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Improving Coordination of Legal-Based Efforts across Jurisdictions and Sectors for Obesity Prevention and Control

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Introduction

This paper is the companion to the “Assessment of Coordination of Legal-Based Efforts across Jurisdictions and Sectors for Obesity Prevention and Control” paper, and the third of four white papers outlining actionable options that policymakers can consider as discussed as part of the National Summit on Legal Preparedness for Obesity Prevention and Control. The goal of this paper is to identify potential action and policy strategies related to coordination across jurisdictions and sectors that can be adopted by policymakers and implemented by practitioners to address the obesity epidemic. The paper examines collaboration among four sectors – community agencies and organizations (with a special focus on enhancing the built environment), schools, health care institutions, and workplaces – and examines collaboration from both vertical and horizontal perspectives. Additionally, the paper is structured around three legal themes – which are posed as questions – to frame the policy action discussion:

- What is the extent of authority and who has it?
- How can coordination or collaboration be facilitated?
- How can implementation and enforcement of policy strategies be ensured?

The multi-factorial nature of obesity risk factors requires the involvement of a wide range of organizations that cut across disciplines for prevention and control efforts. The coordination required to meet these public health needs occurs under many guises and through various legal mechanisms. When the government, with its considerable economic power, addresses a pressing public health issue like obesity, it employs three primary approaches: (1) mandates action or regulates public and private sector behavior, e.g., seat belt laws; (2) induces voluntary action by providing funding or other incentives tied to desired outcomes, e.g., Coordinated School Health Program and the ACHIEVE program; or (3) leverages its informational and educational influence to shape responses of citizens and the private sector, e.g., Surgeon General Reports.

Government action can range from extensive regulatory schemes to more informal and cooperative engagement. Further, even when regulation by a federal agency is extensive, these same agencies often delegate authority to administer the federal rules and otherwise share power with state governments. Under a federalist system, a more nuanced kind of collaboration occurs often characterized by a tight regulatory regime. Similarly, although many day-to-day public health functions are established by state law, their administration and enforcement are carried out by county and city health departments.

When the private sector addresses public health issues such as obesity, it too uses its economic power to drive outcomes. For instance, companies require measurable returns on their investments when implementing wellness programs and will utilize incentives such as

reimbursement schemes to encourage employee participation in corporate weight loss or other health promotion programming.

What Is the Extent of Legal Authority and Who Has It?

Effective action to address the obesity epidemic must be undertaken by an entity that has the requisite authority to act. In general, governmental agencies have broad authority to act in the interest of the health, safety, and welfare of the public. This *police power*, as outlined in the Laws and Legal Authorities paper, gives governments the ability to take action in the public interest, including engaging in public-private partnerships or by enacting laws or regulations to address targeted public health issues. In fact, the protection of public health is a core exercise of the police power.¹ In many instances, this power is executed among multiple governmental agencies. For instance, under the Family Educational Rights Protection Act (FERPA) both state and private educational authorities and the U.S. Department of Education coordinate action to protect student records. If those records contain information related to a disability claim for a child with extreme obesity, coordination with additional jurisdictions and sectors (e.g., health law attorneys and social workers) becomes necessary.

Examples of the needed authority to prevent and control obesity by sector include the following:

- **Communities:** Urban Design and Land Use Zoning to Improve Health
 - Empower local governments under state law to enact and update comprehensive land use plans with obesity prevention elements (such as has been done in California, Oregon, Washington, and some other states). With this approach, local decision making is guided by smart growth principles such as “walkable” and “bikeable” communities.
 - Demonstrate how state governments can offer fiscal/financial incentives to local governments to regularly revise and adopt comprehensive land use plans with obesity prevention elements.²
 - Participate in environmental review laws (e.g., the National Environmental Policy Act) to require local public health and urban planning departments to conduct public health impact assessments for new developments.
 - Demonstrate how state and local authorities can offer economic development incentives and permit streamlining for development projects that foster and improve access to healthy foods to address the “food desert dilemma” found in many underserved communities.
 - Advance state and local laws to limit *siting* of quick-service restaurants within one mile (or some reasonable distance) of a public school.
 - Empower appropriate authorities with expanded authority to regulate healthy foods such as requiring mobile vendors to sell produce and other healthy snacks or prohibiting the *siting* of new quick-service restaurants in neighborhoods with a disproportionate share of such facilities.
- **Schools:** Joint Use Agreements to Improve Community Health Outcomes
 - Educate and encourage joint use agreements by state and local education agencies. Local education authorities have broad discretion about whether and how to collaborate with other sectors of government or community

