Legislative Task Force on

Obesity

Alabama Department of Public Health

JANUARY, 2006

Table of Contents

Letter from the Legislative Task Force on Obesity Chair

Overweight and obesity are among the most important health problems we face as a society. Obesity is related to many other health conditions and is a leading cause of preventable deaths due to lifestyle choices, second only to tobacco use. Medical costs associated with obesity are sky rocketing. Medical costs associated with overweight and obesity involve direct and indirect costs. According to a study of national costs attributed to both overweight and obesity, medical expenses accounted for 9.1 percent of total U.S. medical expenditures in 1998 and may have reached as high as $78.5 billion ($92.6 billion in 2002 dollars).

The health department acknowledges the importance of every person, no matter what size. Our concern is with the ill effects of improper weight on the body. While it is true that being too thin is just as unhealthy as being obese, the state is currently facing an epidemic associated with too much weight. Eight out of ten obese persons have additional health problems; we must address obesity as a disease state and find various approaches to reach the solution.

The Alabama Legislature passed House Joint Resolution HJR40, Act No. 2005-257 establishing the Legislative Task Force on Obesity. As chair of this task force, I led the process in producing this report for Governor Riley and the Legislature. As charged by the resolution, this report notes gaps in existing service related to reducing obesity in Alabama. This report is an important tool when considering the approaches taken in our state to reduce obesity and improve overall health. This report also helps illustrate that with the support of private/public partners we have an opportunity to improve our state's health.

Obesity is very complex. Even though most studies continue to indicate that the majority of cases of obesity are associated with improper diet and lack of physical activity, it will take a sustained effort over time from business, government, schools, communities, places of faith, and individuals to make lasting improvements in the health of our citizens.

Donald E. Williamson, MD, State Health Officer

Chair, Legislative Task Force on Obesity

Executive Summary

During its regular 2005 session, the Alabama Legislature passed House Joint Resolution HJR40, Act No. 2005-257 establishing the Legislative Task Force on Obesity. The Task Force was charged to study the various approaches available to address the impact of obesity on Alabama's citizens, including, but not limited to, educational awareness, lifestyle or behavioral choices, community based environmental strategies, and medical or pharmacological interventions. A report identifying the gaps in services was mandated. The resolution specified organizations to be represented. Members, serving without compensation, met monthly and reviewed the State Obesity Task Force State Plan, the Alabama State Department of Education's health plan, as well as other agency and private approaches in addressing obesity. The review also used information obtained from literature reviews, analyses of available surveys and other reports, existing compilations of research and data related to the issues under study, and input from a broad range of stakeholders. Areas noted as lacking intervention are explained in detail in this report. The Legislative Task Force on Obesity made recommendations in three areas: medical interventions, state legislature or local government policy involvement, and population based incentives. The task force dissolved upon completion of this report.

Full Report January 1, 2006

INTRODUCTION

In the United States, obesity has risen at an epidemic rate during the past 20 years. Approximately 119 million Americans weigh too much. Of the 64.5 percent of adult Americans who are either overweight or obese, 28.9 percent are obese and 35.7 percent are overweight. Estimates of the number of obese American adults rose from 23.7 percent in 2003 to 24.5 percent in 2004. According to the Alabama Behavior Risk Factor Surveillance System (BRFSS), from 1991 to 2001 obesity rates increased 76 percent. [1]

In 2003, 15 states had obesity prevalence rates of 15 to 19 percent; 31 states had rates of 20–24 percent; and four states had rates more than 25 percent. Alabama was one of these four states. In November 2004, Alabama had the highest percentage of overweight/obesity in the nation. In 2005, Alabama dropped to second place, not because of weight loss, but because Mississippians gained more pounds.

Approximately 28 percent of adults in Alabama are obese, with rates similar for men (27.1 percent) and women (29.6 percent). In addition, approximately 35 percent of the adults are overweight -- considerably more males (42.9 percent) than females (27.3 percent). Racial and socioeconomic differences in prevalence rates are also evident. In the overweight category, the Hispanic population is at 50.3 percent, the Caucasian population at 34.7 percent, and the African American population at 32.4 percent. Obesity is prevalent in 37 percent of African American versus 26.5 percent of Caucasian, and only 14 percent of Hispanics. The prevalence of obesity among persons at the lowest income levels (less than $15,000 annually) is approximately 32 percent, compared to a prevalence of almost 25 percent among persons with annual incomes at or exceeding $50,000. Obesity occurs in approximately 28 percent of adults with less than a high school education, as compared to 22 percent among college graduates. A geographic study of obesity in Alabama was completed utilizing BRFSS obesity data from 1995 to 2000 combined with US Census 2000 data. The geographic distribution of obesity illustrates the highest burden is located in the Black Belt region of Alabama; however, even counties outside this region exceed the national average. No county in Alabama can boast of low obesity rates. [1]

The causes of obesity are complex. The most widely accepted reason is consuming too many calories as compared to the physical expenditures made. Genetics or family history is a valid point for some, but the rapid increase of obesity for the general population indicates lifestyle issues instead of changes in human genetics.

