



To: Members of the Health and Human Services Committee  
 Fr: Hilary Schneider, Director of Government Relations, American Cancer Society Cancer Action Network; Becky Smith, Director of Government Relations, American Heart Association/American Stroke Association; Lance Boucher, Director of Public Policy, American Lung Association of the Northeast  
 Date: November 6, 2015  
 Re: Fund for a Healthy Maine Review re: Maine’s public health care and preventive health priorities and goals

As your committee works to identify or review the state's current public health care and preventive health priorities and goals, our organizations would appreciate you taking the following information into consideration.

In 2013, 7,556 Mainers died from cancer, heart disease, lung disease (including COPD and asthma), or stroke.<sup>1</sup> As you can see in the table below, cancer, heart disease, lung disease, and stroke make up four of the top five leading causes of death in Maine.<sup>2</sup>

**Maine Leading Causes of Death, 2013<sup>3</sup>**

Cause of Death	Total Deaths	State Death Rate	State Rank	U.S. Death Rate
Cancer	3,227	<b>175.2</b>	12	163.2
Heart Disease	2,807	152.3	31	169.8
Chronic Respiratory Diseases	902	<b>49.1</b>	16	42.1
Accidents	644	<b>42.6</b>	29	39.4
Stroke	620	33.4	36	36.2
Alzheimer's Disease	401	21.6	29	23.5
Diabetes	373	20.4	28	21.2
Influenza/Pneumonia	258	14	38	15.9
Kidney Disease	252	<b>13.6</b>	25	13.2
Suicide	245	<b>17.4</b>	11	12.6

Note: State death rate is bold where it is higher than the U.S. death rate.

<sup>1</sup> US CDC, Stats of the State of Maine, [http://www.cdc.gov/nchs/pressroom/states/ME\\_2015.pdf](http://www.cdc.gov/nchs/pressroom/states/ME_2015.pdf), accessed on October 29, 2015.

<sup>2</sup> The top 5 causes of death of Mainers are cancer, heart disease, chronic lower respiratory diseases (i.e., lung disease), accidents and stroke (listed in order of prevalence).

<sup>3</sup> US CDC, Stats of the State of Maine, [http://www.cdc.gov/nchs/pressroom/states/ME\\_2015.pdf](http://www.cdc.gov/nchs/pressroom/states/ME_2015.pdf), accessed on October 29, 2015.

It is estimated that 8,810 Mainers will be diagnosed with cancer and that 3,300 will die from the disease this year. As of January 1, 2014, the American Cancer Society estimated that there were 79,400 cancer survivors living in Maine. In 2010, 7.5%, or nearly 72,000 of Maine's adults (not living in long term care facilities), reported that their doctor diagnosed them with coronary heart disease. Twenty-nine thousand had a history of stroke.

Much of the suffering and death from all of these diseases could be prevented by more systematic efforts to reduce tobacco use, improve diet and physical activity, reduce obesity, expand the use of established screening tests, and regulate cholesterol and blood pressure. Tobacco use is the leading preventable risk factor for all four of these diseases. The American Cancer Society estimates that in 2015, about 171,000 cancer deaths in the U.S. will be caused by tobacco smoking alone. Tobacco use increases the risk of at least 15 types of cancer, and 30 percent of all cancer deaths, including 80 percent of lung cancer deaths, can be attributed to using tobacco. In addition, Maine's smoking attributable mortality rate is higher than the national average, due in part to Maine's adult smoking rate being higher than the national average.

The World Cancer Research Fund estimates that approximately one-quarter to one-third of the 1.7 million cancer cases expected to occur in the United States in 2015 can be attributed to poor nutrition, physical inactivity, overweight and obesity.

Regular use of established cancer screening tests can prevent cancer through identification and removal or treatment of pre-malignant abnormalities. They can also improve survival and decrease mortality by detecting cancer at an early stage when the disease is more treatable. Also, 1 in 3 adults have high blood pressure. Blood pressure and cholesterol screenings are the first step to reducing the risk of cardiovascular disease and stroke.

It is important to recognize that while there is substantial evidence supporting the types of programs that have proven effective at reducing preventable disease risk factors, there is not one single "silver bullet" solution. Individual health behaviors are influenced and supported by a complex set of factors that not only relate to personal attitudes and beliefs, but also relate to the built environment, culture, race, education, income and many other factors. Social, economic, and legislative factors profoundly influence individual health behaviors. Examples of this include:

- The price and availability of healthy foods and tobacco products
- Incentives and opportunities for regular physical activity in schools and communities
- Content of advertising aimed at children
- Availability of insurance coverage for screening tests and tobacco addiction

Examples of evidence-based programs that decrease preventable risk factors for heart disease, lung disease and cancer include:

- Increases in tobacco excise taxes, restrictions on tobacco use in public places, reducing access barriers to tobacco cessation, and effective media campaigns that counter tobacco industry marketing.
- Establishment of strong nutrition standards for all foods and beverages sold and served in school, increases in the quality and quantity of physical education in K-12 schools, supplemented by additional school-based physical activity, increases in funding for research and interventions focused on improving nutrition, physical activity and reducing obesity, and reducing the marketing of unhealthy foods and beverages, particularly to youth.
- Efforts to improve access to and utilization of recommended screening tests (e.g., mammograms, pap tests, lung and colorectal cancer screening, blood pressure, and cholesterol).
- Effective sun safety community programs in schools and recreation/tourism, which include education about sun safety and providing physical environments (e.g., shaded areas) that support sun safety.
- Well-funded and planned Complete Streets, Safe Routes to School and healthy food financing initiatives.
- Increases in health coverage for all Mainers for prevention and early detection of cancer, heart disease, and lung disease.