organizations. To date, joint use agreements such as those discussed in the Assessing Coordination of Legal-Based Efforts across Jurisdictions and Sectors for Obesity Prevention and Control that enable schools to formalize shared ownership and/or maintenance of school facilities for broader community use during after-school hours are relatively rare. State-level policy that encourages such use could improve opportunities for schools to collaborate with local partners to meet broader community needs; this would be particularly helpful in more disadvantaged communities where there are often fewer options for safe and inviting places to engage in physical activity.

- Garner buy-in from local educational authorities by leveraging incentives for joint use arrangements as the best option to open school facilities for after-school use. Use of the community's recreational department, capital funds, supplemental grants, cost-sharing arrangements, and private philanthropy represent potential models to implement or underwrite the costs of these efforts (without interfering with an educational mandate).
- **Health Care: Monitor and Referral to Improve Access to Care and Treatment**
 - Establish coverage for comprehensive obesity counseling and health interventions for children identified as overweight or obese under state Medicaid and SCHIP programs.
 - Identify obesity reduction initiatives as a condition of award to local health agencies and other program recipients under Title V maternal and child health programs.
 - Consider classifying obesity as a reportable health condition in children and establish online registry systems so that accurate estimates can be drawn across health care sectors, including physicians offices, schools, and other settings in which health and developmental assessments in young children, school-age children, and youth are completed.
 - Incentivize states to work with their community health center primary care associations to provide obesity prevention and treatment services in medically underserved communities.
 - Permit states to prohibit insurers from underwriting obesity as a health condition in its own right in the small group and individual markets.
 - Encourage nonprofit hospitals governed by §501(c)(3) obligations to implement obesity prevention and management initiatives
 - Require managed care organizations, as a condition of participation in Medicaid and SCHIP, to offer childhood obesity prevention and treatment services.
 - Encourage state Medicaid and SCHIP programs and public and private employer sponsored group benefit plans to uniformly adopt pay for performance incentives to promote higher quality performance in obesity prevention and management at the clinical practice and health system level.
 - Make accommodation of obese patients a consideration for accreditation by the Joint Commission (formerly, The Joint Committee on the Accreditation of Hospitals)

- **Workplaces:** Use of Incentives and Wellness Programs to Improve Employee Health
 - Leverage tax incentives to attract companies with demonstrated success in promoting workplace wellness, as well as to motivate existing organizations to develop robust obesity prevention offerings. Such incentives may be especially beneficial to smaller employers and those employing a disproportionate number of persons at risk for or experiencing chronic diseases.
 - Allow local, state, tribal and federal authorities to offer tax and financial incentives to corporations to prompt or expand support of communities, schools, and health care organizations for the implementation of obesity prevention strategies. For example, incentives might be structured to both motivate and reward organizations for contributions made to support school-based obesity prevention efforts or to reduce obesogenic factors.
 - Provide federal tax deductions to individuals to minimize costs associated with participation in non-subsidized workplace wellness offerings.
 - Integrate, at the state and national levels, obesity prevention and control strategies into existing policies (e.g., OSHA regulations to incorporate in workplace safety activities, the SAFEATEA transportation bill for safe routes and bicycle paths).

