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Prescriptions for Excellence in HEALTH CARE

A COLLABORATION BETWEEN JEFFERSON SCHOOL OF POPULATION HEALTH AND LILLY USA, LLC

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Editorial

Partnering to Achieve National Health Goals

By David B. Nash, MD, MBA
Editor-in-Chief

This issue of *Prescriptions for Excellence in Health Care* marks the beginning of a third volume of newsletters focused on health-related issues of importance to our country. As in previous years, this volume is based on the proceedings of an invitation-only roundtable discussion among national experts who are passionate about the issues.

Convened by the National Quality Forum, the National Priorities Partnership (NPP) represents a diverse group of high-profile stakeholders who are committed to affecting measurable, positive change in US health care in a relatively short time frame. Its signature initiative - a core list of National Priorities and Goals - is expected to yield positive outcomes in terms of improved care, equity, safety, and efficiency over the coming 3 to 5 years. The articles in this issue of the newsletter, and the 3 newsletters that follow, will focus on a broad range of initiatives that target 1 or more of these NPP priorities and goals.

The first article, "National Priorities Partnership: Setting a National Agenda for Health Care Quality and Safety," provides background on the origin of the NPP and an overview of the National Priorities and Goals. A unique program for achieving excellence in hospital nursing is discussed in the second article, "Magnet Recognition Program: Building Capacity for Innovations in Nursing." The author also features specific initiatives undertaken by nurses in her health system hospitals.

The third article, "Reducing Waste and Overuse: A National Priorities Partnership Recommendation," explores this important recommendation and related goals in greater depth. A new approach to one of America's leading population health issues – obesity – is discussed in the final article, "The University of Baltimore Obesity Report Card: Deconstructing the Obesity Infrastructure."

As I watch Congress buckling under the enormous challenges of health care reform, the NPP's efforts give me some optimism for the future of health care in the United States. I hope that,

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like me, you will be energized by the enthusiasm with which stakeholders from across the country are responding to the National Priorities and Goals.

As always, I am interested in your feedback; you can reach me by email at: david.nash@jefferson.edu or visit my blog at: nashhealthpolicy@blogspot.com.

David B. Nash, MD, MBA *is Founding Dean and the Raymond C. and Doris N. Grandon Professor, Jefferson School of Population Health.*

A Message from Lilly

Tailored Therapeutics

By Marc L. Berger, MD

The National Priorities Partnership (NPP), convened by the National Quality Forum to address the challenges of our health care system, released its list of National Priorities and Goals. The first 2 goals are particularly relevant to the mission of Eli Lilly and Company. The first goal is to engage patients and families in managing their health and making decisions about their care, and the second is to improve the health of the population. These goals are aligned with Lilly's mission to provide "answers that matter" to patients, and to make medicines that help people live longer, healthier, and more active lives. Recently, these twin goals were crystallized in a new vision statement for the corporation:

We will make a significant contribution to humanity by improving global health in the 21st century. Starting with the work of our scientists, we will place improved outcomes for individual patients at the center of what we do. We will listen carefully to understand patient needs and work with health care partners to provide meaningful benefits for the people who depend on us.

To make this vision a reality, Lilly has committed to a strategy of developing tailored therapeutics. By tailored therapy, we mean any application of information at the individual patient level that leads to substantial improvement in the ratio of benefits to risk for that patient, thereby improving the predictability of therapeutic response.

Tailored therapies focus not only on identifying the right patients with greater specificity, but also on excluding from treatment the "wrong patients" (eg, those who have a low expectation of benefit or are at higher risk for harm). These dual aims are addressed by applying all available information that helps to individualize optimal timing, dose, and duration of therapy. This may include insights whereby functional genetic differences among individuals are measured and used to determine - even predict - what a specific drug will do to an individual's body or how the drug will be metabolized by the body.