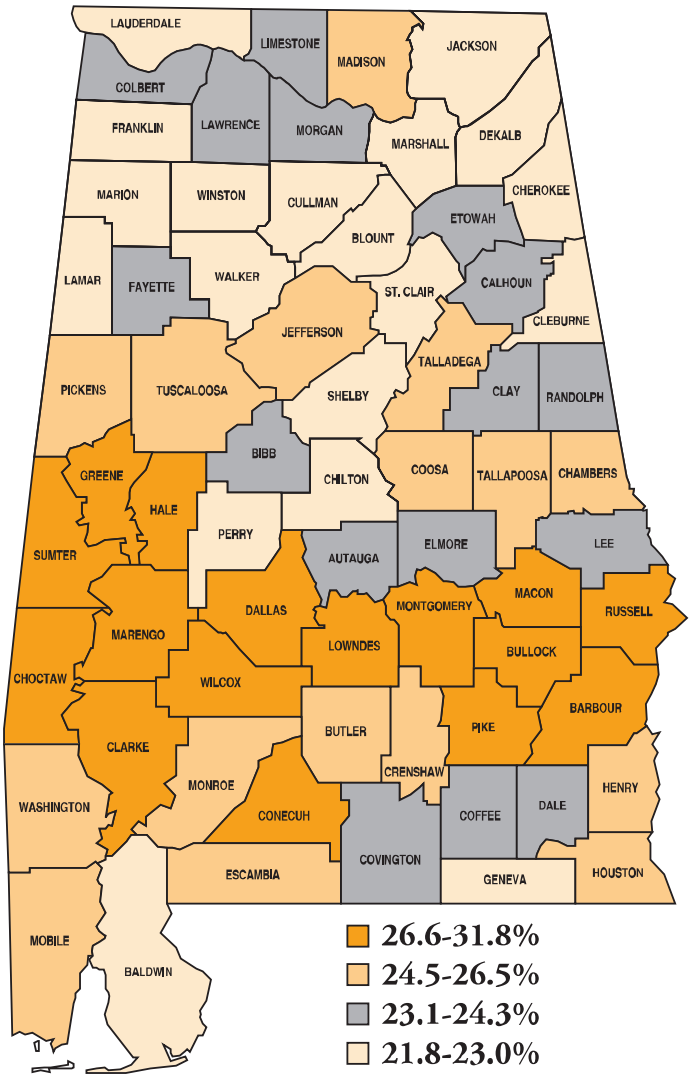
It is well established that consuming five or more servings of fruits and vegetables a day and three servings of low fat milk are beneficial in weight control. However, in Alabama 77.4 percent of adults do not eat five servings of fruit and vegetables a day. There is little doubt that regular physical activity is good for overall health. Physical activity decreases the risk for diseases such as colon cancer, diabetes, and high blood pressure and is beneficial for bone health, enhancing mental clarity, and as a stress reducer. It is very important in weight control. Despite all the benefits of being physically active, most Alabamians are sedentary. Alabama ranks as the tenth worst state in terms of prevalence of leisure time physical activity. Twenty-seven percent of Alabama adults reported participating in no leisure time physical activity. In addition, 60 percent of the population did not meet the national guidelines for moderate physical activity, and 79 percent did not meet the guidelines for strenuous activity. [1]

The life expectancy rate for an Alabama citizen is 74.1 years as compared to 77.2 years for the average adult in the United States. In 2001, the life expectancy for an Alabama adult was comparable to the American adult in 1981. This places Alabama 20 years behind the average state in terms of average life expectancy in the United States. Unless changes are made in lifestyles and behaviors, today's youth may be the first generation in history not to outlive their parents. Rates of chronic diseases in which obesity is a risk factor are high in Alabama, including the top two causes of death in Alabama, cardiovascular disease (CVD) and cancer. Alabama ranks above the national average in deaths due to heart disease, ranks third in

terms of adult hypertension, and has one of the highest rates of diagnosed diabetes (8.4 percent). Diabetes is the sixth leading cause of death in Alabama with 3,964 or 3 percent of all deaths from 1998 to 2000.[1] Population-based statistics are not yet available regarding the prevalence of type 2 diabetes in schoolchildren. Verbal reports, however, indicate that diabetes in children is growing. Because of elevated risks in Alabama school students, Alabama experiences an even greater potential for type 2 diabetes in school-age children.