American government operates under the core principle of federalism. Federal, state, and local laws outline the respective roles and responsibilities for each level of government depending on the public policy issue. In some areas, such as national defense and regulation of interstate commerce, the federal government reigns supreme, but even in these areas, Congress can identify opportunities to share that power with state and local governments. Implementation of initiatives that moves from the top-down and include all levels of government is often called vertical policy integration. Government interventions often require coordination among agencies charged with slightly different missions; this is often called horizontal policy integration. Examples of agencies and other entities that could coordinate in these ways are offered in Tables 1 and 2. Furthermore, although state and local governments have broad authority to enact and enforce laws, the authority is not unlimited. For example, under the Supremacy Clause of the U.S. Constitution, federal law can prevail over, and thus preempt, contrary state and local law³ and under state constitutions, state law can preempt local laws. The legal principle of preemption is discussed in greater detail in the companion papers on Laws and Legal Authorities.

To address questions of preemption, the benefits and risks with regard to the level of government best suited to take action must be evaluated. For example, the benefit of federal or state preemption is that the government establishes a consistent and uniform set of standards that protect individuals and foster equitable policy implementation. The risk of such preemption is that local authority cannot respond to the specific communities needs.

- **Community**
 - Ensure a certain level of uniformity and expansion of federal, tribal, state, and metropolitan/regional transportation planning and funding to foster more transit-oriented development that promotes compact and walkable neighborhoods.
 - Establish minimal levels of public health and safety protections under state housing and building codes.

- Provide incentives to maintain or revitalize town centers, especially in rural areas, to stimulate physical activity and improve healthful food options.
- **Schools**
 - Encourage state governments to follow the lead of California, Rhode Island, and Arkansas, by enacting nutritional standards for foods sold in competition with school breakfast, lunch, and snack programs (known as “competitive foods”) with the goal of having more states requiring standards for beverages and snack foods sold on K-12 campuses nationwide.
 - Ban sole source vending contracts.
 - Standardize physical education requirements so that all students have meaningful levels of training and engagement.
 - Provide school health obesity prevention and treatment grants.
- **Health care**
 - Design a uniform national benefit that includes evidence-based obesity prevention and management benefits as part of universal coverage; empower states to require greater protections (HIPAA preemption standard).
 - Expand health centers to include child and family obesity prevention and treatment services in all medically underserved communities.
 - Provide school health obesity prevention and treatment grants.
- **Workplaces**
 - Leverage federal and state tax incentives to encourage comprehensive workplace health promotion programs.
 - Reconcile state variation in policies related to the legal recognition of workplace discrimination based on employee weight.
 - Strengthen anti-discrimination policies so that they remain an important component of efforts to maintain workplace equity, yet do not constrain the ability of workplace health promotion programs to provide incentives for healthful employee behavior change. Implement by-pass provisions to ensure that innovation in behavioral intervention science is appropriately reflected in program design.⁴
 - Mandate minimum standards for commercial building codes that incorporate obesity prevention principles under state building codes.

The risk of preemption is that local and state innovations can be squelched, thus inhibiting experimentation with new ways to address recalcitrant problems, like weight control. For example, when smart growth principles are not supported or are undermined by private sector development, de facto *taking* and *eminent domain* can result. Therefore, coordination of efforts across jurisdictions and sectors should include a focus on the benefits and strengths of cooperative federalism whereby express preemption statutes include, in the legislation, a “savings clause” providing that relevant state laws are not preempted as long as they are *more* protective than the federal law. In these cases, the federal law sets a minimum, or “floor,” that the state law can build upon.