John Lechleiter, President and Chief Executive Officer of Eli Lilly and Company, put it succinctly when he said that "the power of tailored therapeutics is for us to say more clearly to payers, providers, and patients, 'this drug is not for everyone, but it is for you'..." To this end, we are developing biopharmaceutical products that target difficult to treat conditions and pursuing qualitative research and analyses to help identify specific populations and individual patients for whom these products will be most beneficial.

We at Lilly applaud the efforts of the NPP and are committed to doing all we can to engage patients and families in making decisions about their care and to improve the health of the population.

Marc L. Berger, MD, is Vice President of Global Health Outcomes at Eli Lilly & Company.

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National Priorities Partnership: Setting a National Agenda for Health Care Quality and Safety

By Karen Adams, PhD

In recent years, many individuals and organizations have made great strides toward improving the quality, efficiency, and safety of care delivered to patients—but most have not come to grips with the level of structural and systemic change required to produce the dramatic improvements in health and health care that are critical to achieve sustainable reform. Most Americans do not benefit from the growing evidence base because, too often, "best practices" are not disseminated. The health care system's skyrocketing costs, questioned value, and persistent disparities still exist. Breakthrough change requires focused commitment from all stakeholders.

To meet these challenges, the National Quality Forum convened the National Priorities Partnership (NPP) in November 2008. NPP is a collaborative effort of 32 organizations representing those who give, receive, pay for, and evaluate health care. The Partners influence every part of the health care system and are working toward transformational change to ensure that all patients have access to a high-performing, high-value health care system.

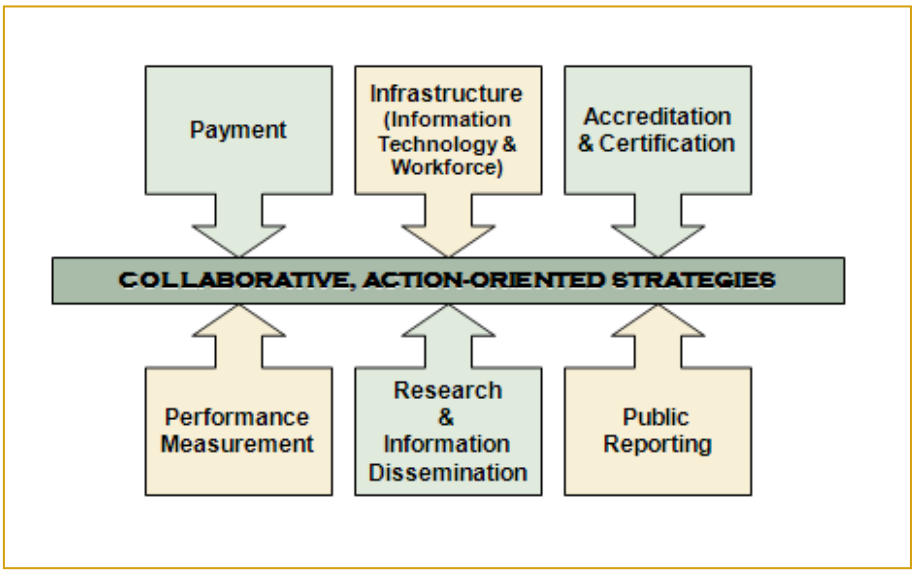
As a first step, the Partners set National Priorities and Goals for improvement. The Partners agreed that efforts targeting the quality, safety, and efficiency of care should move forward in a more coordinated fashion with the focus on the collective whole rather than the individual parts. As a result, the National Priorities and Goals all contribute to eliminating harm, eradicating disparities, removing waste, and improving the delivery of care. The Priority areas address care coordination, overuse, palliative and end-of-life care, patient and family engagement, population health, and safety.

Now, the Partners are working to align the drivers of change around the National Priorities and Goals. There are a handful of extremely effective mechanisms that can truly spur change in the health care system: performance measurement, public reporting, payment systems, research and knowledge dissemination, professional development, and system capacity. The Partners are working with policy makers, health care leaders, and the community at large to build on the NPP framework (Figure 1) and ensure that the necessary improvements are made.

