, and healthy eating food outlets, especially for low resource and high-crime neighborhoods.

Environmental Change

- Improve access to public transportation.
- Support and integrate health impact assessments in planning to inform activity-friendly design and development.

- Create public facilities (e.g. schools, parks, etc.) within convenient walking distance of major residential areas.
- Incorporate zoning for mixed-use development that creates walkable and bikeable communities.
- Implement school siting, complete streets, smart growth and transit friendly design and develop initiatives that promote physical activity and utilize best practices.
- Increase utilization of data — GIS, inventory infrastructure, etc., — to inform planning decisions.
- Enhance personal safety in areas where persons are or could be more physically active.
- Enhance traffic safety in areas where persons are or could be more physically active.



GOAL 6

Increase the number and utilization of safe, accessible routes that support diverse modes of transportation in our communities.

Recommended Actions:

Build Capacity

- Support transportation agencies’ research, development and pilot programs to develop market based tools to encourage more active transportation.
- Engage community-based organizations that represent disparate populations in policy development, accountability and advocacy activities.
- Establish local non-motorized transportation citizen committees that report to city officials such as city councils, mayors, etc.
- Implement safe routes initiatives such as Safe Routes to Schools, Bike to Work and other active transportation programs.
 - Ensure accommodations for children and adults with disabilities.
- Locate schools within easy walking distance of residential areas.
- Improve access to outdoor recreation facilities.

Environmental Change

- Increase equitable distribution of safe, walkable and bikeable routes, connectivity and accessibility to essential community destinations.
- Enhance traffic safety near areas where persons are or could be more physically active (e.g., schools, parks, recreations areas).
- Incorporate wayfinding signage to inform public of access to walking and biking routes in their area.

Advocate, Adopt and Implement Policies

- Promote development and dissemination of model zoning and land use policies incorporating transportation impacts on land use patterns and support physical activity.
- Support and increase incentives for the adoption of policies and standards that support “complete streets” and “livable community” in the planning and development of transportation networks.
- Promote changes in local transportation policy and funding to promote walking, biking and the use of public transit.



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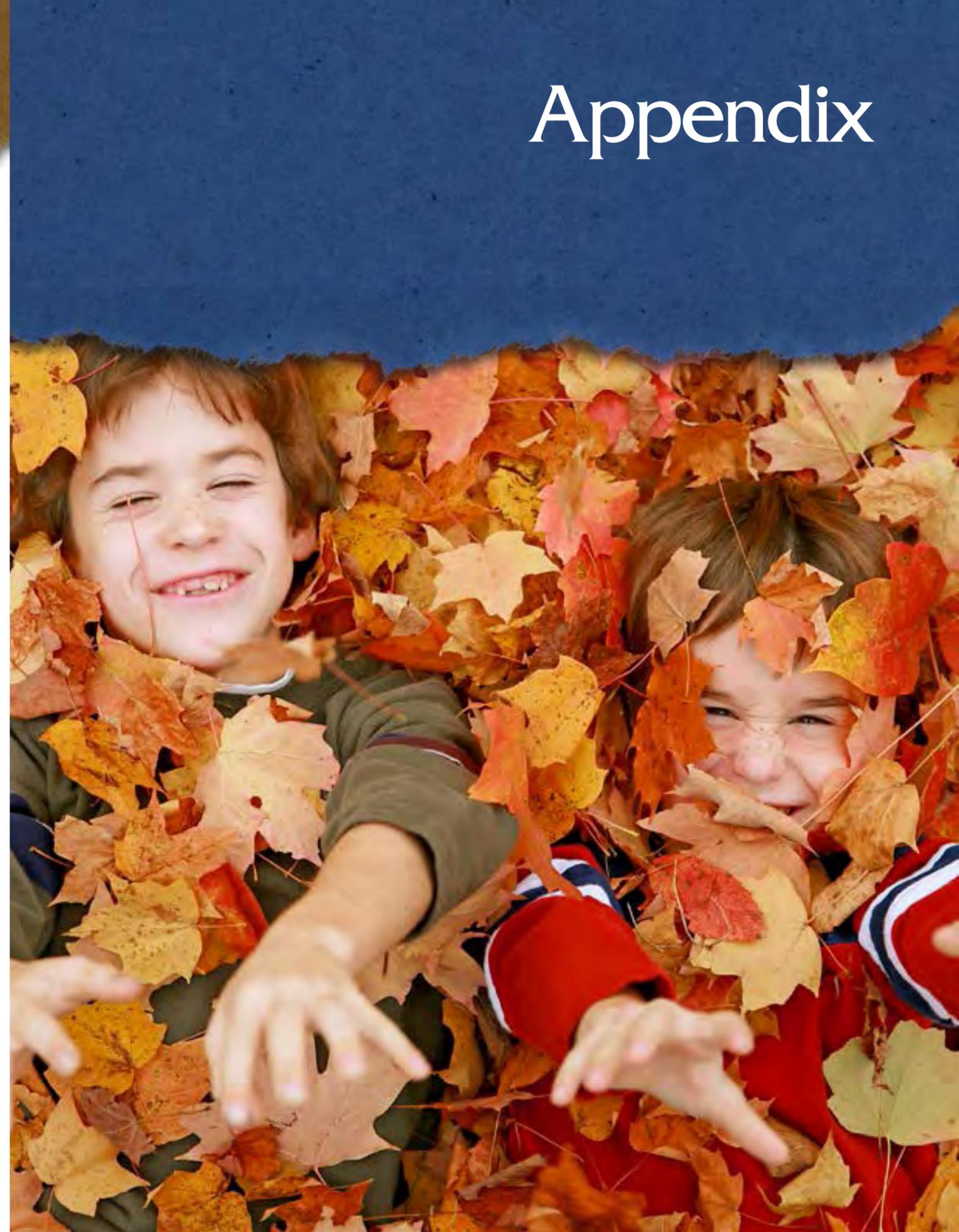
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Appendix



Kootenai Health Triathlon for Kids.
Kootenai Medical Center.

The Obesity Epidemic in Idaho

A Report Describing the Burden of Obesity in Idaho



Idaho Physical Activity and Nutrition Program
Bureau of Community and Environmental Health
Division of Public Health
Idaho Department of Health and Welfare
July 2013



HEALTH & WELFARE

Methodology

A note about confidence intervals and statistical significance:

95% Confidence Interval - A statistical range with a specified probability (i.e., 95%) that a given measure lies within the range. In other words, a 95% confidence interval for a percentage is the range of values within which the mean sample percentage will be found at least 95% of the time. Statistical significance for the purposes of this document is therefore predicated on the situation where the confidence intervals for two or more estimates do not overlap.

Any difference determined to be statistically significant (using 95% confidence intervals) was designated as such and will be preceded by the words “significantly” or “statistically.”

Idaho Behavioral Risk Factor Surveillance System (BRFSS) and Youth Risk Behavior Survey (YRBS) Data

Where available, 2011 Idaho BRFSS estimates of chronic disease prevalence and associated risk factors are presented in graphical and narrative formats. Because of significant changes to the survey methodology employed for the 2011 Idaho BRFSS, direct comparisons to previous years' data are not recommended. Therefore, trend charts and those measures which require the aggregation of two or more years of data do NOT display 2011 Idaho BRFSS data. For questions about the data presented within *The Obesity Epidemic in Idaho* please contact Joseph Pollard at 208.332.7302 or pollardj@dhw.idaho.gov.

Unless otherwise noted, the majority of adult data were obtained from the Idaho BRFSS survey. For more information about the BRFSS, visit <http://www.cdc.gov/brfss/>. For specific information regarding the Idaho BRFSS, please contact the Bureau of Vital Records and Health Statistics at (208)332-7326 or www.healthstatistics.dhw.idaho.gov. The majority of youth data (unless otherwise noted) were obtained from the Idaho YRBS. For more information about the YRBS, contact Patricia Stewart of the Idaho Department of Education at (208)332-6929. It is important to note that the data presented in this report are focused on the risks associated with unhealthy weight, therefore all of the charts and tables highlight those populations which may be at risk for unhealthy weight, poor fruit and vegetable intake, physical inactivity, excessive TV watching, etc.

The Obesity Epidemic in Idaho

The Obesity Epidemic

Obesity in the United States is at epidemic proportions, and Idaho is not immune. The dramatic increase in obesity rates has serious implications for the health of Idahoans today and into the future. Being overweight or obese increases the risk of many diseases and chronic health conditions, and the related cost to the U.S. health care system is estimated to exceed \$100 billion. The percentage of adults in Idaho who are obese has increased significantly in the past ten years from 20% in 1999 to 25% in 2009. Obesity is now rivaling tobacco use as the leading cause of preventable death.

While the focus of this report is obesity, measures of overweight have been included because of the impact that both have on health. Furthermore, overweight adults are at an increased risk of becoming obese without implementing behavioral changes that promote healthy eating and active living.

What is Body Mass Index (BMI)?

Body Mass Index (BMI) is a proxy measure for body fat percentage utilizing the ratio of weight and height (Figure 1). Historically, BMI was developed for population-based studies and may not be the most suitable measure for weight-related problems at the individual level. In adults, a BMI of 18.5 to 24.9 is considered to be ideal, and anything above 24.9 is considered to be overweight or obese (when BMI is 30 or higher). Among children and teens aged 2 to 20 years, BMI categories are determined by comparing the resulting BMI value against sex- and age-specific growth chart percentiles. Overweight is defined as between the 85th and 95th percentiles, while obese is defined as a BMI for age and sex at or above the 95th percentile.