Attached is a summary of the U.S. CDC's most-recently updated version of its evidence-based guide for state investment in tobacco control, *Best Practices for Comprehensive Tobacco Control Programs*. Also, attached is a fact sheet from ACS CAN on the link between healthy eating, active living and cancer as well as evidence-based policy strategies related to this topic and one from the American Heart Association with prevention strategies to reduce cardiovascular disease.

We applaud the Health and Human Service Committee's hard work and efforts to tackle the task of reviewing the Fund for a Healthy Maine allocations in light of the state's current public health priorities. However, we caution you from relying on information that is not evidence-based. Each of our organizations holds evidence-based public health at the core of our mission. As such, we believe it is important that you know that our three organizations, as well as the Maine Medical Association, the Maine Osteopathic Organization, and the Maine Public Health Association withdrew support from the State Health Improvement Plan (SHIP) due to actions that were taken during the drafting of this report that resulted in the removal of evidence-based strategies and the addition of strategies that are not evidence-based. While all of our organizations were invited and participated in the development of the plan, we regretfully were compelled to withdraw our support in February 2014 as outlined in the attached communication to Commissioner Mayhew.

Thank you for the opportunity to provide these comments as your Committee undertakes its work. We would be happy to answer any questions you may have about these comments or provide you with additional information.



*Defines the specific annual investment needed for state comprehensive tobacco control programs to implement what we know works to improve health.*

### Core Comprehensive Tobacco Control Program Components:

1. State and Community Interventions
2. Mass-Reach Health Communication Interventions
3. Cessation Interventions
4. Surveillance and Evaluation
5. Infrastructure, Administration, and Management

### What is a Comprehensive Tobacco Control Program?

A comprehensive tobacco control program is a statewide, coordinated effort to establish smoke-free policies and social norms, to promote quitting and help tobacco users quit, and to prevent tobacco use initiation. These programs reduce tobacco-related disease, disability, and death.

### Goals:

1. Prevent tobacco use initiation among youth and young adults
2. Promote quitting among adults and youth
3. Eliminate exposure to secondhand smoke
4. Identify and eliminate tobacco-related disparities

### Comprehensive tobacco control programs work and are a public health "best buy."

- Investments in comprehensive tobacco control programs have high return on investment.
- Sustained funding for these programs improves health and leads to even greater returns on investment.

### CDC's Best Practices–2014 Recommended Funding Levels by Program Component

Recommended National Investment	Total	State and Community Interventions	Mass-Reach Health Communication Interventions	Cessation Interventions	Surveillance & Evaluation	Infrastructure, Administration, & Management
Total Level (dollars in millions)	Minimum: \$2,325.3	Minimum: \$856.7	Minimum: \$370.1	Minimum: \$795.1	Minimum: \$202.6	Minimum: \$100.8
	Recommended: \$3,306.3	Recommended: \$1,071.0	Recommended: \$532.0	Recommended: \$1,271.9	Recommended: \$287.7	Recommended: \$143.7
Per Person (based on total state population)	Minimum: \$7.41	Minimum: \$2.73	Minimum: \$1.18	Minimum: \$2.53	Minimum: \$0.65	Minimum: \$0.32
	Recommended: \$10.53	Recommended: \$3.41	Recommended: \$1.69	Recommended: \$4.05	Recommended: \$0.92	Recommended: \$0.46

## FAST FACTS

Tobacco use is the single most preventable cause of death and disease.

1 in 4 adults uses tobacco.

There is no risk-free level of secondhand smoke exposure.

Tobacco use costs the United States \$289–\$332.5 billion in direct health care costs and productivity losses every year.



## Executive Summary

Tobacco use is the single most preventable cause of disease, disability, and death in the United States. Nearly one-half million Americans still die prematurely from tobacco use each year, and more than 16 million Americans suffer from a disease caused by smoking. Despite these risks, approximately 42.1 million U.S. adults currently smoke cigarettes. And the harmful effects of smoking do not end with the smoker. Secondhand smoke exposure causes serious disease

and death, and even brief exposure can be harmful to health. Each year, primarily because of exposure to secondhand smoke, an estimated 7,330 nonsmoking Americans die of lung cancer and more than 33,900 die of heart disease. Coupled with this enormous health toll is the significant economic burden. Economic costs attributable to smoking and exposure to secondhand smoke now approach \$300 billion annually.