Care Coordination. By 2020, an estimated 157 million Americans will be grappling with at least 1 chronic condition.[1] They will require personalized attention and seamless transitions from one care setting to another; many will suffer due to a lack of communication with or between providers. The Partners envision health care organizations that solicit and carefully consider feedback from all patients, and that communicate clear medication and other health information to patients, family members, and the next health care professional to provide care. Additionally, Partner organizations across multiple settings of care will work collaboratively with patients to reduce 30-day readmission rates and preventable emergency department visits.

Overuse. Reducing waste and ensuring that all patients receive appropriate care, especially preventive services, can result in dramatic improvements in health care efficiency and effectiveness. The Partners envision health care organizations that will strive to improve the delivery of appropriate patient care, and substantially and measurably reduce extraneous services such as inappropriate medication use; unnecessary laboratory tests and consultations; unwarranted diagnostic procedures, maternity care interventions, and inappropriate non-palliative services at end of life; potentially harmful preventive services with no benefit; and preventable emergency department visits and hospitalizations.

Figure 1. NPP Framework: Drivers and Strategies



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Palliative and End-of-Life Care. More than 1 million people die each year without access to hospice and palliative care services and without care that takes into account their physical, social, and spiritual needs.[2] These patients also may endure prolonged and needless suffering and costly or ineffective treatments. Evidence suggests that patients who are enrolled in palliative care programs are more satisfied with their care and have better outcomes in addition to the cost savings.[3] The Partners envision a health care system in which all patients with life-limiting illnesses will have access to effective treatment for relief of suffering; help with psychological, social, and spiritual needs; and will receive effective communication from health care professionals about their diagnoses, options for treatment, and high-quality palliative care and hospice services.

Patient and Family Engagement. Often, patients are not asked how they want to be treated or for feedback about their experiences. They may not feel adequately informed or involved in decisions about their care. They frequently do not understand the important information health care professionals discuss with them, and they often lack the knowledge or support to maintain and improve their health. Engaging patients as active partners in their care can lead to better health outcomes, lower service utilization, and lower costs.[4]

Population Health. Inconsistent preventive services and poor lifestyle behavior choices have led to a shocking decline in our national health, threatening both individual lives and America's economic prosperity. In fact, nearly half of all adults in the United States do not receive appropriate screening and preventive care.[5] The Partners are working to ensure that all Americans receive the most effective preventive services recommended by the US Preventive Services Task Force and adopt the most important healthy lifestyle behaviors known to promote health. The goal is for healthier communities according to a national index of health.

Safety. Every year more people die as a result of avoidable medical errors than from car accidents, breast cancer, or AIDS. While quality and safety vary from organization to organization, few patients have access to performance information and data with which to choose the most appropriate health care organization. Too often, consumers are constrained by geography, health plan provider networks, and cost. The Partners will endeavor to ensure that all health care organizations and their staff will strive for a culture of safety while working to lower the incidence of health care-induced harm, including all health care-associated infections and serious adverse events.

Putting It All Together

There are emerging synergies between President Obama's plan for health reform and NPP's Priorities and Goals, which should provide momentum to achieve reform. For example, the President's plan includes investing in public health measures to reduce obesity, sedentary lifestyles, and smoking, as well as guaranteeing access to preventive services.

Current reform proposals also call for continued efforts to improve patient safety and end-of-life care, and to reduce waste and inefficiencies in health care. The American Recovery and Reinvestment Act of 2009 includes funding for health information technology, which has the potential to greatly improve efforts in care coordination. Significant funding for comparative effectiveness research, if aligned with the Priorities and Goals, could further the evidence base needed to help providers improve patient care.

In April 2009, the Senate Finance Committee proposed policy options to improve patient care and reduce health care costs, including a reduction of payments to hospitals with high readmission rates for select conditions. Recently, the NPP Priority areas were used to create the framework for "meaningful use" of an electronic health record as outlined by the Department of Health and Human Services' Health Information Technology Policy Committee.