Figure 1. Body Mass Index Categories and Values for U.S. Adults and Children

Age Group	BMI Category	BMI Values	How Calculated
Adults 21+ Years of Age	Underweight	Less than 18.5	Calculated using the following formula: $\text{BMI} = \left[\frac{\text{weight (pounds)}}{\text{height (inches)} \times \text{height (inches)}} \right] \times 703$
	Ideal Weight	18.5 to 24.9	
	Overweight	25 to 29.9	
	Obese	30 or higher	
Children 2 to 20 Years of Age	Underweight	Less than 15th Percentile	Calculated using the revised Centers for Disease Control and Prevention (CDC) Growth Charts for the U.S.
	Ideal Weight	15th to 85th percentile	
	Overweight	85th to 95th percentile	
	Obese	95th percentile or higher	

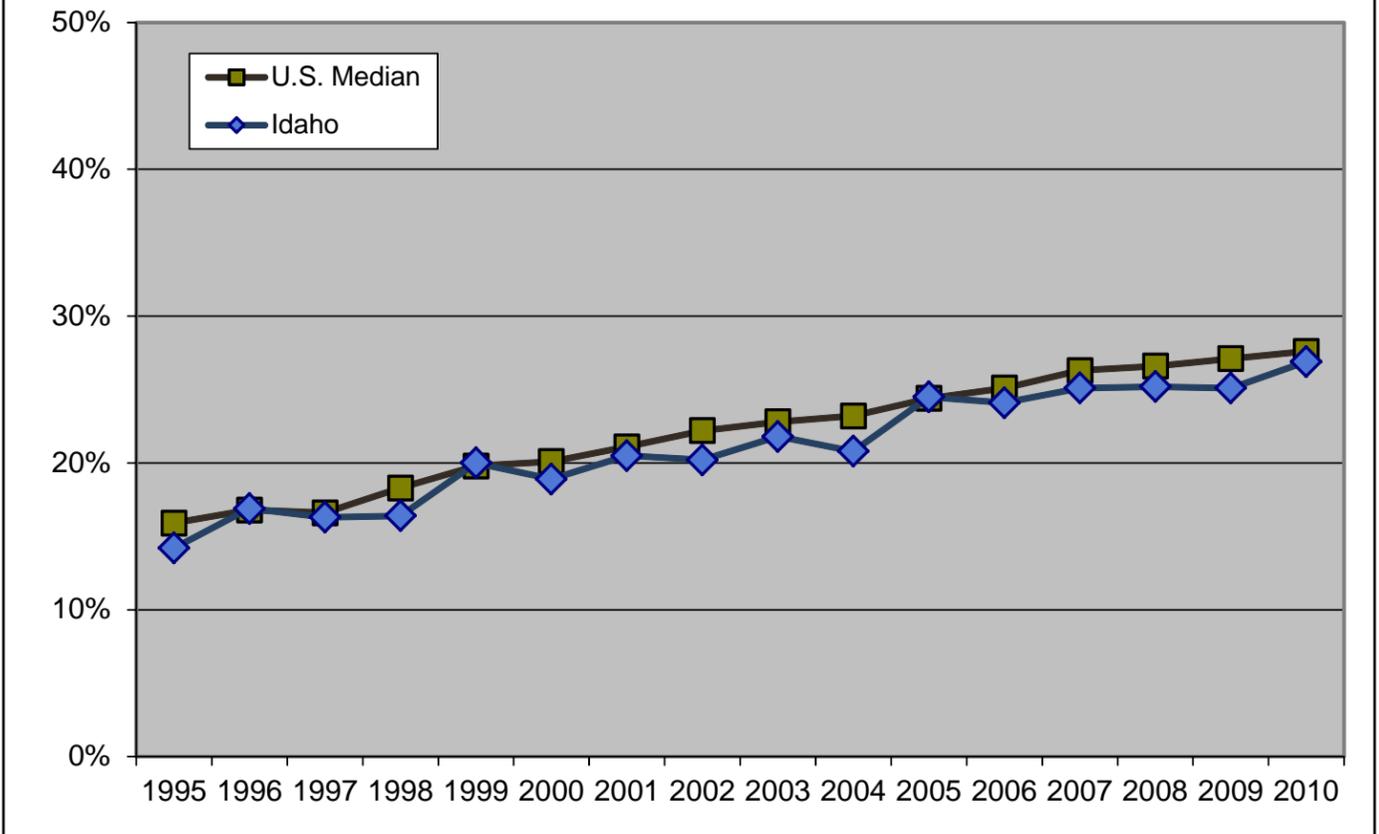
The Idaho Physical Activity and Nutrition Program

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The Obesity Epidemic in Idaho

The percentage of Idaho and U.S. adults who are considered obese (based on a BMI of 30 or higher) has increased significantly over time (Figure 2). The rate of obesity among Idaho adults nearly doubled over the past 15 years from 14.2% in 1995 to 26.9% in 2010. Similar increases were seen nationally as the percentage of obese adults in the U.S. went from 15.9% in 1995 to 27.6% in 2010.

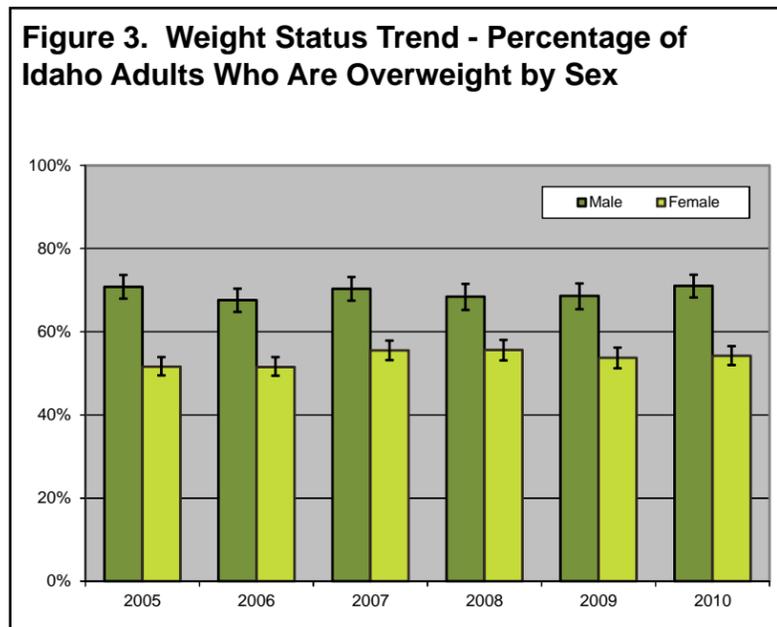
Figure 2. Obesity - The Percentage of Obese Adults in Idaho and U.S., 1995-2010



Idaho Source: Idaho BRFSS, Bureau of Vital Records and Health Statistics
 U.S. Source: BRFSS (median), Centers for Disease Control and Prevention

Weight Status of Idaho Adults

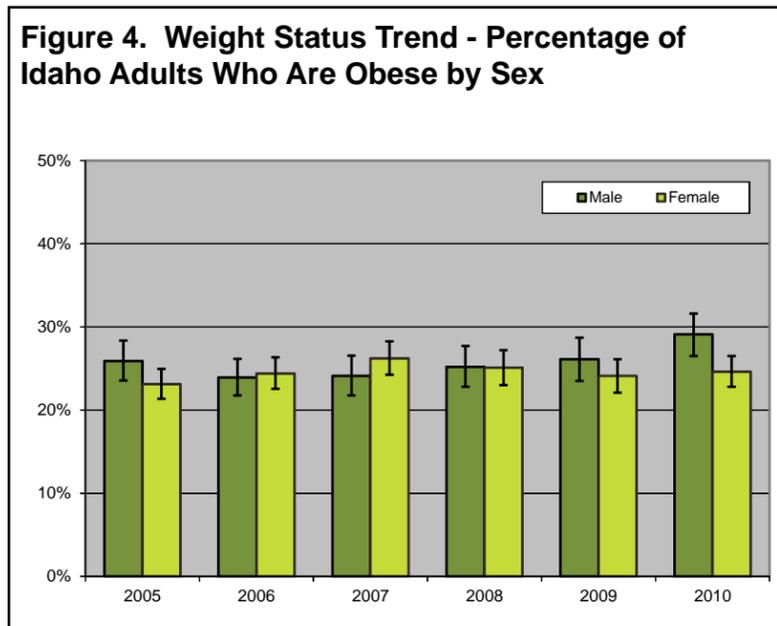
The percentage of Idaho adults who are considered overweight (based on BMI greater than 25 and less than 30) differs significantly between males and females. In 2010, 41.9% of males were overweight compared to 29.6% of females. The difference in overweight prevalence has decreased slightly during the past 5 years, however men continue to be at greater risk for being overweight (Figure 3).



Source: 2005-2010 Idaho BRFSS

In contrast to overweight status, the prevalence of obesity among males and females in Idaho does not differ significantly. In 2010, 29.1% of males and 24.6% of females were obese. Previous to 2010, the differences in obesity prevalence between males and females has not differed significantly (Figure 4).

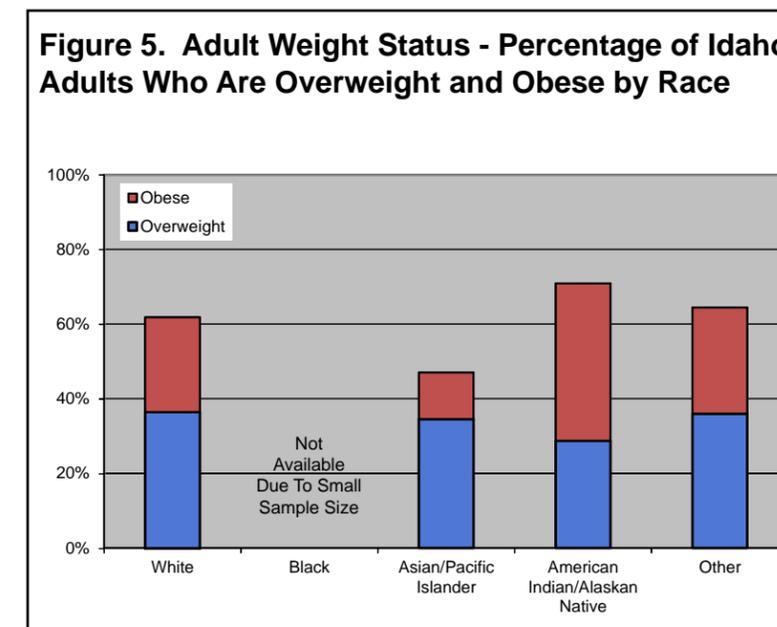
These weight status data suggest that the overall increase in the percentage of Idaho adults who are at an “unhealthy weight” (i.e., overweight or obese) has been driven primarily by an increase in the percentage of obese men and a slight increase in the percentage of overweight women.