Fifty years have passed since the 1964 Surgeon General's report on smoking and health concluded: "Cigarette smoking is a health hazard of sufficient importance in the United States to warrant appropriate remedial action." There now is a robust evidence base for effective tobacco control interventions. Yet, despite this progress, the United States is not currently on track to achieve the *Healthy People 2020* objective to reduce cigarette smoking among adults to 12% or less by the year 2020. A 2007 Institute of Medicine (IOM) report presented a blueprint for action to "reduce smoking so substantially that it is no longer a public health problem for our nation." The two-pronged strategy for achieving this goal includes: 1) strengthening and fully implementing currently proven tobacco control measures; and 2) changing the regulatory landscape to permit policy innovations. Foremost among the IOM recommendations is that each state should fund a comprehensive tobacco control program at the level that the Centers for Disease Control and Prevention (CDC) recommends.

Evidence-based, statewide tobacco control programs that are comprehensive, sustained, and accountable have been shown to reduce smoking rates, as well as tobacco-related diseases and deaths. A comprehensive statewide tobacco control program is a coordinated effort to establish smokefree policies and social norms, to promote and assist tobacco users to quit, and to prevent initiation of tobacco use. This comprehensive approach combines educational, clinical, regulatory, economic, and social strategies. Research has documented the effectiveness of laws and policies in a comprehensive tobacco control effort to

protect the public from secondhand smoke exposure, promote cessation, and prevent initiation, including: increasing the unit price of tobacco products; implementing comprehensive smokefree laws that prohibit smoking in all indoor areas of worksites, restaurants, and bars, and encouraging smokefree private settings such as multiunit housing; providing insurance coverage of evidence-based tobacco cessation treatments; and limiting minors' access to tobacco products. Additionally, research has shown greater effectiveness with multicomponent interventional efforts that integrate the implementation of programmatic and policy initiatives to influence social norms, systems, and networks.

CDC's *Best Practices for Comprehensive Tobacco Control Programs—2014* is an evidence-based guide to help states plan and establish comprehensive tobacco control programs. This edition updates *Best Practices for Comprehensive Tobacco Control Programs—2007*. The 2014 edition describes an integrated programmatic structure for implementing interventions proven to be effective and provides the recommended level of state investment to reach these goals and to reduce tobacco use in each state.

These individual components are most effective when they work together to produce the synergistic effects of a comprehensive statewide tobacco control program. On the basis of evidence of effectiveness documented in the scientific literature and the experiences of state and local programs, the most effective population-based approaches have been defined within the following overarching components.

## I. State and Community Interventions

State and community interventions include supporting and implementing programs and policies to influence societal organizations, systems, and networks that encourage and support individuals to make behavior choices consistent with tobacco-free norms. The social norm change model presumes that lasting change occurs through shifts in the social environment—initially or ultimately—at the grassroots level across local communities. State and community interventions unite a range of integrated activities, including local and

statewide policies and programs, as well as initiatives to eliminate tobacco-related disparities.

The most effective state and community interventions are those in which specific strategies for promoting tobacco use cessation, preventing tobacco use initiation, and eliminating exposure to secondhand smoke are combined with mass-reach health communication interventions and other initiatives to mobilize communities and to integrate these strategies into synergistic and multicomponent efforts.

## II. Mass-Reach Health Communication Interventions

An effective state-level, mass-reach health communication intervention delivers strategic, culturally appropriate, and high-impact messages through sustained and adequately funded campaigns that are integrated into a comprehensive state tobacco control program. Typically, effective health communication interventions and countermarketing strategies employ a wide range of paid and earned media, including: television, radio, out-of-home (e.g., billboards, transit), print, and digital advertising at the state and local levels; promotion through public relations/earned media efforts, including press releases/conferences, social media, and local events; health promotion activities, such as working with health care professionals and other

partners, promoting quitlines, and offering free nicotine replacement therapy; and efforts to reduce or replace tobacco industry sponsorship and promotions.

Innovations in health communication interventions include the ability to target and engage specific audiences through multiple communication channels, such as online video, mobile Web, and smartphone and tablet applications (apps). Social media platforms, such as Twitter and Facebook, have facilitated improvements in how messages are developed, fostered, and disseminated in order to better communicate with target audiences and allow for relevant, credible messages to be shared more broadly within the target audiences' social circles.

## III. Cessation Interventions

Comprehensive state tobacco control program cessation activities can focus on three broad goals: (1) promoting health systems change; (2) expanding insurance coverage of proven cessation treatments; and (3) supporting state quitline capacity.

Health systems change involves institutionalizing cessation interventions in health care systems and seamlessly integrating these interventions into routine clinical care. These actions increase the likelihood that health care providers will consistently screen patients for tobacco use and intervene with patients who use tobacco, thus increasing cessation. Expanding cessation insurance coverage removes cost and administrative

barriers that prevent smokers from accessing cessation counseling and medications, and increases the number of smokers who use evidence-based cessation treatments and who successfully quit. Expanding cessation insurance coverage also has the potential to reduce tobacco-related population disparities.