The Partners share a sense of urgency and believe that repairing the broken health care system should, and will soon be, a top national priority. They believe that solving this complex and costly crisis will require nonpartisan leadership from public and private sectors, and a commitment to work cooperatively to translate this agenda into action and achieve these goals that will vastly improve the health care delivery system.

To learn more about the National Priorities Partnership and download the November 2008 report *National Priorities & Goals: Aligning Our Efforts to Transform America's Healthcare*, please visit http://www.nationalprioritiespartnership.org.

Karen Adams, PhD Vice President of National Priorities at the National Quality Forum and oversees the National Priorities Partners. She can be reached at: kadams@qualityforum.org.

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Magnet Recognition Program: Building Capacity for Innovations in Nursing

By Nancy Valentine, RN, MPH, PhD

The Magnet Recognition Program was developed by the American Nurses Credentialing Center (ANCC) to recognize health care organizations that demonstrate nursing excellence and to provide a vehicle for disseminating successful nursing practices and strategies.[1,2] With a focus on quality patient care, nursing excellence, and innovations in professional nursing practice, this program offers consumers the ultimate benchmark for the quality of care that they can expect to receive. Of the hospitals listed on *U.S. News & World Report*'s exclusive 2007 Honor Roll rankings for "America's Best Hospitals" (July 23, 2007), 7 of the top 10 were Nurse Magnet hospitals.

The Magnet Recognition Program is based on quality indicators and standards of nursing practice as defined in the newly revised 3rd edition of the *ANA Nursing Administration: Scope & Standards of Practice* (2009). The Magnet designation process includes the appraisal of qualitative factors in nursing, referred to as "Forces of Magnetism." These Forces are evidenced by a professional environment guided by a strong, visionary nursing leader who advocates for and supports professional development and excellence in nursing practice. In fact, the nursing profession benefits from the program in terms of elevated nursing standards and reputation.

Approximately 5.8% of all health care organizations in the United States have achieved ANCC Magnet Recognition status. Clearly there is opportunity for all hospitals to aspire to this level of practice.

The Magnet Vision and Goals

Magnet organizations value knowledge and expertise, settling for nothing less than excellence in the delivery of nursing care. Magnet organizations are committed to leading health care reform and constantly strive for discovery and innovation. There is no room for a business as usual approach. Primary research, replication of best practices, and the creation of a network of Magnet hospitals wherein nurses across organizations can share their practice excellence are examples of how the Magnet momentum is gaining hold within the larger nursing community.

The Magnet designation is recognized as important by the Centers for Medicare and Medicaid Services, The Joint Commission, and *US News & World Report*. The Magnet designation enables hospitals to market excellence to the communities they serve, affording a competitive edge within local and regional markets. Moreover, the broad Magnet network provides opportunities for partnerships among organizations that seek solutions to our most challenging issues.

The Magnet Program is a cutting-edge strategic plan an organization can use to meet its business goals and achieve recognition in the marketplace through the full engagement of nurses as leaders in determining the quality of care. The goals of the program are displayed in Figure 1.

Main Line Health Magnet Experience

Main Line Health (MLH), a system of community-based hospitals and services in Southeastern Pennsylvania, first received the Magnet designation as a system in 2005. Since that time, the Magnet model has evolved from an emphasis on processes for creating the infrastructure for excellence to a focus on outcomes that are essential to develop and sustain a culture of excellence and innovation. These qualitative and quantitative outcomes are related to the impact of structure and process on the patient, the nursing workforce, the organization, and the consumer. Dynamic and measurable, these outcomes may be reported

Figure 1. Magnet Goals

1. **Transformational leadership,** which drives the cultural change via strategic planning, influence, advocacy, and visibility
2. **Structural empowerment,** which provides the forums for collaboration and program development via engagement, professional development, commitment to community involvement, and recognition of nursing
3. **Exemplary professional practice** that addresses infrastructure elements that support integrated top clinical team performance – Professional Practice Model (PPM); care delivery system; staffing, scheduling, budgeting; interdisciplinary care; accountability, competence, autonomy; ethics; diversity; culture of safety; and quality
4. **New knowledge, innovations, and improvements** that demonstrate utilization of evidence-based practice, support for knowledge inquiry, and that result in improved outcomes in attaining excellence in care delivery.