Source: 2005-2010 Idaho BRFSS

Weight Status of Idaho Adults by Race

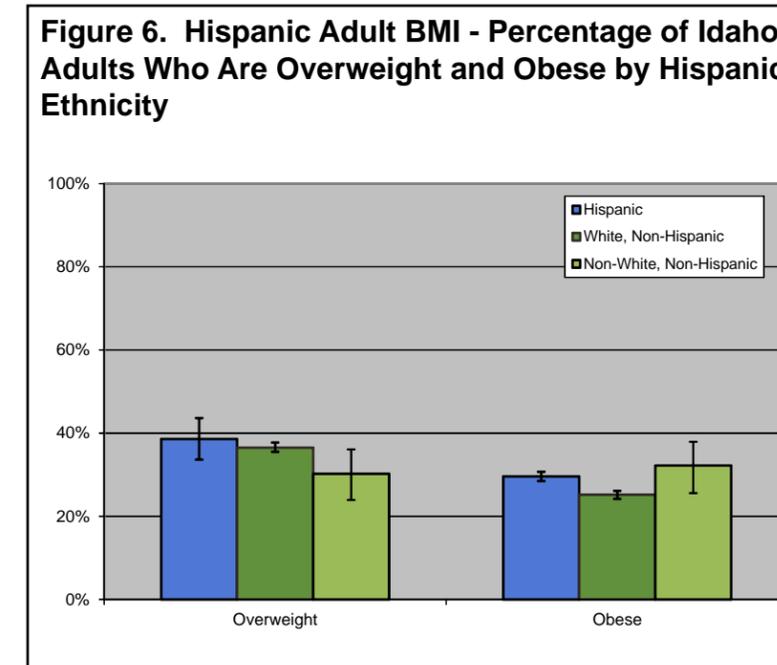
Among Idaho adults, the percentage who are considered overweight or obese (based on BMI above 25) is lowest among Asians (46.9%) and highest among American Indians (70.9%). The overweight or obese rate among Asian adults in Idaho is significantly lower than American Indians. In contrast, American Indian adults in Idaho are least likely to be considered overweight with 28.7% of American Indian adults reporting a BMI between 25 and 29.9 compared to overweight rates of roughly 35% for the other racial categories (Figure 5).



Source: 2008-2010 Aggregated Idaho BRFSS

BMI of Hispanic Adults

In Idaho, 38.6% of Hispanics are considered overweight (based on BMI between 25 and 29.9) compared to 36.5% of White, Non-Hispanics and 30.2% of Non-white, Non-Hispanics. Although the rates of overweight differ between ethnicities the differences are not statistically significant. When it comes to rates of obesity, Hispanic adults (29.6%) in Idaho are significantly more likely than White, Non-Hispanic adults (25.2%) to be obese (BMI equal to or greater than 30). Non-White, Non-Hispanic adults have the highest rate of obesity, however the rate is not significantly higher than Hispanic and White, Non-Hispanic adults (Figure 6).



Source: 2008-2010 Aggregated Idaho BRFSS

In 2006, the Idaho Partnership for Hispanic Health (IPHH) interviewed 519 Hispanic adults living in southwest Idaho. Among those participants who were categorized as obese:

- 27% didn't believe their weight impacted their health in a negative manner
- 56% reported that their general health was good or excellent
- 21% felt their health was worse than it was 12 months prior to being interviewed

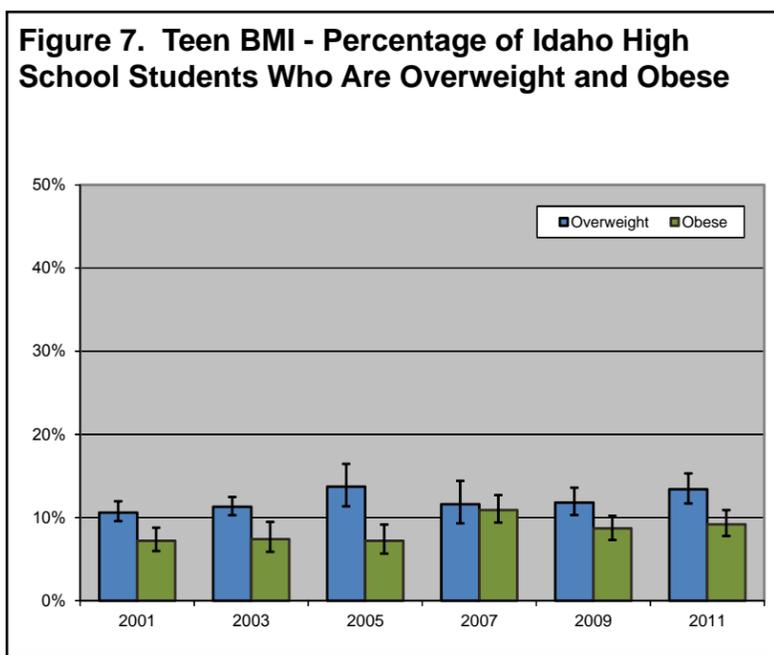
(Source: Idaho Partnership for Hispanic Health. *Study Highlights: Obesity Issues*. For additional information, contact Linda Powell at 1.800.836.8064 ext. 235)

BMI of Idaho Children and Teens

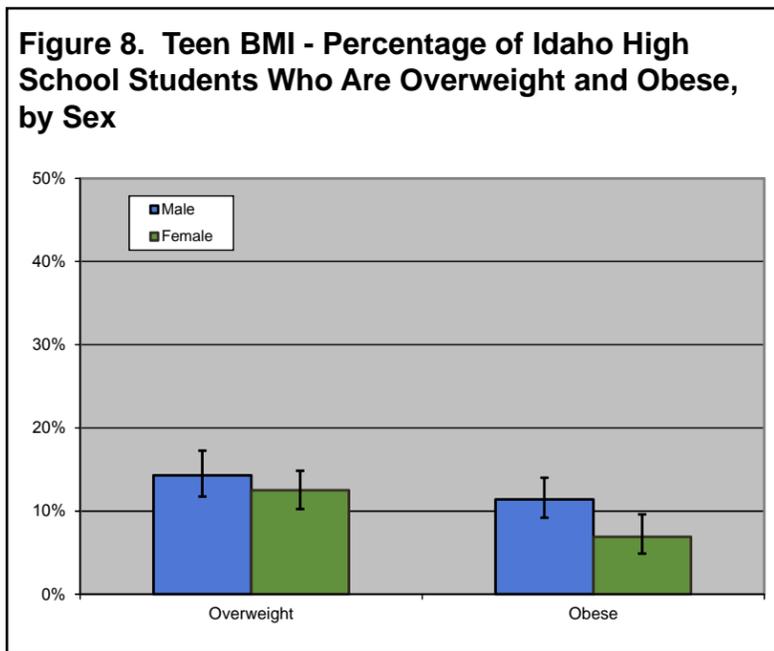
Although not statistically significant, the percentage of both overweight and obese teens (high school students in grades 9 through 12) in Idaho increased between 2001 and 2011 (Figure 7). In 2011, 13% of teens were overweight (based on an age- and sex-specific BMI value between the 85th and 95th percentile) and 9% of teens were obese (based on a BMI for age and sex greater than the 95th percentile). Among sexes, male students were slightly more likely than female students to be categorized as overweight or obese (Figure 8).

Although Idaho does not currently have trend data for younger Idaho kids, the Bureau of Community and Environmental Health (BCEH) conducted a statewide 3rd grade BMI assessment during the 2011/2012 school year which found 15% of students to be overweight and 15% of students to be obese. During the 2008-2009 school year, Idaho's State Department of Education (SDE) conducted a BMI assessment of public school students in grades 1, 3, 5, 7, 9, and 11. Overall, 29% of students were classified as overweight or obese. The only statistically significant differences in rates of obesity were between grades 1 and 5 where obesity rates were 10% and 17% respectively. American Indian students were most likely to be categorized as obese (28%), while Asian students were least likely to be categorized as obese (7%). Although it is notable that 51% of Native American students and 42% of Hispanic students were overweight or obese, sample sizes were too small to reach definitive conclusions.

Using free and reduced school lunch (FRSL) as a proxy measure for socio-economic status, students who attend the most economically disadvantaged schools (i.e., schools with 60% or greater students who qualify for FRSL) are more likely to be obese. In Idaho schools with 60% or more students receiving FRSL, 16% are categorized as obese (compared to an obesity rate of 9% in schools with less than 20% of students receiving FRSL).