Quitlines potentially have broad reach, are effective with and can be tailored to diverse populations, and increase quit rates. Because state quitline services are free, remove time and transportation barriers, and are confidential, they are one of the most accessible cessation resources. Optimally, quitline counseling should be made available to all tobacco users willing to access the service.

#### IV. Surveillance and Evaluation

Surveillance is the process of continuously monitoring attitudes, behaviors, and health outcomes over time. Statewide surveillance is important for monitoring the achievement of overall program goals. Evaluation is used to assess the implementation and outcomes of a program, increase efficiency and impact over time, and demonstrate accountability.

Publicly financed programs need to have accountability and demonstrate effectiveness, as well as have access to timely data that can be used for program improvement and decision making.

Therefore, a critical infrastructural component of any comprehensive tobacco control program is a surveillance and evaluation system that can monitor and document key short-term, intermediate, and long-term outcomes within populations. Data from surveillance and evaluation systems can be used to inform program and policy directions, demonstrate program effectiveness, monitor progress on reducing health disparities, ensure accountability to those with fiscal oversight, and engage stakeholders.

#### V. Infrastructure, Administration, and Management

A comprehensive tobacco control program requires considerable funding to implement. Therefore, a fully functioning infrastructure must be in place in order to achieve the capacity to implement effective interventions. Sufficient capacity is essential for program sustainability, efficacy, and efficiency, and it enables programs to plan

their strategic efforts, provide strong leadership, and foster collaboration among the state and local tobacco control communities.

An adequate number of skilled staff is also necessary to provide or facilitate program oversight, technical assistance, and training.

The primary objectives of the recommended statewide comprehensive tobacco control program are to reduce tobacco use and the personal and societal burdens of tobacco-related disease and death. Research shows that the more states spend on comprehensive tobacco control programs, the greater the reductions in smoking. The longer states invest in such programs, the greater and quicker the impact.

Implementing comprehensive tobacco control programs at the levels of investment outlined in this report would have a substantial impact. As a result, millions of fewer people in the United States would smoke and hundreds of thousands of premature tobacco-related deaths would be prevented. Long-term investments would have even greater effects.

We know what works to effectively reduce tobacco use, and if we were to fully invest in and implement these proven strategies, we could significantly reduce the staggering toll that tobacco takes on our families and in our communities. We could accelerate the declines in cardiovascular mortality, reduce chronic obstructive pulmonary disease, and make lung cancer a rare disease. With sustained implementation of state tobacco control programs and policies, the *Healthy People 2020* objective of reducing adult smoking prevalence to 12% or less by 2020 could be attainable.





# Healthy Eating, Active Living, and Cancer

Making healthy lifestyles a national priority

## **The Cancer Link**

Obesity, physical inactivity, and poor nutrition are major risk factors for cancer, second only to tobacco use. Up to one third of the estimated 589,430 cancer deaths in the US this year can be attributed to poor diet, physical inactivity, and excess weight. Currently, approximately two in three adults and one in three youth are overweight or obese.

Excess weight is associated with increased risk for several common cancers, including colon, esophageal, kidney, pancreatic, endometrial, and postmenopausal breast cancer. The biological link between excess weight and cancer is believed to be related to multiple factors including fat and sugar metabolism, immune function, hormone levels and proteins that affect hormone levels, and other factors related to cell growth. Maintaining a healthy body weight throughout life is key to reducing cancer risk.



## **Nutrition**

Poor nutrition and the consumption of high-calorie foods and beverages are major contributors to excess weight and increase the risk of cancer. The American Cancer Society (ACS) recommends consuming a healthy diet, with an emphasis on plant foods, in order to reduce cancer risk. Recommendations include choosing foods and beverages in amounts that achieve and maintain a healthy weight, limiting consumption of processed and red meats, consuming fruits and vegetables and whole grains instead of refined grain products, and limiting alcohol intake. Recent research has found that non-smoking adults who followed the ACS guidelines for weight control, diet, physical activity, and alcohol lived longer and had a lower risk of dying from cancer and cardiovascular disease.

## **Physical Activity**

Regular physical activity helps maintain a healthy body weight by balancing caloric intake with energy expenditure. Physical activity may also reduce the risk of breast, colon, endometrial, and advanced prostate cancer, independent of body weight. ACS recommends that adults engage in at least 150 minutes of moderate-intensity or 75 minutes of vigorous-intensity activity each week and that children and adolescents engage in at least 1 hour of moderate- or vigorous-intensity activity each day. Physical activity may also be beneficial after a cancer diagnosis, reducing the risk of recurrence or death and improving quality of life.

## **Combating the Problem**

Despite the evidence linking excess weight, poor nutrition, and physical inactivity to increased cancer risk, the majority of Americans are not meeting recommended nutrition and physical activity targets. Social, economic, environmental, and cultural factors strongly influence individual choices about diet and physical activity. Reversing obesity trends and reducing the associated cancer risk will require a broad range of strategies that include policy and environmental changes that make it easier for individuals to regularly make healthy diet and physical activity choices.