Obesity costs are of importance as well. Costs are incurred at different levels; namely the individual's physical and mental health care costs, business' costs related to employees, and population based costs directed by hospitals, businesses, and insurances – including Medicaid and Medicare. Based on research by MetLife, the CDC, and the American College of Cardiology, three conditions related to obesity - diabetes, arthritis, and heart disease - cost employers more than $220 billion annually in medical care and lost productivity. [2] A study published in the "American Journal of Health Behavior" showed that annual medical expenses for a large city's employees increased from $114 for normal-weight individuals to $573 for the overweight - to $620 for the obese.[2, 3] Obesity is associated with 39 million lost workdays; 239 million restricted-activity days; 90 million bed days; 63 million physician visits. Obese individuals have higher health care utilization rates: 36 percent higher inpatient and outpatient spending; 77 percent higher medication spending; 45 percent more inpatient days; 48 percent more expenditures over $5000 11 percent higher annual health care costs.[3] The report, "F as in Fat: How Obesity Policies are Failing in America," stated that Alabama spent the equivalent of $293 per person on its 4 million plus residents last year paying for health care costs related to obesity - the ninth highest amount in the nation.[4] Because of increases in health care costs and health insurance for state employees and public education employees, the Legislature held a special session in November 2004 to address ways to contain the rise in health insurance costs.

Estimated Number of People at Risk for Obesity among Adults Aged 18 and Over Bases on Distribution by Age, Race, and Sex and Assigned Risk from the BRFSS, Alabama 2000



Current Alabama Interventions:

Despite limited resources, the Alabama Department of Public Health (ADPH) and the University of Alabama in Birmingham (UAB) pledged to work together to address healthy opportunities for all Alabamians. The first State Obesity Task Force meeting was held in May 2004. Over 70 representatives attended from public health, academia, health care, education, businesses, and community groups. The charge of the task force was to develop and implement a comprehensive state plan to reduce obesity in Alabama among all segments of the population. The purpose was not to change the approaches already in progress, but rather to help Alabama work together as a whole. The task force members agreed to utilize evidenced based practices in developing the plan. Members agreed to address weight concerns through emphasizing a healthy relationship with food, a healthy body weight, and a physically active lifestyle. Pharmacological and medical interventions were not addressed, as the plan focused on interventions suitable for any person, regardless of their weight status. In May 2005, the Alabama Obesity Task Force's Strategic Plan for the Prevention and Control of Overweight and Obesity in Alabama was released.

Also in May 2004, a joint resolution from the Alabama Legislature urged Alabama schools to provide age-appropriate and culturally sensitive instruction to help students develop the knowledge, attitudes, skills, and behaviors to adopt, maintain, and enjoy healthy lifestyle habits relating to eating habits and being physically active. The State Department of Education convened a statewide committee to review and make recommendations that address the state of health of Alabama's youth. This committee developed specific recommendations for implementation in all public schools addressing the nutrition and physical activity opportunities during the school day. The State Board of Education adopted the recommendations and implementation began in the 2005-2006 school year.

Together One CHOICE AT A TIME
ALABAMA

The State Plan Media plan emphasizes individuals making good choices.

Legislative Task Force on Obesity Appointed:

The two state plans, the State Obesity Plan and the Department of Education's committee report, were coordinated to prevent duplication of efforts. However, in comparing plans, it was noted that all approaches to address obesity were not covered. Therefore, during its regular session the Alabama Legislature passed House Joint Resolution HJR40, Act No. 2005-257 establishing the Legislative Task Force on Obesity to study the various solutions available to address the impact of obesity on Alabama's citizens, including, but not limited to, educational awareness, lifestyle or behavioral choices, community based environmental strategies, and medical or pharmacological interventions. The resolution listed the organizations to participate. Members served without compensation. The task force dissolved upon completion of the report. (Member listing is Attachment 1.)

Donald E Williamson, MD, State Health Officer, convened the first Legislative Task Force on Obesity meeting on September 26, 2005. At this meeting, members began the process of studying various solutions available to address the impact of obesity. Dr. Williamson provided an overview of obesity in Alabama. The two statewide plans, various non-related interventions occurring at the county and local levels, research initiatives from state universities, interventions through other state agencies, such as the Department of Agriculture and Industries, and "for profit" weight loss programs were presented. In addition, the Women's Health Advisory Council provided an example from volunteer health related councils. The task force members understood these examples were non- inclusive and that obesity was being addressed by others, such as the Cooperative Extension Service, private physicians, wellness groups, and others. All used comparable interventions.