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at an individual unit, department, population, or organizational level.

Energized by the challenge of taking MLH to a new level of development, we have developed 2 *Magnet Exemplars*, cutting-edge programs that illustrate our commitment to innovation.

I. Magnet Model Component: Structural Empowerment

Question: How does an organization develop a model for nurses to engage in research?

With the goal of creating an infrastructure to support bedside nurses to engage in research, MLH developed partnerships with established researchers as part of the Lankenau Institute for Medical Research (LIMR) and instituted a program whereby nurses could acquire basic research skills. A pilot program was launched in the spring of 2009. Beginning with 10 nurses drawn from each of 3 system hospitals, the 2-week program provided basic instruction in clinical research and exposure to bench research.

The pilot achieved a nucleus, stimulus, and resource for the expansion of nursing research in MLH. Lectures by 4 LIMR researchers focused on basic science, clinical research design, biostatistics, and intensive study. The short-term goals were to enable these nurses to: implement a clinical research study; recruit patients, obtain written consent, and collect data for clinical studies; search relevant computer databases; identify clinical problems worthy of investigation; and develop and write publishable papers. Long-term goals include developing a nucleus of nurse research champions, improving the quality of patient care and outcomes, and supporting requirements for Magnet status.

Nurses and researchers reported great success and enthusiasm for the program, and recommended that it be continued on an annual basis. Mutual interest among team members yielded potential nurse-driven studies including measuring the effectiveness of a unit-based nurse champion model to build a unit-based culture of safety and quality accountability, evaluating education and family satisfaction with end-of-life care, and reducing ventilator-associated pneumonia through measurement of nurse compliance with a chlorhexidine oral care protocol.

II. Magnet Model Component: New Knowledge, Innovations, and Improvements

Question: How do we build champions of quality improvement and address key patient care needs?

In developing educational programs to support nurse-driven self-care models for improving patient compliance in chronic disease management, MLH was introduced to Communication Science SelfCareKits.[3] These kits are developed utilizing an evidence-based approach; for example, prior to designing materials for a heart failure (HF) self-care kit, evidence was gathered by anthropologists who observed HF patients at home. Evidence for design choices is made by sociolinguists and artists who craft the communication.

This ethnographic approach incorporates research from disparate fields - functional flow analysis (an engineering approach to step-by-step instructions), cognitive mapping, and linguistic pragmatics (focus on patient vocabulary and grammar) - to make the material memorable.

MLH nurses have chosen to use 2 SelfCareKits to generate their own evidence:

1. *Heart Failure SelfCareKit*: Past studies using kits for discharged HF inpatients have shown 38%-74% reductions in readmissions and up to a full day shorter length of stay (LOS). MLH nurses have designed their own study to measure emergency room visits, readmissions, and LOS on readmission.

2. *Post Prostatectomy SelfCareKit*: Past studies using the kits have shown increases in patient satisfaction of nearly 300% and decreases in length of time to discharge. MLH nurses have designed their own study to measure satisfaction.

Combining this product with nursing practice will enable nurses to use the tool kit from the time of admission (ie, to educate the patient on self-care principles and techniques) and throughout the hospital stay, before giving the kit to the patient and/or family for use in the home environment.

In conclusion, the Magnet Recognition Program has been the stimulus for a relentless pursuit of care improvements. With the focus on quality and innovation, MLH nurses have been challenged to improve care and simultaneously have found increasing joy in our work.

Nancy Valentine, RN, MPH, PhD is Senior Vice President and Chief Nursing Officer of Main Line Health. She can be reached at: ValentineN@MLHS.org.