If preemption analyses answer questions of “vertical” authority between different levels of government and private sector stakeholders, questions of “horizontal” authority can arise between agencies at the same level of government or between private and public organizations. Policymakers and staff will need to identify shared interests, formulate mutual goals, and draft agreements that share power and outline roles and responsibilities. For example:

- **Community**
 - Participation in smart growth “blueprint” projects throughout California by Regional Councils of Government to jointly plan for urban growth boundaries, regional transit commitments, “green” development standards, access to open space and other amenities in the built environment that affect public health.
 - Use of Municipal Joint Powers Agreements, found in different forms in all 50 states, to administer a broad range of government services, including health care delivery, park access and maintenance, transportation agencies, and the like.
 - Support healthy food coalitions, such as The Food Trust in Philadelphia which manages a public-private partnership that brings healthy foods into low-income communities.⁵
- **Schools**
 - Employing joint use agreements with local governments is a classic example of horizontal integration. Not only can joint use agreements be established between government agencies such as school and park departments, but they also can be established between schools and nonprofit organizations such as YMCAs or youth soccer leagues to supervise and manage on-site programming.
- **Health care**
 - Sharing of BMI screening data collected in schools by school health personnel with students’ health care providers.
 - Extending communication from schools to communication with community organizations and workplace managers to create linkages to comprehensive wellness programs in those settings.
 - Facilitating information sharing in ways that address individual privacy concerns while providing access to meaningful data (e.g., the Privacy Rule of the Health Insurance Portability and Accountability Act).
- **Workplaces**
 - Provide guidance as to whether workplace health promotion for state employees represents an unfair benefit for state workers. If not, these could become model programs.

How Can Coordination Be Facilitated?

Any plan that calls for increased government action must address how coordination will occur. The legal term for collaborative processes implemented by government agencies is “procedural due process” which arises from the Fifth and Fourteenth Amendments of the U.S. Constitution and which is replicated in each state’s constitution. Procedural due process ensures the transparency of government actions, allows for public participation in

democratic governance, and can require cross-jurisdictional consultation and review. Many states have established laws (often called “sunshine laws”) to ensure that state and local government agencies make policy decisions consistent with the due process guarantees of adequate notice and a fair and open public hearing process. Procedural due process is a flexible concept that can result in various innovative strategies to ensure that public health goals are promoted throughout government action, whether by traditional command-and-control rulemaking or the development of voluntary public-private partnerships.

- **Community**
 - Require or otherwise encourage local public health departments to weigh in on the health impacts of land use decision making to ensure public health interests are protected and promoted by private and public developers.
 - Develop strong nutrition standards on which to assess and evaluate government contracts for the purchase of food for hospitals, prisons, schools, or other facilities (e.g., NYC Health Code § 41.36, requiring menu labeling in all food service establishments). Create incentives through the public contracting process, to allow public bidding processes for private sector food vendors to improve the nutritional quality of the foods served in these institutions.
 - Cultivate expertise and provide resources for community gardening, composting, and recycling.
- **Schools**
 - Incentivize schools and other agencies to work together to find appropriate sites for new (or newly rehabilitated) schools – sites that are located to encourage walking/biking to school and are in close proximity to the neighborhoods they serve.
 - Incentivize new schools, at the time of *siting*, to discuss joint use (or co-location) possibilities during the planning stages. Devise a good faith process so that the parties cannot conclude it “will not work” before an honest attempt to cooperate occurs.
- **Health care**
 - Require hospitals, community health centers, and for-profit clinics to work together to prevent duplication of services and to make sure all sectors of society are reached.
- **Workplaces**
 - Encourage public health agencies at the state and local levels to work with municipalities to integrate obesity prevention principles into commercial building codes and tax incentive policies.
 - Clarify the language and exceptions noted in applicable laws pertaining to the offer of incentives in workplace health promotion programs. These laws include Health Insurance Privacy and Portability Act, Employment Retirement Income Security Act, and Americans with Disabilities Act at the federal level and anti-discrimination laws at the state level.⁶

How Can Implementation and Enforcement of Policy Strategies Be Ensured?

All too often legislation is passed that is predominantly aspirational in nature. Lofty language is used on the intent of the legislation to address a vexing public health problem such as obesity, but two fatal flaws often occur: (1) no financial resources are committed to address problem, and (2) no enforcement provisions are included.