The packet of materials provided included the State Obesity Plan; the State Board of Education's adopted recommendations and additional explanatory materials used to implement the recommendations; materials from the American Heart Association; handouts from the Women's Health Advisory Council and from the Department of Agriculture and Industries; excerpts from the Trust for America's Health Report; and highlights from states receiving funding from CDC to address obesity. These materials provided information on state activities as well as actions outside Alabama. Dr. Williamson's PowerPoint presentation to the task force was also provided.

In preparation for the second meeting, members e-mailed comments to Dr. Williamson on the charge given, which was:

- To verify existing interventions were targeted to all races, ages, both genders, different economic levels, and different educational levels
- To identify gaps or areas not addressed
- To list interventions not utilized in Alabama

At the second meeting, October 19, 2005, the committee received information on a surgical intervention used in addressing obesity. Following the discussion, Dr. Williamson began the process of reviewing the comments emailed while providing opportunity for additional comments to be made. A summary of the gaps was e-mailed to members for review and comment. The summary was used at the third meeting, November 16, 2005, to enable members to discuss thoroughly the aspects of each recommendation.

Recommendations:

The members of the Legislative Task Force on Obesity identified three areas where gaps existed or enhancements were needed in the current efforts to address the obesity epidemic in Alabama. The areas are listed below.

- Medical interventions
- State legislature or local government policy involvement
- Population incentives

MEDICAL INTERVENTIONS

The etiology of obesity includes multiple factors that need to be addressed in order to sustain significant and sustained weight loss. One is recognition of obesity as a disease state, instead of only a lack of individual will power. Physicians play a key role in assessing, evaluating, and treating the patient. Despite the prevalence and health complications of obesity, some physicians may be reluctant to address this condition with their obese patients.[5, 6] Less than half of obese adults report being advised to lose weight by health care professionals.[5] There are various reasons for the lack of counseling. Some physicians feel that giving advice to patients about weight loss will go unheeded, while others are concerned with the amount of time that appropriate counseling requires. Without adequate reimbursement, physicians and other health care workers may be hesitant to take on long-term patient obesity management.[7,8] Examples of possible reimbursement include plans from Blue Cross/Blue Shield of North Carolina offering some of the most extensive coverage for obesity treatment in the nation. The insurer assumes that the cost of helping people slim down will be lower than that of treating obesity-related diseases. Some physicians point to a lack of tools and training to implement these interventions. Still others avoid talking about weight because they fear offending their patients. However, persons who reported receiving advice to lose weight from their physicians were significantly more likely to report trying to lose weight than those who did not.[5]

Weight counseling, somewhat different from other disease states, has better outcomes utilizing a team approach. Patient care skills from nurses, registered dietitians, psychologists, and exercise therapists are important for making long-term changes.[7] All providers need effective communication skills to talk to a person about overweight/ obesity.

Committee members voiced several concerns. The first concern was that medical doctors might not be adequately educated in clinical nutrition during college or residency, resulting in a weaker background in nutrition for weight loss. A second area of concern was in counseling skills. It was agreed that all medical providers, regardless of discipline, needed to have appropriate counseling skills. These skills include motivational interviewing and techniques for behavioral changes to help people understand how to change instead of only what to change. Committee members also voiced the concern that even trained providers may feel they do not have the time to provide a service, such as weight loss counseling if there is no reimbursement. However, the committee did not feel a mandate requiring such coverage was appropriate. Therefore, recommendations for managing overweight and obese persons are:

- Providers should receive appropriate training and adequately assess patients for obesity.
- Obesity should be recognized as a disease state.
- If obesity is a covered benefit, the provider should receive appropriate reimbursement.

Bariatric surgery involves reducing the size of the gastric reservoir, with or without a degree of associated malabsorption.[9] As a result, the amount of food consumed is lessened, and weight loss occurs. It must be emphasized that these procedures are in no way to be considered as cosmetic surgery. While obesity, of itself, is a risk factor,[10] most associated mortality and morbidity is associated with co-morbid conditions. Weight loss surgery is an option for carefully selected patients with clinically severe obesity; i.e. a BMI> 40, or a BMI > 35 with co- morbid conditions when less invasive methods have failed and the patient is at high

risk for obesity associated morbidity or mortality.[11, 12] Bariatric surgery was recognized by the National Institutes of Health Consensus Conference, 1992, as a treatment option.[11]

Data supports the fact that patients are more likely to have successful surgical outcomes if the surgery is performed in a facility that is adequately equipped and staffed by a surgeon who is properly trained and has performed a number of surgeries.[13, 14] The benefits of the surgery must be balanced against the risk of perioperative death and short-term adverse outcomes. The risk and complications are not well known by the public.[14,15] The complication rates are reported primarily from academic centers with specialized programs.[14, 16] Patients aged 65 and older seem to have a substantially higher risk of death in the early postoperative period than younger patients do; however, there is no consensus regarding the efficacy and safety of this surgery in older adults.[15] Similarly, performing surgery for older children and teenagers continues to be an unresolved debate.