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Reducing Waste and Overuse: A National Priorities Partnership Recommendation

By Louis H. Diamond, MB, ChB

The triple threat of covering the uninsured, closing the quality gap, and slowing the rate of the projected cost escalation continues to haunt the US health care delivery system. The National Priorities Partnership (NPP) has made a valuable contribution by galvanizing coordinated national action to attack 2 of these threats - quality improvement and cost reduction. The Partners have agreed on 6 National Priorities, one of which is to attack waste and overuse.

The importance of highlighting waste and overuse cannot be overemphasized. Prior and current efforts to reform health care delivery have focused on underuse and misuse, both of which have financial implications. The correction of misuse often has an immediate and easily measurable cost-saving impact. Underuse is more complicated, often requiring a long-term view and consideration of the more general impact on health and productivity management. Highlighting waste and overuse addresses costs directly, while bringing into play complex issues of uncertainty, professional judgment, and patient preference.

The NPP's approach focused directly on waste and overuse, relying heavily on a study conducted by the New England Healthcare Institute[1] and a survey of the leadership of national specialty societies. The latter focused on answering the question, "What services and procedures do you think are being overused?"[2] Nine categories of waste and overuse are included in the NPP recommendations (Table 1).

The NPP approach took a focused, clinical view of the problem. Other areas of waste and overuse were not dealt with explicitly. For instance,

Table 1. NPP Recommended Areas of Focus to Reduce Overuse While Ensuring Appropriate Patient Care

1. **Inappropriate Medication Use**
   - Antibiotics
   - Polypharmacy
     - Multiple chronic conditions
     - Antipsychotics

2. **Unnecessary Laboratory Tests:**
   - Panels (eg, thyroid, metabolic [SMA20])
   - Special tests, such as Lyme disease, with regional considerations

3. **Unwarranted maternity care interventions:**
   - Cesarean section

4. **Unwarranted diagnostics, testing:**
   - Cardiac computed tomography (CT) (non-invasive coronary angiography and coronary calcium scoring)
   - Lumbar spine magnetic resonance imaging prior to conservative therapy without red flags
   - Chest/thorax CT for screening, uncomplicated
   - Bone or joint X-ray prior to conservative therapy without red flags
   - Chest X-ray, preoperative, on admission, or routine monitoring
   - Endoscopy

5. **Inappropriate nonpalliative services at end of life:**
   - Chemotherapy in the last 14 days of life
   - Aggressive interventional procedures
   - More than 1 emergency department visit in the last 30 days of life

6. **Unwarranted procedures:**
   - Spine surgery
   - Percutaneous transluminal coronary angioplasty/stent
   - Knee/hip replacement
   - Coronary artery bypass graft
   - Hysterectomy
   - Prostatectomy

7. **Unnecessary consultations**

8. **Preventable emergency department (ED) visits and hospitalizations:**
   - Potentially preventable ED visits
   - Hospital admissions lasting <24 hours
   - Ambulatory care-sensitive conditions

9. **Potentially harmful preventive services with no benefit:**
   - BRCA mutation testing for breast and ovarian cancer for women at low risk for these cancers
   - Coronary heart disease screening using electrocardiography, exercise treadmill test, electron beam computer tomography for adults at low risk for heart disease
   - Carotid artery stenosis screening for the general adult population
   - Cervical cancer screening for women older than age 65, those at average risk, and those post hysterectomy
   - Prostate cancer screening for men older than age 75

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administrative issues, such as the transaction costs that result from the need for providers to deal with multiple public and private sectors payers, all of which utilize non-standardized procedures, is wasteful and an enormous cost driver. Similarly, the NPP did not deal directly with documented variation in care, expensive inputs, fraud and abuse, or defensive medicine.