The American Cancer Society Cancer Action Network (ACS CAN) is focused on creating healthy social and physical environments and providing consumers with clear, useful information that support making healthy lifestyle choices.

### **At the Federal Level**

ACS CAN's federal advocacy work is largely focused on protecting and implementing recent improvements in school nutrition and food labeling, increased access to evidence-based obesity screening and weight loss interventions, and funding for evidence-based prevention programs.

#### **Affordable Care Act**

The law contains several key prevention and wellness provisions including:

- **Calorie labeling of standard menu items in chain restaurants**, supermarket cafes, convenience stores, and other ready-to-eat food retailers and of items in certain vending machines.
- **Coverage of preventive health services, including obesity screening and counseling and behavioral interventions for weight loss, with no cost sharing** through private insurance plans in the health insurance exchanges and Medicare, and an incentive for states to cover them in Medicaid.
- **The Prevention and Public Health Fund**, providing \$1 billion per year through FY 2017 and increased amounts thereafter for prevention, wellness, and public health activities. A significant portion of this money has been spent on community-based initiatives focused on making community, school, and worksite environments healthier.

ACS CAN strongly supports the full implementation of and opposes efforts to dismantle these key provisions.



#### **Child Nutrition Reauthorization**

ACS CAN strongly supported the last bill to reauthorize the federal child nutrition programs, the Healthy, Hunger-Free Kids Act of 2010. This law includes a number of ACS CAN-supported provisions to improve school nutrition and wellness:

- **Updated evidence-based national nutrition standards for school meals**, coupled with increased federal reimbursement;
- **National evidence-based nutrition standards for foods sold in schools during the school day** outside of the school meal programs, including those in vending machines, school stores, and a la carte; and
- **Strengthened local school wellness policies** that require school districts to set goals for food marketing, physical activity, nutrition education and promotion, and foods sold outside of meal programs.

As Congress seeks to reauthorize these programs, ACS CAN will advocate to protect and support continued implementation of the recent improvements in school nutrition and wellness.

### **At the State & Local Levels**

There are also many ways that state and local governments can improve nutrition and increase physical activity through policy change.

- **Quality physical education** for students in grades K-12 provides them with structured physical activity and the information and skills to be physically active for life. Physical education should be required for all students, supplemented with additional school-based physical activity, such as recess, classroom physical activity, intramural sports, and walk-to-school programs, and include knowledge and fitness assessments, to ensure it is having the intended health benefits.
- **Federal school nutrition standards** provide a national baseline, but have some exemptions and will not apply to foods sold in schools after school hours. States and localities should fully implement the federal standards and close loopholes.
- **Food and beverage marketing** influences children's food and beverage beliefs, preferences, and consumption decisions. The marketing to youth of unhealthy foods and beverages should be curtailed, including being prohibited in schools and other youth-focused venues.
- **Funding for research and evidence-based interventions** to improve nutrition, increase activity, and achieve a healthy weight should be increased at all levels of government.

Contributions or gifts to the American Cancer Society Cancer Action Network are not tax deductible.

*2015 American Cancer Society Cancer Action Network*

# FACTS

## An Ounce of Prevention...

## The Value of Prevention for Cardiovascular Disease

### OVERVIEW

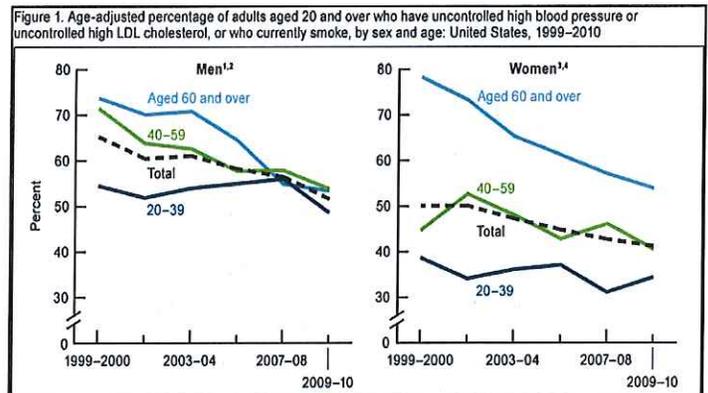
Cardiovascular disease (CVD) is the leading cause of mortality in the U.S.<sup>1</sup> The factors that increase risk of CVD can begin in childhood<sup>1</sup> and are influenced by unhealthy environments and behaviors and modifiable risk factors such as smoking, obesity, physical inactivity, high blood pressure, elevated blood cholesterol, and type 2 diabetes.<sup>1,2</sup> Research has shown that preventative measures are cost-effective and have a valuable impact on public health and the productivity of our nation's workforce.<sup>3</sup> The ultimate goal of CVD prevention is to increase the number of years that people can enjoy a high quality of life.