Committee members expressed the desire for successful surgeries, with low to zero complication rates, to be available in Alabama with strict safety codes in place. Barriers, including costs, were identified. Whereas total insurance coverage would be one solution, the realities of small businesses not being able to cover the premium costs, an increasing turnover rate of employees resulting in businesses not receiving the direct benefit from employee weight loss, and the need for additional cost benefit studies with risk factors considered were acknowledged. The rate at which bariatric procedures are being performed is rapidly increasing. The committee unanimously agreed to the following recommendations for bariatric surgical procedures for the State of Alabama:

- Develop or adapt specific guidelines, such as the National Institutes of Heath, statewide in order to qualify persons for weight loss surgery.
- Require all weight loss surgery be performed within a comprehensive surgical weight loss program that provides a medical team approach (e.g., The American Society of Bariatric Surgery's standards for recognition as a Bariatric Surgery Center of Excellence or their equivalent).
- Recommend that businesses consider potential benefits to be gained from providing coverage to their employees.
- Inform business leaders of the benefits, risks, and cost from validated research studies.

Most medical reviews of the benefit for pharmacotherapy on weight loss are from studies that include advice or behavioral therapy promoting reduced energy intake and increased physical activity. Such data reports weight loss from these drugs after one year is modest. However, since 1995, the use of the prescription drugs for weight loss has increased greatly. The increased interest in drug treatment of obesity derives from the poor long-term results often obtained with behavior therapy, including diet and physical activity. The pharmacotherapy recommendation from NIH states: "Weight loss drugs approved by the FDA for long-term use may be useful as an adjunct to diet and physical activity of patients with a BMI> 30 and without concomitant obesity related risk factors or diseases. Drug therapy may also be useful for patient with a BMI > 27 who also have concomitant obesity related risk factors or diseases."[11] Continual assessment of drug therapy for efficacy and safety is necessary.[12] Although diet, behavior modification, and physical activity will always be appropriate, forecasting indicates new, effective medication with minimal side effects for treatment will be in the near future.[17]

Due to the rapidly evolving information regarding the use of pharmacotherapy for weight loss the committee's recommendation for pharmacotherapy is:

- Payers should have the option of providing coverage with more drug options for weight loss treatment.

STATE LEGISLATURE OR LOCAL GOVERNMENT POLICY INVOLVEMENT

Physical activity and energy expenditure is much more than planned exercise; it also includes physical activity aspects of the total day. The opportunity to be physically active is primarily dependent upon the organization of the community. Obesity is linked with areas of residence, resources, television, community 'walkability', land uses, sprawl, and level of deprivation.[18] An assessment will assist in determining the community's ability to help or hinder physical activity and healthful eating and will review the built environment.[19] The built environment includes urban design factors, what the land is used for, available public transportation for a region, and the available activity options. Measures of the built environment and travel patterns are important predictors of obesity across gender and ethnicity.[20] The American Institute of Architects encourages community planning that supports continuous pedestrian linkages among the residential, institutional, commercial, and recreational places that support our daily lives.[21] In addition, experts in law, urban planning, and public health are increasingly calling for changes to zoning that will facilitate pedestrian-friendly development.[22] Policy makers can reform zoning regulations and land uses policies. The results provide a walking- friendly environment and supports walking/ biking as an attractive alternative to driving for a more physically active and healthy citizenry.[22]

The committee agreed that the environment influences a person's choice to be physically active. Committee members voiced that barriers in communities included the lack or poor repair of sidewalks, the lack of safe walking and biking paths, and poor lighting could be a deterrent to walking in some communities. Therefore, the committee recommends:

- An evaluation of ways to encourage increased physical activity in communities and housing developments should be made widely available to policy makers, community planners, builders, and others, as the Legislature deems appropriate.

When an issue is considered a priority, attention and resources are received to address the concern. The committee also felt that obesity issues should be a priority. The committee agreed that public and private partnerships are needed to provide the leadership necessary to reduce and prevent obesity by making the issue a priority and communicating its importance. This effort will require increased and sustainable funding. The committee recommends:

- The Legislature should consider allocating funds to implement the plans from the State Obesity Task Force and the Department of Education's Student Health Task Force without increasing taxes.