Source: 2001-2011 Idaho YRBS

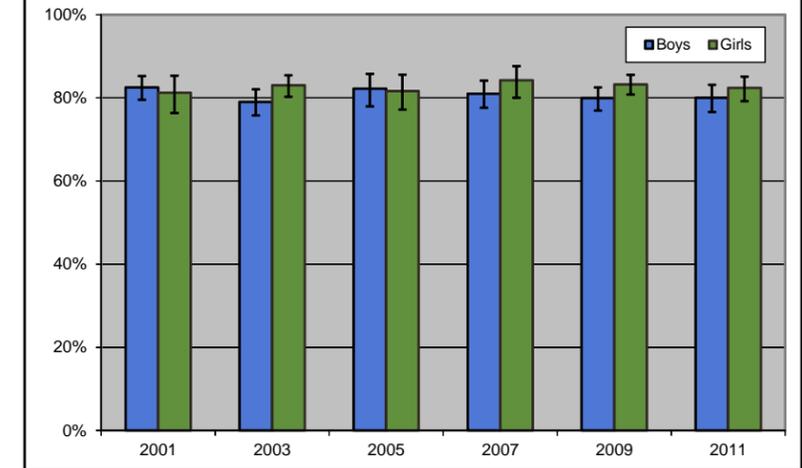


Source: Idaho 2011 Idaho YRBS

Nutrition

The percentage of Idaho high school students who consumed less than the recommended amount of fruit and vegetables each day (5 or more servings per day, based on CDC recommendations prior to the new food pyramid guidelines) remained relatively unchanged between 2001 and 2011 (Figure 9). In most years that data were collected, female students were slightly more likely than male students to report consuming less than 5 servings of fruits and vegetables per day, however the difference between male and female students is not statistically significant.

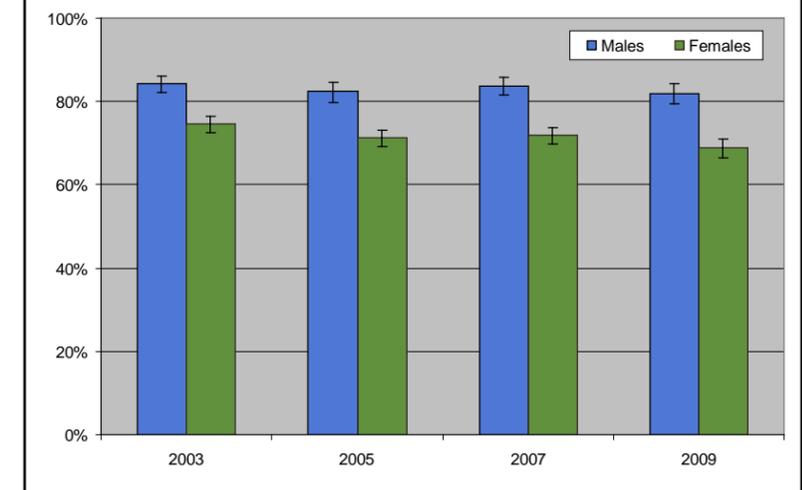
Figure 9. Nutrition - Percentage of Idaho High School Students Who Consume Fruits and Vegetables Fewer than Five Times Per Day by Sex, Over Time



Source: 2001-2011 Idaho YRBS

Among Idaho adults, the percentage who consumed fruits and vegetables less than 5 times per day decreased significantly from 79% in 2003 to 75% in 2009. Among Idaho adults, females were significantly more likely to consume the recommended amount of fruits and vegetables than males (Figure 10). Note: Fruit and vegetable question was last asked in 2009.

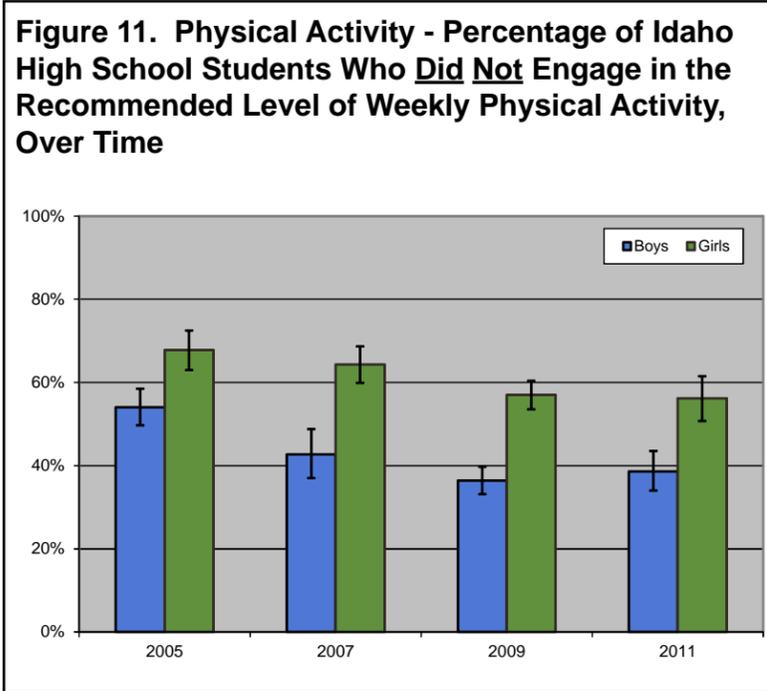
Figure 10. Nutrition - Percentage of Idaho Adults Who Consume Fruits and Vegetables Less Than Five Times Per Day by Sex, Over Time



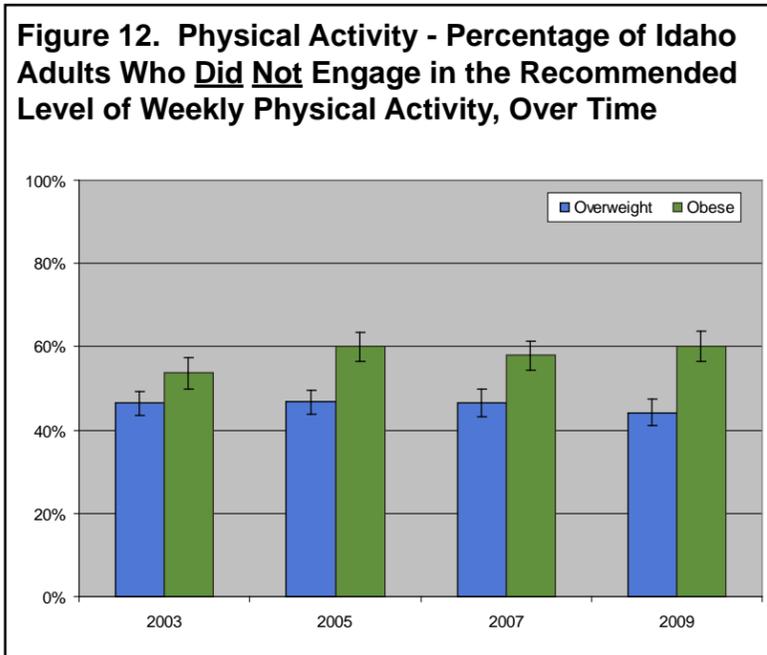
Source: 2003-2009 Idaho BRFSS

Physical Activity

In 2005, 61% of Idaho high school students did not engage in the recommended level of weekly physical activity (i.e., at least 60 minutes per day on 5 or more days). In 2011, the percentage of Idaho high school students not engaging in the recommended level of physical activity decreased significantly to 47%; meaning that more students were engaging in the recommended level of physical activity each week. However, female students were significantly more likely than male students to not get the recommended amount of exercise (56% and 39% respectively) (Figure 11).



Source: 2005-2011 Idaho YRBS



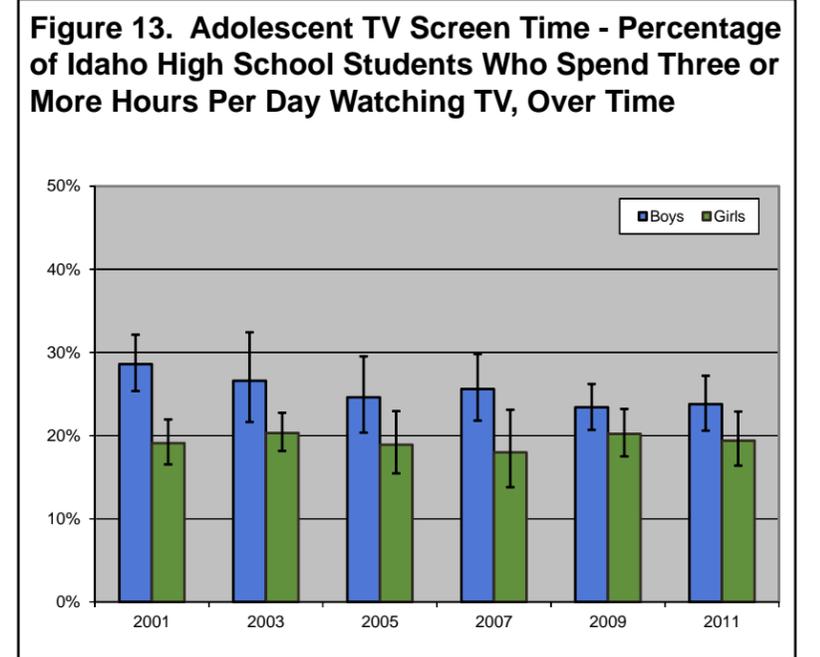
Source: 2003-2009 Idaho BRFSS

Among Idaho adults, those who are considered obese (based on BMI of 30 or higher) are significantly less likely to engage in the recommended levels of physical activity than those Idaho adults who are overweight. There has been very little change over time in the percentage of Idaho adults who engage in the recommended level of physical activity (Figure 12).

Note: the recommended levels of physical activity for adults are 30+ minutes of moderate physical activity five or more days per week, or vigorous physical activity for 20+ minutes three or more days per week. This physical activity measure was replaced in 2011 in order to match new physical activity recommendations.

TV Screen Time Among Idaho High School Students

The percentage of Idaho high school students who spend three hours or more per day watching TV has decreased slightly from 24% in 2001 to 22% in 2011 (Figure 13). The decrease appears to be driven mainly by the decrease among male students, who in 2001 were significantly more likely than female students to spend three or more hours per day watching TV. Another issue to consider is that the amount of time that Idaho's high school students spend using a computer (for non school-related purposes) increased from 15% in 2007 to 22% in 2011. (Note: the computer use question was first asked in 2007.)