There is evidence and a literature base supporting all areas included in the NPP categories. An example is the preventable readmission problem. Medicare costs in 2004 for readmissions were estimated to be $17.4 billion. Jencks et al reported a 20% readmission rate within 30 days and a 34% readmission rate within 90 days for Medicare beneficiaries.[3] Medical conditions accounted for 67% and surgical conditions for 51% of the index and initial admissions, whereas 70% of readmissions among surgical patients were driven by medical problems. Variation in readmission rates was documented as well (eg, 13% in Idaho, 23% in Washington). No bill was found for a physician service in half of the readmissions within 30 days of a medical discharge, highlighting a potential lack of coordination and providing clues to correct the problem of preventable rehospitalization.

As a plan of attack is developed, a number of issues must be faced – among them, the nature of the evidence available to support an overuse definition. There is a paucity of evidence generation focused on these issues, as well as a failure to convert evidence into clinical practice guidelines and actionable applications (eg, rules and alerts, order sets).

Both the science and the application of shared decision making are in their infancy. The latter is essential to facilitate informed decision making by the patient, the physician, and members of the health care professional team. With the exception of those in large group practices that have mature information systems, physicians lack knowledge of their own practice patterns. Further, the reimbursement system is not designed to improve quality and reasonably contain costs.

Going forward, an action plan must include the elements in Figure 1.

Figure 1. Action Plan Elements

1. Create a robust effort to evaluate and understand the nature and magnitude of overuse. This will require literature review and an analysis of actual data of current experience. Both efforts must be ongoing.
2. Commit to an information-driven approach. Information about costs and trends must be generated. Physicians must receive information regarding their practice patterns as compared with their colleagues. Performance measures must be created and deployed. Point-of-care decision-support tools must be made available to support shared decision making.
3. Inform, educate, and "activate" patients. These efforts should include a public education campaign about overuse generally, along with some specific examples.
4. Engage the top clinical and administrative leadership, the "C suite" level, to lead from the top and make the right tools available to patient and health care professionals.
5. Realign financial incentives in the payment systems for hospitals and physicians.
6. Take steps to redesign the delivery system by supporting organizational systems such as the medical home and accountable care entities.
7. Create a research agenda that covers the many issues that impact waste and overuse. Topics should include evidence generation and the standardization of clinical practice guidelines. New approaches to performance measures are needed, and tools should be developed to support shared decision making and patient activation at the point of care. Issues regarding the health information infrastructure and the payment systems required to support these activities would round out a partial research agenda.

Louis H. Diamond, MB, ChB, is Vice President and Medical Director at Thomson Reuters Healthcare and President, Performance Excellence Associates. He can be reached at: louis.diamond@thomsonreuters.com

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The University of Baltimore Obesity Report Card: Deconstructing the Obesity Infrastructure

By Alan Lyles, ScD, MPH

Obesity and excess weight are issues that adversely affect all demographic groups, but no clear solution exists. In the past 25 years, the percent of American adults who are obese more than doubled with two thirds now overweight (Table 1). Childhood obesity has undergone similar increases, placing overweight children at increased risk of morbidity and premature death.[1] Currently 12.4% of children aged 2 to 5 are obese, as are ~17% of those aged 6 through 19 (Table 2).

Once a person becomes overweight, sustained weight loss is rare. After 5 years, just 40% of participants in an intensive regimen sustained a 5% weight loss; and after 7 years, a mere 25% sustained a 10% weight loss.[2] It is evident that reversing obesity's trajectory will go well beyond health services, touching upon individual and societal, public and private sector, and obesogenic[3] factors. Unfortunately, there can be no unified national health policy or directives on obesity because health is regulated by individual states under the United States Constitution.[4] State actions are critical if the environment and incentives for obesity are to change.

The Surgeon General has issued decennial reports on the nation's health since 1979. In partnership with public and private stakeholders, these reports set national consensus goals and specific objectives within them. *HealthyPeople 2010* contains 28 focus areas with 467 objectives in total. These were not developed by federal agencies, nor do they represent an enforceable national health policy.

Overweight and obesity and *physical activity* are among the 10 most urgent health priorities designated as Leading Health Indicators (LHI).[5] Voluntary measuring and monitoring of LHI objectives provides a focus for state and private sector actions, and facilitates alignment of efforts and resources to goals that cannot be mandated. Unfortunately, publishing and tracking performance against national consensus goals has been ineffective at reducing obesity and excess weight, particularly in young people.