### MAKING THE CASE

- Research shows that reducing modifiable risk factors such as hypertension and smoking results in lower incidence of heart attack and stroke.<sup>1,4</sup>
- Counseling to improve diet or increase physical activity lowers the likelihood of obesity, hypertension, and high cholesterol.<sup>5,6</sup>
- Comprehensive coverage of tobacco cessation services in the Medicaid program can lead to reduced hospitalizations for heart attacks.<sup>7</sup> It also leads to \$3.12 in medical savings for each program dollar spent and a \$2.12 return on investment to Medicaid for every dollar spent.<sup>7,8</sup>
- Approximately 44% of the decline in U.S. age-adjusted CHD death rates from 1980-2000 can be attributed to improvements in risk factors including reductions in total blood cholesterol, systolic blood pressure, smoking prevalence, and physical inactivity.<sup>9</sup> However, these improvements have been partially offset by increases in body mass index and prevalence of diabetes.<sup>9</sup>
- Estimates of investments in community-based programs to increase physical activity, to improve nutrition, and to prevent smoking and other tobacco use can save \$16 billion on healthcare costs within five years.<sup>10</sup>
- Every \$1 spent on workplace wellness, decreases medical costs by about \$3.27 and increases productivity, with absenteeism costs decreasing by about \$2.37.<sup>11</sup>
- Comprehensive school-based initiatives to promote healthy eating and physical activity can reduce overweight and obesity rates over adolescents' lifespans, decrease medical care costs by \$586 million and have shown a cost effectiveness of about \$900-\$4305 per quality-of-life-year saved.<sup>12,13,14</sup>

### HOW ARE WE DOING?

In 2011-2012, about 92% of adults had at least one of seven risk factors for cardiovascular disease that could be reduced via preventive efforts.<sup>1</sup> Although the prevalence of some risk factors has been decreasing and we are placing a greater emphasis on prevention, we still have a long way to go to reach our goals.<sup>1</sup> In 2013, 43 states had adult obesity rates that equaled or exceeded 25%, with 20 exceeding 30%.<sup>15</sup>



SOURCE: Fryer CD, et al. NCHS Data Brief #103: Prevalence of Uncontrolled Risk Factors for Cardiovascular Disease: United States, 1999-2010. August 2012.

- The obesity epidemic is spreading to our children at an alarming rate. 31.8% of children and adolescents ages 2-19 are considered overweight or obese.<sup>1</sup>
- The number of obese preschoolers aged 2-5 jumped from 5% to 10% between the late 1970s and 2008.<sup>16</sup> Additionally, research has shown that obese children's arteries resemble those of a middle-aged adult.<sup>17</sup> However, we are making some progress. Recent studies have shown the progression of childhood obesity is slowing in some age groups and in a few major metropolitan areas.<sup>18</sup>
- After years of steady progress, declines in the use of tobacco by youth have slowed, however each day more than 3,200 young people under 18 years of age smoke their first cigarette.<sup>19</sup> In 2013, 23.3% of high school students reported current use of at least one tobacco product.<sup>20</sup> If the current rate of smoking persists, 5.6 million of today's youth will die prematurely from smoking-related illness. That would represent 1 in every 13 children who are alive today.<sup>19</sup> And children are increasingly using the new smokeless tobacco products entering the market as well as cigars.<sup>21</sup>
- About 1 of 3 U.S. adults (about 80 million people) have high blood pressure.<sup>1</sup> Only 54% of these people have their blood pressure under control.<sup>1</sup>

- A sedentary lifestyle contributes to CHD. However, moderate-intensity physical activity, such as brisk walking, is associated with a substantial reduction in chronic disease.<sup>22,23</sup> It is estimated that for every \$1 invested in walking trails and programs, \$3 could be saved in healthcare costs.<sup>3,24</sup> Still, 30% of U.S. adults report that they do not engage in any leisure-time aerobic physical activity.<sup>1</sup>
- At least 68% of people age 65 or older with type 2 diabetes die from some form of heart disease and 16% die of stroke.<sup>1</sup> Unfortunately, diabetes prevalence increased 90% from 1995-1997 to 2005-2007.<sup>25</sup> About 29.2 million have diagnosed or undiagnosed diabetes, and the prevalence of pre-diabetes in the adult population is 35%.<sup>1,26</sup> Diabetes disproportionately affects African Americans, Mexican Americans, Hispanic/Latino individuals, and other ethnic minorities.<sup>1</sup>
- Approximately 27% of U.S. adults have high low-density lipoprotein (LDL), or “bad” cholesterol.<sup>1</sup> Despite cholesterol screening levels reaching as high as 84% in some states, fewer than half of adults with high LDL cholesterol are receiving cholesterol lowering treatment, and only one-in-three with high LDL cholesterol have their condition under control.<sup>1,27</sup>

## THE ASSOCIATION ADVOCATES

In order to achieve its goals of improving the cardiovascular health of the U.S. population by 20% by the year 2020,<sup>28</sup> the association advocates for:

- The Prevention and Public Health Fund, maintaining the Fund at funding levels designated through the Affordable Care Act.
- Million Hearts, a national initiative to prevent one million heart attacks and stroke by 2017.
- Comprehensive clean indoor air laws.
- Excise taxes on all tobacco products.
- Funding for comprehensive smoking cessation/prevention programs at all levels and in all coverage plans; for programs that eliminate health disparities; for active transportation such as walking and biking trails, Safe Routes to School, and Complete Streets; coordinated school health programs; and state heart disease and stroke programs.
- Strong implementation of FDA regulation of tobacco.
- Comprehensive health care coverage for preventive services; prevention, diagnosis, and treatment of overweight and obesity;
- Efforts to design workplaces, communities, and schools around active living; integrating physical activity opportunities throughout the day.
- Sports, community recreational opportunities, parks, and green spaces.
- Quality physical education in schools at recommended amounts of activity.
- Accurate measures of obesity and related risk assessments in diverse populations.
- Comprehensive worksite wellness programs.
- Strong local wellness policies in all schools.
- Comprehensive obesity prevention strategies in early childhood and day care programs.
- Access to healthy foods by eliminating food deserts and improving access.

- Updated nutrition standards for all foods sold in school.
- Robust nutrition standards in all government nutrition assistance or feeding programs.
- Strong nutrition and physical activity standards for universal pre-k and child care programs.
- Improved food labeling and menu labeling in restaurants and where foods are sold for immediate consumption.
- The removal of industrial *trans* fats from the food supply and assure the use of healthy replacement oils.
- Less junk food marketing and advertising to children.
- Limiting added sugars and sodium in the food supply.

<sup>1</sup> Mozaffarian, D., et al. Heart disease and stroke statistics-2015 update: a report from the American Heart Association. *Circulation*. 2015. 131(4): e29-e322.

<sup>2</sup> Yang Q, et al. Trends in cardiovascular health metrics and associations with all-cause and CVD mortality among US adults. 2012. *JAMA*.307:1273-1283.

<sup>3</sup> Weintraub, WS., et al. Value of primordial and primary prevention for cardiovascular disease a policy statement from the American Heart Association. 2011. *Circulation* 124.8: 967-990.

<sup>4</sup> Spring, B et al. Better Population Health Through Behavior Change in Adults A Call to Action. 2013. *Circulation* 128.19: 2169-2176.

<sup>5</sup> Eckel, RH, et al. 2013 AHA/ACC Guideline on Lifestyle Management to Reduce Cardiovascular Risk: A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines. 2013. *Journal of the American College of Cardiology*.

<sup>6</sup> U.S. Preventive Services Task Force. Final Recommendation Statement: Healthful Diet and Physical Activity for Cardiovascular Disease Prevention in Adults with Cardiovascular Risk Factors: Behavioral Counseling. 2014. Available at:

<http://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/healthy-diet-and-physical-activity-counseling-adults-with-high-risk-of-cvd>. Accessed on March 17, 2015.

<sup>7</sup> Land T, et al. A Longitudinal Study of Medicaid Coverage for Tobacco Dependence Treatments in Massachusetts and Associated Decreases in Hospitalizations for Cardiovascular Disease. 2010. *PLoS Med*: 7(12): e1000375.

<sup>8</sup> Richard P, et al. The return on investment of a Medicaid cessation program in Massachusetts. 2012. *PLoS Med*;7(1):e29665.

<sup>9</sup> Ford E, et al., Explaining the decrease in U.S. deaths from coronary heart disease, 1980-2000. 2007. *New Engl J Med*. 356; 2388-2398.

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Commissioner Mary Mayhew  
Department of Health and Human Services  
221 State Street  
Augusta, Maine 04333-0040

Cc: Dr. Sheila Pinette, Nancy Birkheimer, Debra Wigand

February 24, 2014

Dear Commissioner Mayhew:

After careful review of the final draft of the State Health Improvement Plan (SHIP) that was disseminated to partners on February, 7, 2014, we, collectively, withdraw our support. While it dismays us to do so, each of our organizations holds evidence-based public health at the core of our mission and cannot endorse a plan for the state that does not do the same.

As members of several of the priority workgroups, our organizations volunteered significant time and resources to aid in the development and writing of evidence-based objectives and strategies. As the workgroup charge, contained in materials disseminated for the first tobacco workgroup meeting, stated, "The work group is a selection of subject matter experts for tobacco use reduction in Maine from the public and private sectors, and is expected to lend this expertise for this purpose."

Each workgroup was charged with not only creating these evidence-based objectives and strategies but also with presenting research and evidence that supported each recommendation. It was repeated multiple times that the SHIP is "a plan for the state, not by the state;" this is a document that the MeCDC produces and releases as part of the national accreditation process, it is a non-political plan that various and multiple partners within and outside of the MeCDC will implement. The process of researching, vetting and drafting objectives during workgroups were facilitated and created in that vein. The result was a good plan with reasonable, measurable objectives based in data, research and evidence.