Source: 2001-2011 Idaho YRBS

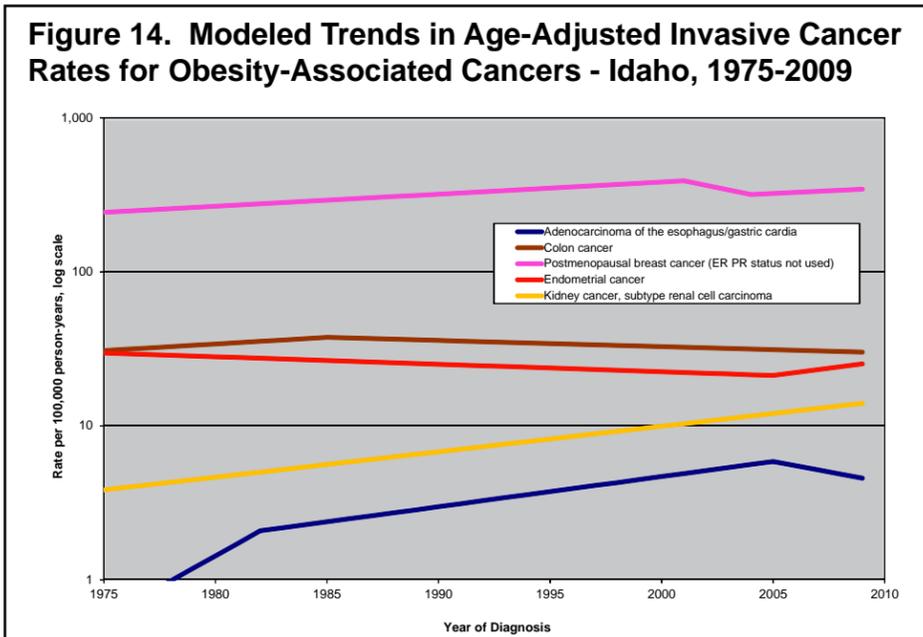
Obesity and Cancer

The American Cancer Society estimates that overweight and obesity contribute to 14% to 20% of all cancer-related deaths in the U.S. Several cancers have been associated with obesity. These include adenocarcinoma of the esophagus/gastric cardia, colon cancer, postmenopausal breast cancer (ER+, PR+), endometrial cancer (subtypes I and II), and kidney cancer (subtype renal cell carcinoma). The following describes trends in the age-adjusted incidence rates of these cancers in Idaho from 1975 to 2009:

- Adenocarcinoma of the esophagus/gastric cardia increased at a rate of about 20.5% per year in Idaho from 1975 to 1982, and at a rate of about 4.6% per year from 1982 to 2005. Since 2005, there has been no significant trend.
- Colon cancer incidence increased at a rate of about 2.0% per year in Idaho from 1975 to 1985. From 1985 to 2009, the rate decreased about 0.9% per year. Colon cancer incidence trends over time were different for males and females. For males, rates increased from 1975 to 1988, then decreased. For females, rates decreased slowly across the entire time series.
- Estrogen receptor positive (ER+) and progesterone receptor positive (PR+) breast cancers among postmenopausal women have been associated with obesity. Because ER/PR status is not available for long-term trend analysis, breast cancer incidence among women aged 50 and older was used for this analysis. Breast cancer incidence increased at a rate of about 1.8% per year among female Idahoans from 1975 to 2001, after which the rate decreased by about 6.6% per year until 2004, then increased by about 1.6% per year. The sharp decrease may have been due in part to a decrease in the use of hormone replacement therapy.
- Endometrial cancer incidence decreased at a rate of about 1.1% per year among female Idahoans from 1975 to 2005, then increased about 4.5% per year from 2005 to 2009.
- Renal cell carcinoma incidence increased at a rate of about 3.9% per year in Idaho from 1975 to 2009. The rate of increase was similar for males and females, although rates of renal cell carcinoma incidence among males were about twice as high as among females.

Other factors besides obesity impact the rates of these cancers and may make interpreting the trends difficult. In particular, trends in the use of hormone replacement therapy among women have impacted the incidence rates of hormone-dependent cancers.

Source: Cancer Data Registry of Idaho, Idaho Hospital Association, 2011.



Obesity and Chronic Diseases

Unhealthy weight has been associated with many of the chronic diseases which subsequently contribute to the leading cause of deaths among Idahoans. Overweight and obesity have been associated with diabetes, hypertension, stroke, heart disease, arthritis, asthma, and some cancers.

Children and adolescents are developing obesity-related diseases, such as type 2 diabetes, that were once seen only in adults. Obese children are more likely to have risk factors for cardiovascular disease, including high cholesterol levels, high blood pressure, and abnormal glucose tolerance. One study of 5- to 17-year-olds found that 70% of obese children had at least one risk factor for cardiovascular disease and 39% of obese children had at least two risk factors.

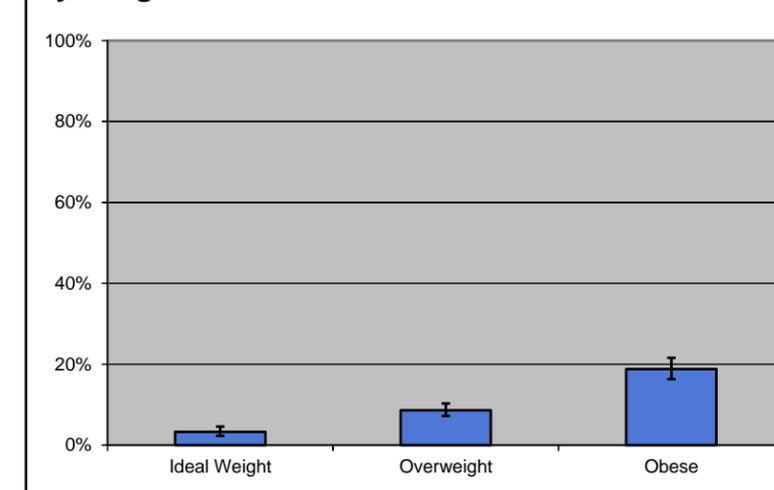
Source: www.cdc.gov/obesity/childhood/basics.html

Among Idaho adults, the prevalence of chronic disease is often significantly higher for those who are overweight or obese. In particular, obese adults are significantly more likely than non-obese adults to have diabetes, high blood pressure, high cholesterol, heart disease, heart attack, and depression.

The determinants of obesity in the United States are complex, numerous, and operate at social, economic, environmental, and individual levels. American society has become 'obesogenic,' characterized by environments that promote increased food intake, nonhealthful foods, and physical inactivity. Public health approaches that affect large numbers of different populations in multiple settings—communities, schools, work sites, and health care facilities—are needed. Policy and environmental change initiatives that make healthy choices in nutrition and physical activity available, affordable, and easy will likely prove most effective in combating obesity.

Source: www.cdc.gov/obesity/index.html

Figure 15. Adult Diabetes - Percentage of Idaho Adults Who Have Been Diagnosed With Diabetes, by Weight Status



Source: 2011 Idaho BRFSS

Diabetes

The percentage of Idaho adults who have been diagnosed with Type 1 and Type 2 diabetes (Figure 15) is significantly higher among those who are considered obese (based on BMI of 30 or greater). In 2011, 18.8% of obese adults and 8.6% of overweight adults had been diagnosed with diabetes. Both groups of adults were significantly more likely to be diagnosed than adults whose weight was considered ideal (3.3%). In 2011, there were an estimated 50,000 obese adults in Idaho who have diabetes.

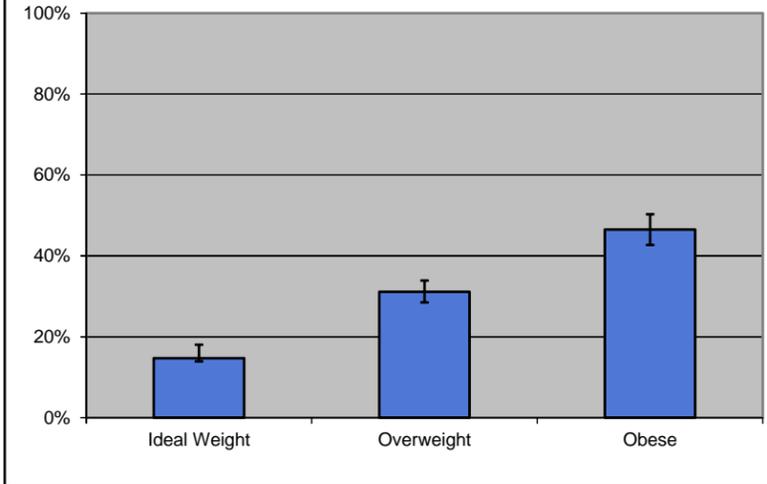
Weight loss has specifically been recommended to lower elevated blood glucose levels among overweight and obese persons with type 2 diabetes.

High Blood Pressure

In 2011, there were an estimated 115,000 obese adults in Idaho with high blood pressure. Furthermore, obese adults (46.5%) in Idaho are significantly more likely than overweight (31.1%) adults to have ever been diagnosed with high blood pressure. Idaho adults who are considered to be at an ideal weight (15.7%) are significantly less likely than overweight or obese adults to have ever been diagnosed with high blood pressure (Figure 16).

High blood pressure can be reduced by maintaining a healthy weight, eating a healthy diet, engaging in physical activity, limiting alcohol intake, and not smoking cigarettes or using chewing tobacco.