The *HealthyPeople 2010* target would have reduced adult obesity from a baseline of 23% (in 1988-1994) to 15%, but by 2006 the actual rate had risen to 33%. Similarly, the actual rate for overweight and obese children ages 6 to 11 was 17% in 2006 – well above the baseline of 11% and the 2010 target of 5%.[6] Clearly, national goals without specific accountabilities become no one's goals, and the trends are in the wrong direction.

Table 1. Age-adjusted Prevalence of Overweight and Obesity Among US Adults, Aged 20-74 Years.

Year	% Overweight (Body Mass Index ≥25)	% Obese (Body Mass Index ≥30)
1999 - 2002	64	31
1988 - 1994	56	23
1976 - 1980	47	15

Source: Centers for Disease Control and Prevention. Available at: http://www.cdc.gov/nchs/products/pubs/pubd/hestats/obese/obse99.htm

The University of Baltimore's (UB) Obesity Report Card assesses individual state legislative efforts based on 8 different types of passed *or* proposed legislation concerning obesity.[7] The composite score for a legislative session determines that state's letter grade, ranging from A (excellent) to F (failing). There are 2 report cards: one for *State Efforts to Control Obesity*, and one for *State Efforts to Control Childhood Obesity*. A color-coded map with each state's letter grade and the state's obesity prevalence ranking superimposed provides public disclosure and stimulates competitive pressures - via reports by CNN,[8] the *Washington Post*,[9] or state government[10] - for individual state legislators and governors.

In principle, childhood is a protected period with a more controlled nutritional environment and less habituated physical activity levels. It is disappointing that 26% of states received a D or F for legislative efforts to control childhood obesity in 2005, and just 1 state (California) received an A. For overall obesity efforts, the results left substantial opportunity for improvement: no state received an A and 32% received a D or an F.[7] In 2006 the results were marginally better; 6 states received an A for legislative efforts to mitigate childhood obesity and 3 states received an A for overall efforts on obesity.[11]

Early life experiences and environment influence health outcomes in subsequent decades, and this is

(*continued on page 10*)

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particularly true for weight.[12,13] Consequently, Lantz et al caution against policy approaches that rely predominantly or exclusively on increasing access to health services.[14] Strategies based on medicalization have failed to halt the explosive increase of obesity.

We now understand that excess weight cannot be attributed to a single factor or a moral failing. Social, genetic, biobehavioral, architectural, economic, and policy factors interact and, over time, produce an infrastructure of obesity. No single intervention will reliably modify population-averaged outcomes.

Obesity, Business and Public Policy[15] developed a model that describes this multifactor obesity infrastructure. A recent Robert Wood Johnson Foundation funded report, *F is for Fat: How Obese Policies are Failing America*, provides state-by-state information on population percentages in various weight categories, data on health indicators, school standards regarding obesity, child care center licensing regulations relevant to children's physical activity and nutritional environments, and relevant legislation for healthy communities.[16] This scoring is useful for detailed examinations whereas the UB Obesity Report Card provides the clarity and transparency necessary for distinctions that must be communicated in political and policy dialogues.

The next steps include report card updates and additional research on public-private initiatives.

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Table 2. Prevalence of Obesity[1] Among US Children and Adolescents (Aged 2-19 Years)

Year	Pre-School 2 - 5 years	School-age 6 - 11 years	Adolescents 12 - 19 years
1976-1980	5.0	6.5	5.0
1988-1994	7.2	11.3	10.5
1999-2002	10.3	15.8	16.1
2003-2006	12.4	17.0	17.6

1. Obese defined as sex- and age-specific body mass index ≥95th percentile based on the Centers for Disease Control and Prevention growth charts
Source: Centers for Disease Control and Prevention. Available at: http://www.cdc.gov/obesity/childhood/prevalence.html

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