In an email from Nancy Birkheimer dated August 28, 2013, our workgroups were informed that DHHS may not approve the SHIP as written stating that there were "three strategies that we are concerned they [DHHS leadership] may not be comfortable including. We have approval to leave them there for the DHHS leadership to review, but are aware that the sugar-sweetened beverages tax, increases to the tobacco tax and increases to funding for tobacco control may not 'survive' this next step in the approval process. If not, we will let you know." This email also stated that "We are continuing the work on the balance of Maine CDC leading the SHIP process and wanting a state-wide plan that is not only for the agency". This email did not state that other strategies, such as insurance coverage, were concerning.

At that point, our organizations communicated with Maine CDC leadership and the State Coordinating Council (SCC) to let them know that many of our organizations were not comfortable with the removal of these evidence-based strategies and our support would likely be withdrawn if they were removed. Not only does it undermine the facilitated process that people volunteered countless hours to partake in, but it also created a document that was no longer based on evidence-based public health principles but ideology and not science. In addition, removal of evidence-based

strategies put forward through the workgroup process undermined the collaborative stakeholder process in which we were asked to take part. Unfortunately, it was not until an email from Dr. Pinette on February 7, 2014, that the final version was made public. There was no mention of the three strategies that Ms. Birkheimer noted in her email and no one “let us know” the status of survival of those strategies. It was up to us to review the 83 page document and find that this version did in fact remove all three of the aforementioned strategies, as well as several others. It has come to our attention that none of the involved stakeholders (workgroup participants) or SCC members were notified of these changes. This lack of transparency not only de-values the participation of many stakeholders who participated in the creation of this document but also undermines future partnerships where the State is relied upon to finalize documents and plans.

Although there may be others, according to our collective records, the following strategies were deleted or added without consensus or discussion among workgroups/content experts or the SCC. There was also no explanation for the removal of evidence-based strategies and the evidence or subject matter expertise upon which removal was based.

Added: Obesity. 1.5 Strategy: Discourage the consumption of sugar-sweetened beverage by seeking a waiver from the federal government to disallow the use of SNAP benefits for purchase of sugar-sweetened beverages.

Removed: Obesity. 1.3 Strategy: 3. Enact an excise tax on sugar-sweetened beverages. Revenue should be directed to programs that prevent and/or treat obesity and related conditions.

Removed: Tobacco. 1.1. Promote tobacco treatment benefits for MaineCare recipients.

Removed: Tobacco. 1.1. Increase the price of cigarettes by 15% through an increase in tobacco excise taxes and ensure that all tobacco products are taxed at equal levels.

Removed: Tobacco 1.2. Increase access to comprehensive insurance coverage of evidence-based treatment for nicotine dependency.

Removed: Tobacco 1.3. Increase state tobacco funding to 75% of CDC Best Practice State Spending Recommendations.

The measurable objectives that were deleted from the earlier document were evidence-based, CDC-recommended strategies. One example is increasing the price of tobacco. Though this certainly isn't the only example, it is an important one since it is the number one recommended strategy by the CDC and because public health experts know that increasing the price will:

- Reduce the total amount of tobacco consumed
- Reduce the prevalence of tobacco use • Increase the number of tobacco users who quit
- Reduce initiation of tobacco use among young people
- Reduce tobacco-related morbidity and mortality

Another example is promoting tobacco treatment options for Medicaid members. According to CDC Best Practices report, “encouraging and helping tobacco users to quit is the quickest approach to reducing tobacco-related disease, death, and health care costs. The best way to reduce tobacco use is to educate members about their cessation benefits.” It is surprising that a strategy that has been proven to increase quitting, reduce costs, and reduce tobacco-related disease in the population most likely to use tobacco would be removed from the plan.

As is the case with all prevention, a comprehensive approach is most effective. Everything can't be solved with an increase in price nor can it be solved when we have a narrow focus such as on smoke-free environments. A State Health

Improvement Plan that aims to make Maine the healthiest state in the nation, needs to be comprehensive, evidenced-based in approach, and take into account our local data, strengths and opportunities.

We would also like to note that there was a recommendation to include a disclaimer that not all organizations, including state government, necessarily agree with every recommendation. It was our hope that the document would stand as written and the disclaimer, if necessary, be included for clarification.

It is with regret that we are now compelled to withdraw our support of the most recent version of SHIP. We request that a prominently placed disclaimer that makes clear that the draft created by workgroups was changed without permission from said workgroups and that, as a result, the following individuals/organizations remove their support for this current plan. We also request to review your final version of SHIP, including the above disclaimer, prior to it being sent to the national accreditation board. If the two above requests are not possible, then we require our names/organizations to be removed from throughout the document. Again, we would like to see and approve the final document before it is sent outside of the state.

Each of our organizations holds evidence-based public health at the core of our mission and cannot endorse a plan that does not do the same. We prefer not to do this as many of us spent significant time and resources in crafting the objectives that were approved and vetted by the committees, but it is critical to us that a public health document that is meant to represent our state as a whole, be reflective of our consensual values and most importantly, is evidence-based.

Sincerely,

American Cancer Society Cancer Action Network

American Heart Association

American Lung Association of the Northeast

Maine Osteopathic Association

Maine Medical Association

Maine Public Health Association