Figure 16. High Blood Pressure - Percentage of Idaho Adults Who Have Been Diagnosed With High Blood Pressure, by Weight Status



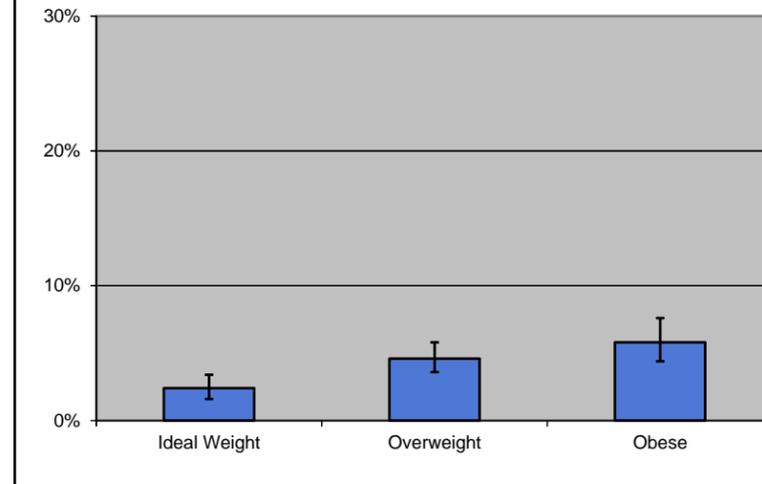
Source: 2011 Idaho BRFSS

Heart Disease/Angina

In 2011, Idaho adults who were at an ideal weight (2.4%) were significantly less likely to have ever been diagnosed with heart disease than those who were overweight (4.6%) or obese (5.8%). This percentage represents an estimated 16,000 obese adults in Idaho who have been diagnosed with heart disease (Figure 18).

The risks for heart disease are overweight, lack of physical activity, diet high in saturated fat and cholesterol, cigarette smoking, and excessive alcohol intake.

Figure 18. Heart Disease/Angina - Percentage of Idaho Adults Who Have Been Diagnosed With Heart Disease, by Weight Status



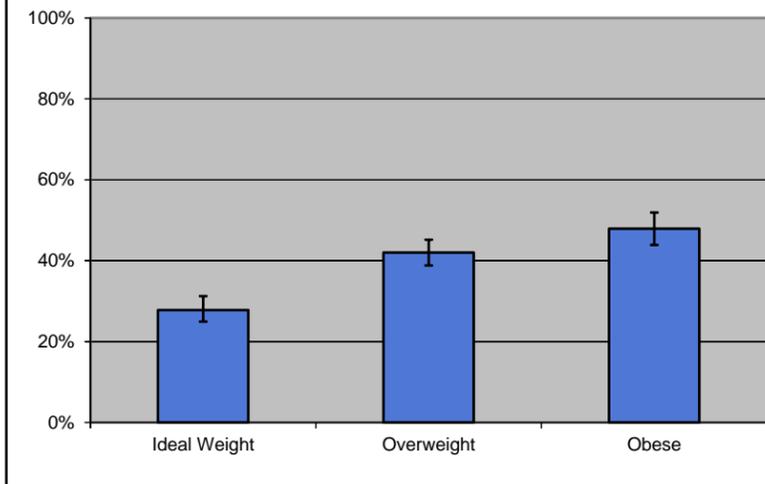
Source: 2011 Idaho BRFSS

High Blood Cholesterol

In Idaho, overweight (42.0%) and obese (47.9%) adults are significantly more likely to have ever been told they have high cholesterol than those adults whose weight is ideal (27.8%). In 2011, there were an estimated 125,000 obese adults with high blood cholesterol (Figure 17).

Many of the same lifestyle choices that can reduce high blood pressure (above) have been recommended for lowering blood cholesterol levels.

Figure 17. High Blood Cholesterol - Percentage of Idaho Adults Who Have Been Diagnosed With High Cholesterol, by Weight Status



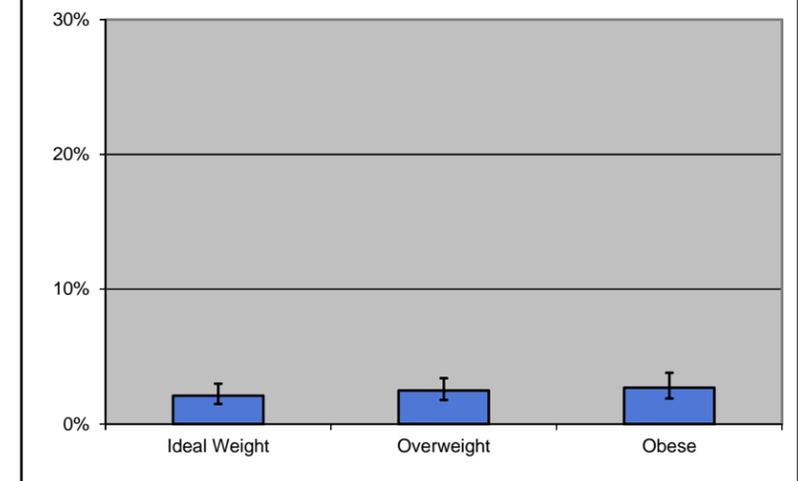
Source: 2009 Idaho BRFSS

Stroke

The percentage of Idaho adults who have ever experienced and survived a stroke is one of the few chronic disease events that does not differ significantly by weight status. However, the risk of having a stroke does increase slightly as a person's weight status increases from ideal (2.1%) or overweight (2.5%) to obese (2.7%). In 2011, there were an estimated 10,000 obese adults in Idaho who had ever had a stroke (Figure 19).

A person's risk for stroke can be reduced by adopting the same healthy lifestyle choices associated with reducing a person's risk for high blood pressure, high cholesterol, and heart disease.

Figure 19. Stroke - Percentage of Idaho Adults Who Have Ever Had a Stroke, by Weight Status



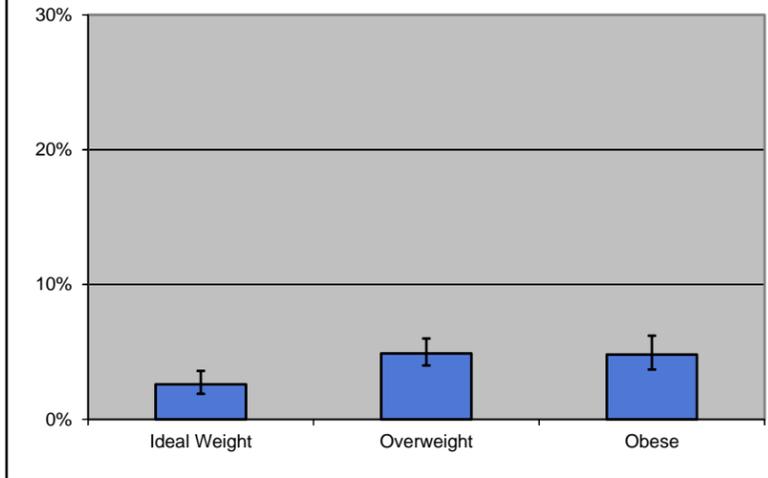
Source: 2011 Idaho BRFSS

Heart Attack

The risk for ever having been diagnosed with having a heart attack increases significantly among Idaho adults who are overweight (4.9%) or obese (4.8%) compared to adults who are an ideal weight (2.6%). Based on these data, an estimated 15,000 obese adults in Idaho have been diagnosed with having had a heart attack (Figure 20).

Sudden cardiac arrest—the stopping of the heart—occurs when the heart stops completely. Unless treated, a person whose heart has stopped will die within minutes. (CDC)

Figure 20. Heart Attack - Percentage of Idaho Adults Who Have Been Diagnosed With a Heart Attack, by Weight Status



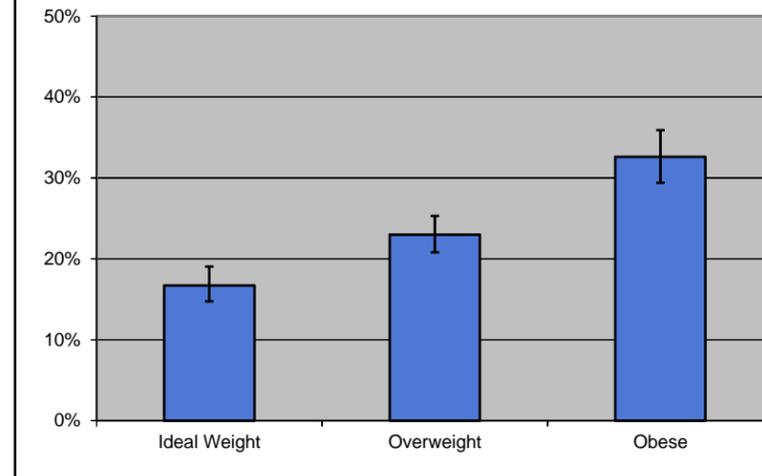
Source: 2009 Idaho BRFSS

Arthritis

Based on 2011 data, a person's risk for being diagnosed with arthritis increased significantly as weight status increased from ideal (16.7%), to overweight (23.0%), and obese (32.6%). This translates to an estimated 90,000 obese Idaho adults with arthritis (Figure 21).

While arthritis cannot be cured, there are ways to manage arthritis and lessen the effects. In particular, people with arthritis are encouraged to obtain self-management education, be physically active, maintain a healthy weight and protect joints. Early diagnosis of arthritis is especially important for people with inflammatory arthritis.

Figure 21. Arthritis - Percentage of Idaho Adults Who Have Been Diagnosed With Arthritis, by Weight Status



Source: 2011 Idaho BRFSS

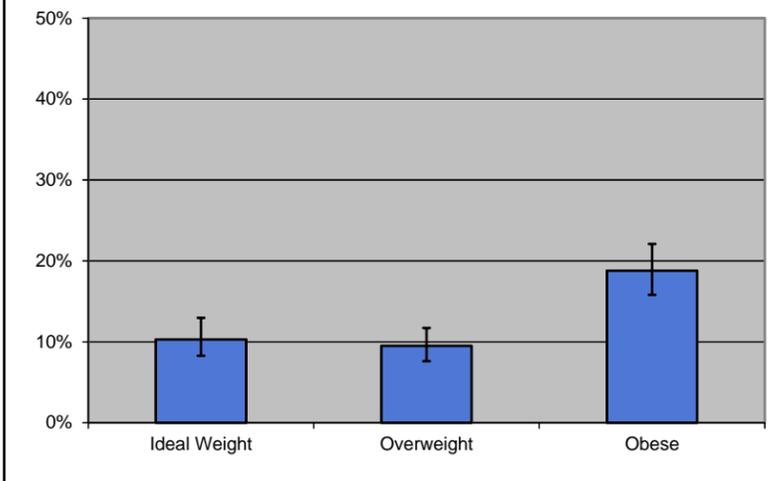
Depression

Although there was very little difference in 2008 between the percentage of Idaho adults at an ideal weight (10.3%) and adults considered overweight (9.5%) who had major depression; obese adults (18.8%) were significantly more likely to have ever been diagnosed with major depression (Figure 21). In 2008, it is estimated that 31,000 obese adults in Idaho had major depression.