When legislatures pass unfunded mandates, or otherwise fail to adequately finance public health programs, the resulting legislation does little more than acknowledge that a problem exists. Although such acknowledgement may represent an important first step in incremental change, a national action plan must call for adequate financing of obesity prevention measures and programs. For example:

- **Community**
 - Expand infrastructure development and repair to enhance smart growth principals, such as in Maryland's Priority Funding Areas program. In this statewide effort, "priority funding areas" receive financial support from the state for building or repairing municipal infrastructure and promoting economic development opportunities.
 - Enhance state redevelopment law to require a percentage of Tax Increment Financing (TIF) generated in redevelopment districts to be dedicated towards smart growth developments, playground construction and repair, bike lanes and other infrastructure needs in under-resourced communities.
 - Expand support of farmers markets and community gardens via the Farm Bill or federal appropriations.
- **Schools**
 - Provide federal grants, awarded through an appropriate state level agency, to local planning teams to support joint use planning processes.
 - Offer a financial match for school capital improvement funds to encourage states to engage in joint use activities. Opportunities for joint use activities would be greatly expanded if these other governmental or community partners offered in-kind services or ongoing programming instead of financial contributions.
 - Educate states about the positive health and educational achievement outcomes of providing capital development funds to supplement school facilities financing to incentivize joint use developments. Adopting a model to finance outdoor recreation similar to those in place in some states to finance classrooms, libraries, and community theatres.
- **Health care**
 - Provide reimbursement for obesity prevention and counseling.
- **Workplaces**
 - Provide fiscal incentives in the form of tax rebates or other financial awards to facilitate the adoption and maintenance of workplace health promotion programs. The Healthy Workforce Act⁷ (pending in 2008) directly addressed this issue by providing a tax credit for the cost of a qualified workplace health promotion program of up to \$200 per employee

for the first 200 employees, and up to \$100 per employee for the remaining employees. These types of incentives could expand access to workplace health programs to workers who currently have less access (i.e., those who work part-time, earn less than \$15/hr, are blue-collar workers, and work for employers employing fewer than 100 workers).

Likewise, the good intent of legislation becomes meaningless if it does not include strong enforcement language such as incentives for action or penalties for failure to take action. As observed by John Adams almost two centuries ago, “[L]aws are a dead letter until an administration begins to carry them into execution.”

Compare, for example, the No Child Left Behind Act⁸ with the local school wellness policy provisions of the Child Nutrition and WIC Reauthorization Act of 2004.⁹ No Child Left Behind with its sweeping standards-based reform and standardized testing to measure school accountability has reverberated in every school system due to fear of financial penalties for under-performance.¹⁰ By way of contrast, as of July 2006, every school system was to have on file a school wellness policy designed to address several laudable goals. However, since the local wellness policy provision did not include any enforcement or reporting requirements, it is difficult to assess whether schools have complied.¹¹ Furthermore, the mere filing of such policies is not likely to have any real impact if dollars for implementation are lacking. Any national action plan to prevent and control obesity will need to support redrafting of the school wellness policy to include meaningful implementation and enforcement provisions.

Finally, implementation and enforcement of policy strategies can be ensured by systematically collecting information on best practices – i.e., which legal frameworks are most effective in at least potentially preventing obesity. A 50-state survey can provide the range of possible options to promote obesity prevention and control, as well as model legislation and identification of best practices. Some specific areas where such an all-state scan would be helpful include: (1) revenue raising approaches, e.g., fees and taxes, to incentivize desired behaviors and fund obesity prevention programs; (2) state and local land use regulations to increase access to healthy foods; and (3) tort liability provisions that incentivize workplace wellness programs, such as on-site exercise opportunities. Collecting and analyzing these sorts of data can facilitate innovation and promote new obesity-prevention programming.