POPULATION INCENTIVES

According to a study of national costs attributed to both overweight (BMI 25–29.9) and obesity (BMI greater than 30), medical expenses accounted for 9.1 percent of total U.S. medical expenditures in 1998 and may have reached as high as $78.5 billion ($92.6 billion in 2002 dollars.[23,24,25] That figure does not include the additional $56 billion in associated indirect costs, bringing the total to about $149 billion.[23] The difference in spending on people who are overweight and those of normal weight were, for the most part, not statistically significant by themselves. However, major differences appeared for those who were obese. The average increase in spending over a person of normal weight was $732 per year -- 37.4 percent more.[24]

Because the financial burden now rivals that attributable to smoking and is increasing, incentives from government and health insurance companies are recommended to help people lose weight.[24] The incentive programs, for persons who reach and/ or maintain appropriate body anthropometrics, would not penalize the overweight or obese person but reward the employee for achieving and maintaining healthy life. Although some insurers subsidize memberships to health clubs to promote physical activity, most do not include incentives to encourage weight loss. There are aspects about health insurance that could increase personal responsibility and harness the free-market power to encourage good decisions on diet and activity. In short, health insurers could compete with each other to contrive a system that best balances the consumer health and self-interest.[23, 24] Incentives at the business place can be attractive to the employee. A wide variety of corporations and health benefit plans have developed comprehensive prevention and treatment plans including discounted health-club and weight-loss program memberships and insurance coverage for medical nutrition therapy, and physician-supervised medical weight management.

Therefore, the committee's recommendation is:

- Businesses and employers should be encouraged to consider incentives, through insurance plans or other means, offered to employees who engage in a wellness program to achieve a healthy body.

Additional comments:

The committee discussed two additional areas. The first area was in strengthening recommendations made through the Alabama Obesity Task Force's Strategic Plan and the State Department of Education's Statewide Committee to Review the State of Health of America's Youth with Particular Emphasis on Alabama's Youth. The second area of discussion was taxation.

Recommendations to strengthen the section of the Alabama Obesity Task Force's Strategic Plan targeting specific groups in the population were noted. In particular, plans directed toward those persons with disabilities need expansion and clarifications to include specific methods to address barriers to mobility, teacher certifications, and referral.

The committee recognizes the benefits of routine physical activity and of annual physical education courses during the school day. Upon reviewing the recommendations of the State Department of Education's Statewide Committee to Review the State of Health of America's Youth with Particular Emphasis on Alabama's Youth, the absence of physical education requirements in the tenth through twelfth (10 – 12) grades was noted. The committee felt this was an area for possible reconsideration in the future.

While discussing other states' actions taken to address obesity, taxation was noted. The committee agreed that although it is the individual who must change his or her behavior, many factors in the environment will influence those decisions. It was agreed that behavioral change occurs through both positive and negative reinforcements. In some states, documentation appears to support that taxes, even at lower levels, generate revenue used to address obesity; however, changing behavior practices in relation to purchasing empty calorie foods are not well documented. Therefore, after much consideration, the committee voted against recommending legislative efforts to pass a sales tax on empty calorie foods and beverages as well as on activities encouraging the lack of physical activity.

Conclusion:

The Legislative Task Force on Obesity made recommendations in three areas: medical interventions, state legislature or local government policy involvement, and for population based incentives. A summary of those recommendations are as follows:

Medical Interventions

- Recommendations managing overweight and obese persons are:
  - providers should receive appropriate training and adequately assess patients for obesity
  - obesity should be recognized as a disease state
  - if obesity is a covered benefit, the provider should receive appropriate reimbursement
- Recommendations for bariatric surgical procedures for the State of Alabama are:
  - to develop or adapt specific guidelines, such as the National Institutes of Heath, statewide in order to qualify persons for weight loss surgery
  - require all weight loss surgery be performed within a comprehensive surgical weight loss program that provides a medical team approach (e.g., The American Society of Bariatric Surgery's standards for recognition as a Bariatric Surgery Center of Excellence or their equivalent)
  - for businesses to consider potential benefits to be gained from providing coverage to their employees
  - to inform business leaders of the benefits, risks, and cost from validated research studies
- The recommendation for pharmacotherapy used for weight loss is that payers should have the option of providing coverage with more drug options for weight loss treatment.