Depression is not just having “the blues” or the emotions we feel when grieving the loss of a loved one. It is a true medical condition that is treatable, like diabetes or hypertension. (CDC)

Note: major depression question was last asked in 2008.

Figure 21. Depression - Percentage of Idaho Adults Who Have Major Depression, by Weight Status

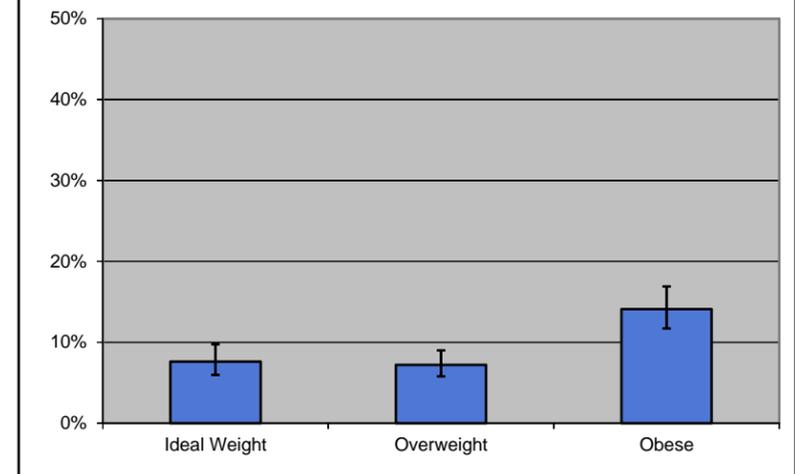


Source: 2008 Idaho BRFSS

Asthma

Asthma risk among adults in Idaho does not appear to differ significantly as a person's weight status increases. Obese adults in Idaho do have the highest risk for asthma (14.1%); adults who are at an ideal weight (7.6%) are not significantly less likely to have current asthma (Figure 22). While there is a significant difference in the percentage of adults who are overweight (7.2%) compared to adults who are obese, the correlation between asthma and weight status does not increase in a linear manner. Despite there not being a strong link between asthma and weight status, 31,000 obese adults in Idaho have been diagnosed with current asthma.

Figure 22. Asthma - Percentage of Idaho Adults Who Have Been Diagnosed With Current Asthma, by Weight Status



Source: 2011 Idaho BRFSS

Food Insecurity

“Food insecurity” is the term used to describe the condition in which a family or individual is faced with not having access to any or enough nutritious food for their next meal. A household or individual is considered food-secure when they do not live in hunger or fear of starvation. Families and individuals with the financial resources to escape extreme poverty rarely if ever experience food insecurity, while poor families and individuals experience a much greater risk of becoming food insecure. For these poorer households, the lack of money contributes to both hunger and obesity; a paradox driven in part by the economics of food buying. Households which lack financial stability often rely on cheaper, high calorie foods to combat hunger. In an attempt to maximize caloric intake for each dollar spent on food, households will often experience an over-consumption of calories obtained from a less healthy diet. Furthermore, research has found that mothers from food insecure households will often restrict their own food intake during periods of food scarcity in order to protect their children from hunger. These patterns of chronic ups and downs in food intake can contribute to obesity among lower-income women.

In 2009, 14.7% of households in the United States (17.4 million households) experienced food insecurity. In Idaho, there are an estimated 267,620 food-insecure individuals. This is 17% or 1 in 6 Idahoans, the 20th highest rate of food insecurity in the country. There are an estimated 95,150 Idaho children (23% or 1 in 4) who are food insecure, the 25th highest rate in the country. Of that total, 23,000 (20%) are children under age 5, the 10th highest age-specific food-insecurity rate in the country.

Source: Idaho Foodbank: www.idahofoodbank.org

Economic Costs

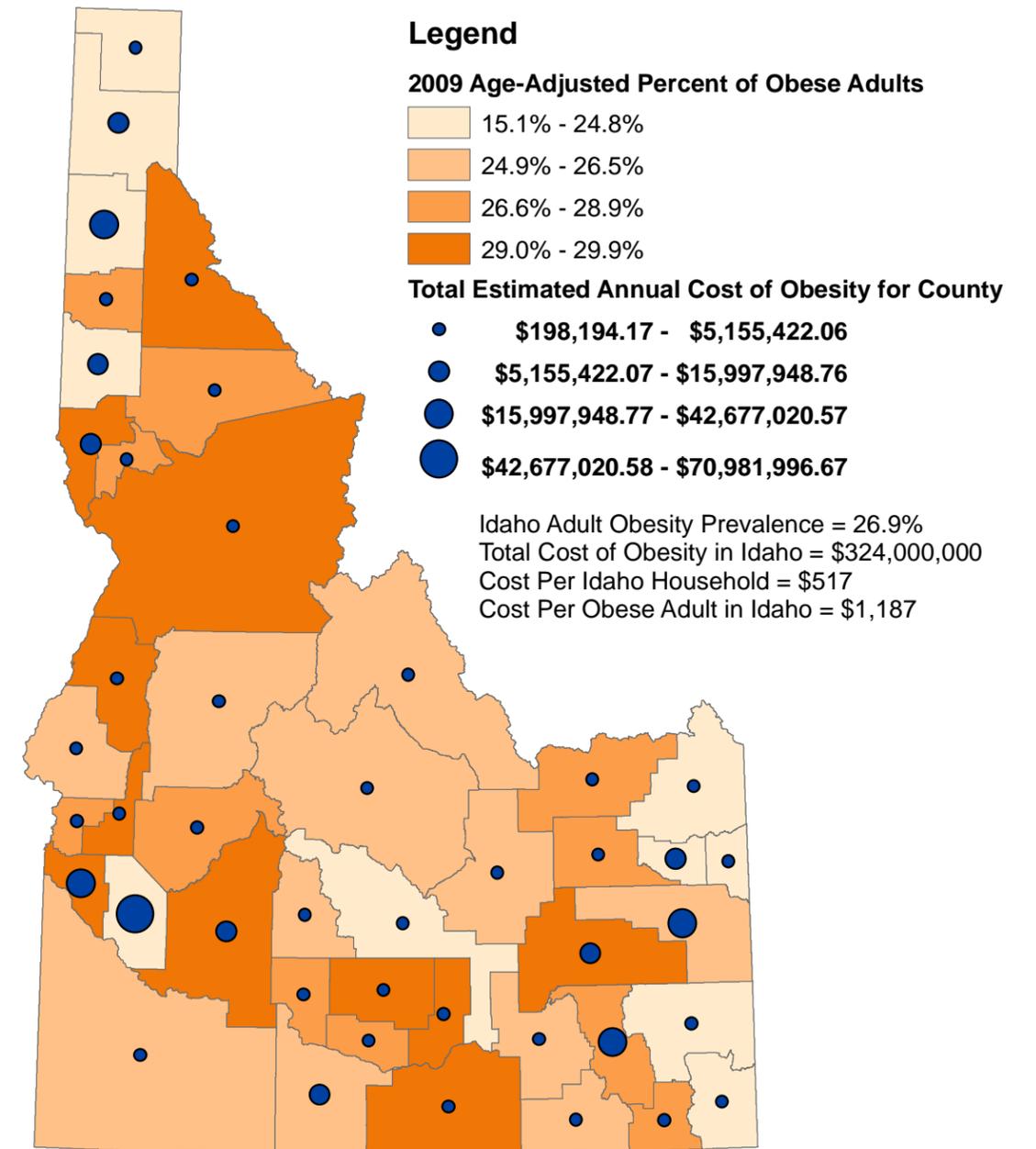
According to the most current estimates, the direct healthcare cost of obesity for Idaho is \$324 million a year. Synthetic estimates of the cost of obesity for individual Idaho counties range from \$198,000 to nearly \$71 million (Figures 23 & 24). Furthermore, based on the projected prevalence of obesity in Idaho, the annual economic cost of obesity will increase to \$1.5 billion by 2018. If the obesity rate in Idaho could be held at today's level (approximately 25%), the savings could be as much as \$932 million in 2018.

Source: United Health Foundation. America's Health Rankings - www.americashealthrankings.org. Accessed on November 30, 2010.

In addition to the medical-related economic costs associated with obesity, there are other real-life costs associated with obesity such as employee sick days, lost productivity, and extra gasoline. When these other real-life costs are considered, it is estimated that the annual cost of being obese is roughly \$4,800 for a woman and \$2,600 for a man. The difference between the costs for men and women is largely driven by studies that suggest obese women earn less than non-obese women. The research also found that medical-related spending on average was about \$1,400 more a year for people who were obese versus those who are not obese.

Source: Associated Press. Article accessed online December 1, 2010.

Figure 23. Obesity - Percent of Obese Adults and Estimated Annual Cost of Obesity by Idaho County, 2009 Age-Adjusted Data



Cost Estimate Source: *America's Health Rankings*, Trust for America's Health.

Estimates based on total cost of obesity in Idaho (\$324 million) divided by number of obese adults in Idaho which is then multiplied by the number of obese adults in each county. County obesity numbers were obtained from the Centers for Disease Control and Prevention's county level estimates accessed on 7.15.2011:

http://apps.nccd.cdc.gov/DDT_STRS2/CountyPrevalenceData.aspx?mode=OBS.