Conclusions

Social change movements need to include legal strategies to ensure ultimate success.¹² The success of comprehensive and integrated efforts to prevent and control obesity will require legal approaches to ensure coordination and collaboration of multiple sectors across all jurisdictional levels. Such coordination and collaboration are not always the norm, as government agencies often work solely within the silos of their statutorily defined parameters, and public-private relationships are not common. In addition, legal incentives to ensure that coordination efforts address social justice concerns are crucial, as many of the most vulnerable, including racial/ethnic minorities, economically disadvantaged, individuals living in rural areas, and those of living on reservations, are at risk due to social and economic policies which are beyond individual control to address.

Further, Summit participants were mindful of the need to consider obesity prevention and control in the context of other pressing societal needs. Coordination of obesity prevention and control efforts with those of the environmental movement, for example, could produce strong partnerships, leverage scarce resources, and produce the political will needed to produce the transformational social change that a national action plan will require.

This paper attempted to summarize ideas that emerged over two days of sessions at the Summit, and is not meant to be comprehensive. In fact, several specific sectors are notably absent, including many of which are not traditional public health partners, such as transportation, environmental agencies, and a wide range of business concerns, including but not limited to food, restaurants, and electronic media. That said, we hope that the ideas gleaned from the broad ranging conversations held during the Summit as outlined in this paper will spur creative thinking and contribute to the policy aspects needed for a national action plan to prevent and control obesity.

References

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Table 1**Coordination for Obesity Prevention and Control: Examples of Vertical Policy Integration**

Federal Government	USDHHS (CDC, NCHS, HRSA, CMS, NIH, ACF), Indian Health Service, USDA, FDA, DOE, DOT, FCC, FTC
State Government	Departments of health/public health, education, transportation, revenue
Local and Regional Governments	Metropolitan planning organizations, cities/towns, counties, economic development authorities, special districts, school boards and districts, planning boards, environmental and resource agencies and committees

USDHHS: United States Department of Health and Human Services

CDC: Centers for Disease Control and Prevention

NCHS: National Center for Health Statistics

HRSA: Health Resources and Services Administration

CMS: Centers for Medicare & Medicaid Services

USDA: United States Department of Agriculture

FDA: Food and Drug Administration

DOE: Department of Education

DOT: Department of Transportation

FCC: Federal Communications Commission

FTC: Federal Trade Commission

Table 2**Coordination for Obesity Prevention and Control: Examples of Horizontal Policy Integration**

Communities	Schools	Health Care	Workplaces
<ul style="list-style-type: none"> • Planning/zoning boards • School Departments • Parks & Recreation Departments • Health Departments • YM/YWCAs • Boys and Girls Clubs • Grass roots organizations/coalitions • Councils on Aging • Social Clubs/New Americans groups • Local agriculture/farms • Chambers of commerce (for local business involvement) 	<ul style="list-style-type: none"> • School Department • School Boards • Parent-Teacher Assns • Professional (teacher) organizations • Teachers unions • Farm to school initiatives 	<ul style="list-style-type: none"> • Community Health Centers • Hospitals • Physician practices • Dental offices • Veterinarians • Health insurers • Health professional organizations (AAP, AMA) • National voluntary associations (AHA, ADA, ACS) • Allied health professionals (PTs, OTs, RDs) • Insurance organizations AHIP (Assn of health insurance providers) • Assns of insurance regulators (NAIC) and legislators (NCOIL) 	<ul style="list-style-type: none"> • Companies/Corporations • Chambers of Commerce • Unions • Workplace wellness companies (WELCO, AWHP) • Human Resources professional organizations

YM/YWCA: Young Men's/Young Women's Christian Association

AMA: American Medical Association

AAP: American Academy of Pediatrics

AHA: American Heart Association

ADA: American Diabetes Association

ACS: American Cancer Society

PT: Physical Therapists

OT: Occupational Therapists

RD: Registered Dieticians

NAIC: National Association of Insurance Commissioners

NCOIL: National Conference of Insurance Legislators

WELCO: WelCo Health Solutions

AWHP: Association for Workplace Health Promotion