State legislature or local government policy involvement

- An evaluation of ways to encourage increased physical activity in communities and housing developments should be made widely available to policy makers, community planners, builders, and others, as the Legislature deems appropriate.
- The Legislature should consider allocating funds to implement the plans from the State Obesity Task Force and the Department of Education's Student Health Task Force without increasing taxes.

Population incentives

- Businesses and employers should be encouraged to consider incentives, through insurance plans or other means, offered to employees who engage in a wellness program to achieve a healthy body.

Together One LIFE AT A TIME
ALABAMA

References:

1. Alabama Department of Public Health. Alabama Obesity Task Force: Strategic Pan for the Prevention and Control of Overweight and Obesity in Alabama. 2005.

2. Neely, J., Obesity Rampant in the Workplace. The Weekly Bulletin, Online Edition. December 6, 2005. Vol. 24, No.9. (www.sbebullentine.com/safety1272005.html)

3. Braun Consulting News. News on Personnel, Labor Relations and Benefits. Summer 2004.Vol.7, No. 5. http://www.braunconsulting.com/bcg/newsletters/summer2004/summer20043.html#sub3

4. Trust for America's Health. Issue Report. F as in Fat: How Obesity Policies are Failing in America 2005. 1707 H. Street, NW, 7th Floor. Washington, DC 20006.

5. Galuska, D.A., Will, J., Serdula, M., Ford, E. "Are Health Care Professionals Advising Obese Patients to Lose Weight?" JAMA. Oct 1999. Vol. 282. pp1576 – 1578.

6. Bowerman S, Bellman M, Saltsman P,et.al. "Implementation of a Primary Care Physician Network Obesity Management Program." Obesity Research .2001. Vol. 9:S321-S325. http://www.obesityresearch.org/cgi/content/full/9/suppl_4/S321

7. Stern, J., et.al. "Future and Implications of Reimbursement for Obesity Treatment." Supplement to The American Dietetic Association. May 2005. pp S104- S108.

8. Kuchler, F. "Obesity Policy and the Law of Unintended Consequences. Amber Waves." June 2005. http://www.ers.usda.gov/AmberWaves/June05/Features/ObesityPolicy.htm

9. Quilici, P. Tovar, A. "Laparoscopic Bariatric Surgery Services" American Society for Bariatric Surgery, Bariatric Surgery Guidelines. April 1998. http://www.transmed.tv/bariatricsurg/asbs.htm

10. USDA Economic Research Service. Taxing Snack Foods: What to Expect for Diet and Tax Revenues. October 2004. http://www.ers.usda.gov/calendar/index.asp?view=whatsnew

11. The National Institutes of Health, The National Heart, Lung, and Blood Institute, and The North American Association for the Study of Obesity. The Practical Guide: Identification, Evaluation, and Treatment of Overweight and Obesity in Adults. NIH Publication Number 00-4084.October 2000. (http://www.nhlbi.nih.gov/guidelines/obesity/e_txtbk/txgd/40.htm; http://www.nhlbi.nih.gov/guidelines/obesity/e_txtbk/methtri/3225.htm)

12. The National Institutes of Health, and National Heart, Lung, and Blood Institute Expert Panel on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults. Journal of the American Dietetic Association. October 1998. Vol. 98, No.10. pp1178- 1191.

13. NAASO, The Obesity Society Comments on Coverage Review of Bariatric Surgery Re: NCA Tracking Sheet for Bariatric Surgery for the Treatment of Morbid Obesity (CAG-00250R). http://www.naaso.org/about/20050708.asp

14. Livingston, E. "Procedure incidence and in-hospital complication rates of bariatric surgery in the United States. American Journal of Surgery. August 2004. Vol. 188, No. 2. pp 105-110.

15. Flum, D., Salem, L, et al. " Early Mortality among Medicare Beneficiaries Undergoing Bariatric Surgical Procedures" Journal American Medical Association. 2205. Vol. 294, No. 15, pp1903-1908.

16. Cournoulas, A., Flum, D. "Filling the Gaps in Bariatric Surgical Research" Journal American Medical Association. 2205. Vol. 294, No. 15, pp1957-1960.

17. Greenway, F. "Another Type of Intervention: Treating Obesity with Medication." The American Dietetic Association. June 2005:Vol.105, No. 6. pp 895-896.

18. Booth, K, Pinkston, MA, et al., "Obesity and the Built Environment" May 2005. Supplement to the Journal of the American Dietetic Association. S110-S116.

19. Gregory, S. Guidelines for Comprehensive Programs to Promote Healthy Eating and Physical Activity. (2002). ISBN: 0-7360-4464-7.