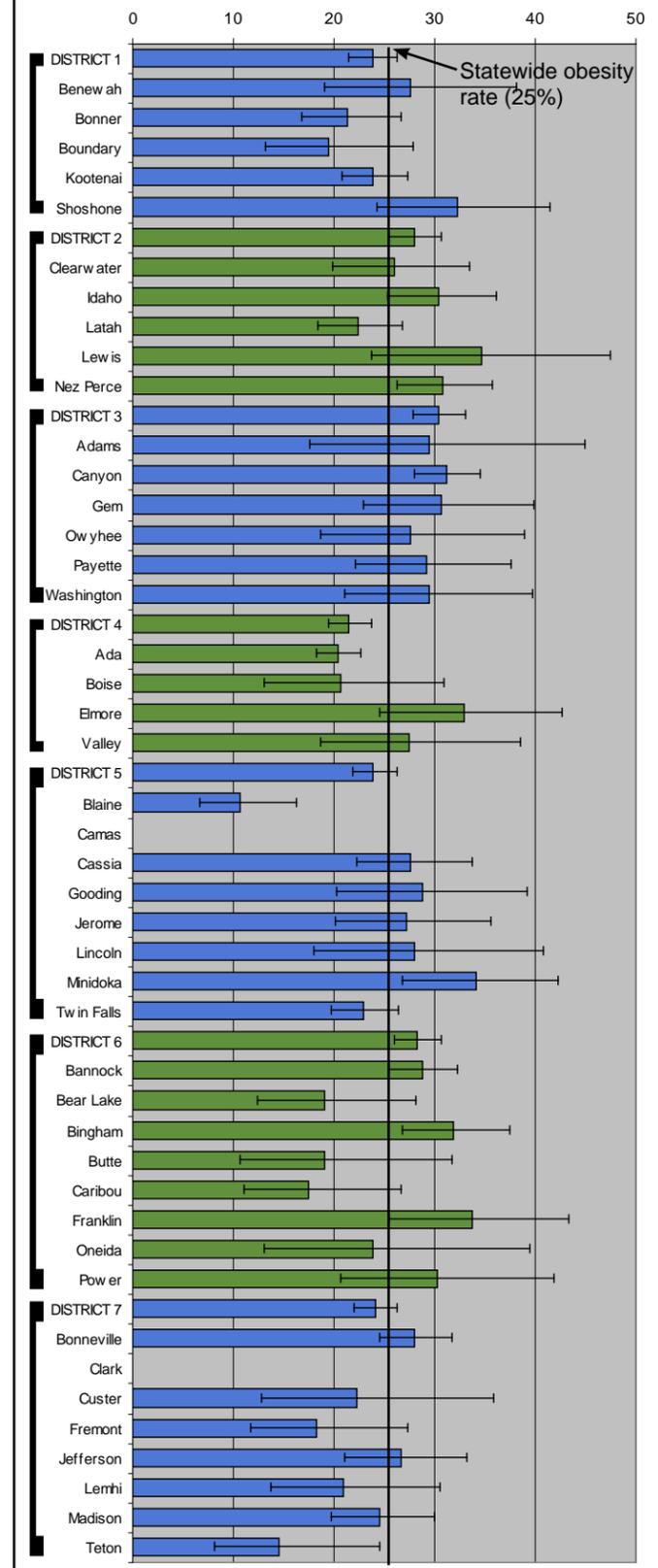
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Figure 24. Obesity - Percent of Obese Adults and Estimated Cost of Obesity by Idaho County, 2009 Age-Adjusted Data

County	Age Adjusted Percent of Obese Adults	Estimated Number of Obese Adults	Estimated Cost of Obesity for County
Ada County	21.8%	59810	\$ 70,981,996.67
Adams County	29.0%	801	\$ 950,619.95
Bannock County	28.9%	16070	\$ 19,071,738.61
Bear Lake County	22.9%	958	\$ 1,136,946.21
Benewah County	26.8%	1884	\$ 2,235,915.09
Bingham County	29.3%	8566	\$ 10,166,055.57
Blaine County	15.1%	2522	\$ 2,993,088.04
Boise County	27.8%	1659	\$ 1,968,887.02
Bonner County	21.3%	6848	\$ 8,127,147.85
Bonneville County	25.6%	17290	\$ 20,519,624.18
Boundary County	24.7%	2031	\$ 2,410,373.44
Butte County	26.5%	538	\$ 638,493.80
Camas County	25.0%	218	\$ 258,720.54
Canyon County	29.5%	35960	\$ 42,677,020.57
Caribou County	23.8%	1182	\$ 1,402,787.49
Cassia County	29.6%	4186	\$ 4,967,909.01
Clark County	26.6%	167	\$ 198,194.17
Clearwater County	26.7%	1778	\$ 2,110,115.20
Custer County	24.9%	864	\$ 1,025,387.81
Elmore County	29.3%	5840	\$ 6,930,862.07
Franklin County	28.9%	2341	\$ 2,778,278.79
Fremont County	21.3%	1800	\$ 2,136,224.61
Gem County	29.5%	3579	\$ 4,247,526.60
Gooding County	27.4%	2711	\$ 3,217,391.62
Idaho County	29.1%	3501	\$ 4,154,956.87
Jefferson County	27.5%	4344	\$ 5,155,422.06
Jerome County	27.4%	3778	\$ 4,483,698.10
Kootenai County	24.4%	24570	\$ 29,159,465.94
Latah County	23.9%	6295	\$ 7,470,852.18
Lemhi County	25.4%	1560	\$ 1,851,394.66
Lewis County	27.5%	748	\$ 887,720.01
Lincoln County	29.3%	894	\$ 1,060,991.56
Madison County	24.8%	5101	\$ 6,053,823.19
Minidoka County	29.8%	3839	\$ 4,556,092.38
Nez Perce County	29.9%	8723	\$ 10,352,381.82
Oneida County	26.3%	786	\$ 932,818.08
Owyhee County	26.2%	1994	\$ 2,366,462.15
Payette County	27.2%	4411	\$ 2,345,937.09
Power County	26.3%	1400	\$ 1,661,508.03
Shoshone County	29.6%	2992	\$ 3,550,880.02
Teton County	20.2%	1218	\$ 1,445,511.99
Twin Falls County	25.7%	13480	\$ 15,997,948.76
Valley County	26.5%	1869	\$ 2,218,113.22
Washington County	25.3%	1899	\$ 2,253,716.96

Estimates based on total cost of obesity in Idaho (\$324 million) divided by number of obese adults in Idaho which is then multiplied by the number of obese adults in each county. County obesity numbers were obtained from the Centers for Disease Control and Prevention's county level estimates accessed on 7.15.2011:
http://apps.nccd.cdc.gov/DDT_STRS2/CountyPrevalenceData.aspx?mode=OBS.

Figure 25. Obesity - Percent of Obese Adults by Idaho Public Health District and County, 2007-2009 Aggregated Age-Adjusted Data



Source: 2007-2009 Idaho Behavioral Risk Factor Surveillance System.
 Note: 2007-2009 aggregate estimates for obesity by Idaho county are the latest available.

Obesity by County and Public Health District

As expected, the percentage of adults in Idaho who are considered to be obese (based on a BMI of 30 or greater) varies by county and local public health district (PHD). Among Idaho's 44 counties (Figure 25), Blaine county (11%) has the lowest percentage of obese adults while Lewis county has the greatest percentage of obese adults (35%).

Among Idaho's seven PHDs, PHD 4 has the lowest rate of adult obesity (24.6%) and PHD 6 has the highest rate of adult obesity (33.5%). (Figure 26)

Figure 26. Idaho Public Health District - Adult Obesity Rates, 2011

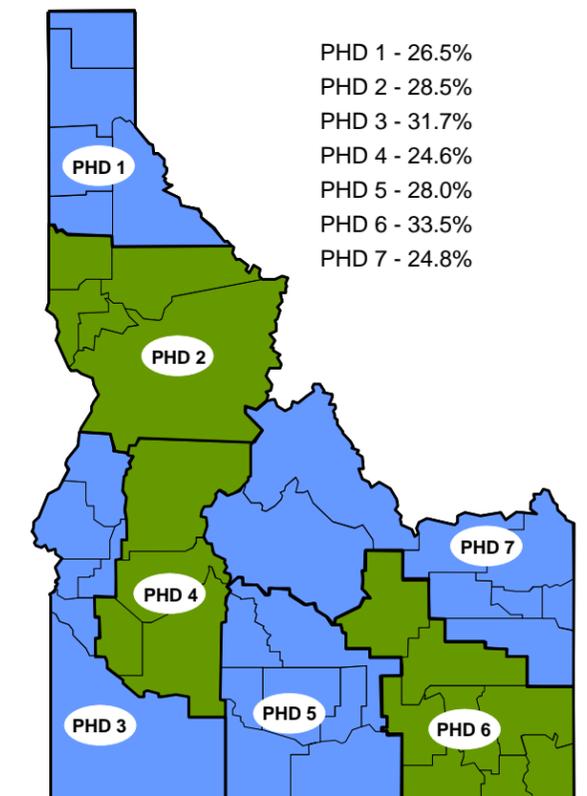


Figure 27. Synthetic Estimate of Number of Obese 3rd Grade Students in Idaho, by County



Note: Obesity is defined as those students whose BMI-for-age-and-sex is equal to or greater than the 95th percentile.
 Methodology: All county estimates are calculated by multiplying the public health district (PHD) obesity rate by the number of 3rd grade public school students in each county.
 Data Sources: Student estimates based on 2011-2012 school enrollment numbers, Idaho State Department of Education. Obese estimates from 2011-2012 Idaho 3rd Grade BMI Surveillance Project, Bureau of Community and Environmental Health, Idaho Department of Health and Welfare.