20. Frank, L.D., et al. "Obesity Relationship with Community Design, Physical Activity, and Time Spent in Cars." American Journal Preventive Medicine. 2004. Vol. 27, No. 2. pp 87-95.

21. Loftness, V. "Designing a Sustainable Built Environment: Liveable Communities" October 13, 2005. The Newsletter of the National Associates Committee The American Institute of Architects. http://www.aia.org/nwsltr_nacq.cfm?pagename=nacq_a_071404_knowledgeCMU_old

22. Schilling, J., Linton, L.S. "The Public Health Roots of Zoning: In Search of Active Living's Legal Genealogy." American Journal Preventive Medicine. 2005. Vol. 28(2S2). pp 96-103.

23. The Associated Press. Obesity Reported To Cost U.S. 93 Billion Dollars A Year. WASHINGTON (AP). May 14, 2003. Copyright 2003

24. Obesity in Young Children: Impact and Intervention. NIHCM Foundation Issue Brief. August 2004. www.nihcm.org/OYCbrief.pdf

25. Centers for Disease Control and Prevention. "Overweight and Obesity: Economic Consequences. www.cdc.gov/nccdphp/dnpa/obesity/economic_consequences.htm

ADDITIONAL SOURCES:

Fierro, M. Issue Brief. "The Obesity Epidemic- How States Can Trim the Fat". 2002. Health Policy Studies Division. NGA Center for Best Practices. http://americanheart.org/presenter.jhtml?identifier=3020513

Weight Control Information Network. December 2004. NIH Publication No. 04-4006 http://win.niddk.nih.gov/publications/gastric.htm

Hanes, C. "Weight Loss: Prescription Weight Loss Medicine" October 2004. http://www.webmd.com/content/article/46/2731_1668.htm

Finkelstein, EA, Fiebelkorn, IC, Wang, G. National medical spending attributable to overweight and obesity: How much, and who's paying?

Health Affairs 2003.W3. pp.219–226.

Finkelstein, EA, Fiebelkorn, IC, Wang, G. State-level estimates of annual medical expenditures attributable to obesity.

Obesity Research 2004. Vol.12. No.1. pp18–24.

Task Force Members

ATTACHMENT #1

Alexander, Donna
Alabama Wholesale Beer Association
Montgomery, AL 36104

Britton, Andy
Alabama Soft Drink Association
Montgomery, AL 36105

Canary, William
(Lawlor, Elizabeth K. - alternate)
Business Council of Alabama
Montgomery, AL 35104

Crawford, Senobia, P.T., Ph.D.
Alabama Physical Therapy Association
Montgomery, AL 36117

Facundus, Edward, C.M.D.
Medical Association of the State of Alabama
Huntsville, AL 35801

Floyd, Ronnie
Alabama Governor's Commission on Physical Fitness
Montgomery, AL 36130

Galliher, Blaine, Honorable
House of Representatives
Montgomery, AL 36130

Galvin, Melissa, PhD, M.P.H.
UAB School of Public Health
Birmingham, AL 35294-0022

Hardy, Jessica, R.N.
(Wilson, Helen - alternate)
Alabama State Nurses Association
Wetumpka, AL 36092

Harvest, Georgette
Alabama Medicaid Agency
Montgomery, AL 36103

Hester, Donna, Ph.D.
(Sims, Sandra- alternate)
Alabama State Association for Health, Physical Ed, Recreation, & Dance (ASAHPERD)
Arley, AL 35541

Holloway, Martha, R.N.
(Webster, Debra- alternate)
Alabama State Department of Education
Montgomery, AL 36104

Howell, Sally, J.D.
Alabama Association of Schools Boards
Montgomery, AL 36123

Jones, Donald
(Blackmon, Rosemary- alternate)
Alabama Hospital Association
Montgomery, AL 36117

Lollar, Dianne, M.P.H., R.D., L.D.
Alabama Dietetic Association
Jasper, AL 35502

Ryce, Patrick, M.D.
Blue Cross & Blue Shield of Alabama
Birmingham, AL 35244

Thacker, Nancy
Alabama Restaurant Association
Montgomery, AL 36117

Thomas, Charlie, R.Ph., F.A.Ph.A.
Alabama Pharmacy Association
Montgomery, AL 36130

Vandiver, Debbie
Alabama Cattleman's Association
Montgomery, AL 36102

Wingate, Alison
Alabama Retail Association
Montgomery, AL 36117

Williamson, Donald, M.D.
(Gaines, Miriam- staff assistant)
Alabama Department of Public Health
Montgomery, AL 36104

State of
Alabama
Department of
Public Health

The RSA Tower
201 Monroe Street
Montgomery, Alabama
36104

www.adph.org